Patient Label

Newborn Discharge Form

Baby's Name: _____

Mother's Name: _____

Address: _____

City: _____

Phone: _____

Birth Weight:_____
Gestational Age:_____

Newborn Assessment
Concerns/Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

If Male: Circumcised Uncircumcised

Discharge Date: _____

D/C Weight: _____

Discharge Vital Signs:
T_____HR_____RR_____

Bili Check: _____Lab_____

Hearing Screen: _____

CCHD Screen: _____

Home Visit Date/Time: _____

Newborn Follow-Up Visit Date/Time: _____
Provider:_____

Community Resources

WIC: YES NO
Form faxed: _____

Health Department:
_____

SDOH
concerns:_____
_____

Resources
given:_____
_____

Feeding: BREAST FORMULA PUMPED BREASTMILK

Number of voids: _____

Number of stools: _____

Scan into chart at discharge. Please fax to providers office where follow up appointment is made.