Postpartum Child Encounter – Newborn Status and Discharge Summary-Midwifery

Patient Label Here OR fill in details	*Maternal Details, fill in if required:*
Family Name _____	*Family Name* _____
Given Name _____	*Given Name* _____
OHIP _____	
Client Code _____	

Baby's Sex: √One □Male □Female □Ambiguous genitalia □Unknown

Head Circumference at Birth :_____cm

Infant Early Attachment/Feeding Initiation: □ Skin to skin contact uninterrupted for at least 1 hour, within the first 2 hours post birth □ Skin to skin contact with interruptions, within the first 2 hours post birth □ Skin to skin with person other than birth mother □ Opportunity to latch in first hour □ Opportunity to latch in the second hour □ Latch achieved □ No Attempt at Breastfeeding or Skin to skin contact within the first 2 hours post birth □ Transfer to NICU/SCN □ No attempt □ Unknown

Arterial Cord blood test status: √One □ Not done □ Done □ Unsatisfactory Specimen □ Unknown
Arterial Cord Blood pH: _____ Arterial Cord Blood Base/Excess/deficit:_____
Venous Cord blood test status: √One □ Not done □ Done □ Unsatisfactory Specimen □ Unknown
Venous Cord Blood pH:_____ Venous Cord Blood Base/Excess/deficit:_____

Neonatal Health Conditions: □ None □ Hyperbilirubinemia □ Hypoglycemia □ NAS - Neonatal Abstinence Syndrome □ Other □ Unknown
Neonatal Birth Complications: □ None □ Caput succedaneum □ Cephalohematoma □ Clavicular fracture □ Facial nerve injury □ Brachial plexus injury □ Birth Injury - other □ Unknown
Congenital Anomalies: □ None □ Suspected: _____ □ Confirmed: _____

Bilirubin Measured within 72 hours of Births: □ Transcutaneous bilirubin (TCB) □ Total Serum Bilirubin (TSB)
□ Newborn Transferred Out □Not Done □ Declined □ Unknown
Hyperbilirubinemia Requiring Treatment: □ Yes □ No □ Unknown
Hyperbilirubinemia Treatment: □ Phototherapy □I IVIG administration □ Exchange transfusion

Highest Serum Bilirubin >340mmol/L □ Yes □ No □ Unknown **Highest Serum Bilirubin >425mmol/L** □ Yes □ No □ Unknown

Pain Relief Measures During Newborn Screening or Serum Bilirubin: □ Sucrose □ Breastfeeding □ Skin to skin □ None □ Other □ Unknown

Newborn Screening: √One □ Not Done □ Obtained □ Declined □ Newborn transferred out □ Unknown

Newborn Hearing Screening Result: □ Pass □ Referral □Inconclusive/no result □Not Done □Unknown

Newborn Feeding from Birth to Discharge from hospital or Birth Centre: □ Breastmilk only □ Combination of breast milk and breast milk substitute □ Breast Milk Substitute-Formula only □ Breast Milk Substitute -Other □ NA □ Other □ Unknown

Reason for Breast milk Substitute: Infant Medical □Hypoglycemia □ Inborn Errors of Metabolism □ Significant weight loss in the presence of clinical indications □ Other clinical indications **Maternal Medical:** □ Active herpes on breast □ Additional health concerns □ Contraindicated maternal medication □ HIV infection □ Severe maternal illness □ Informed Parent Decision to use Any Breast Milk Substitute □ Parental consent not documented □ Birth mother not involved in care □ Unknown

Neonatal Discharged or Transfer to: □ Home □ Transfer to NICU/SCN other hospital and Name of other hospital: _____ □ Transfer to NICU/SCN same hospital □ Transfer to Paediatric unit same hospital □ Transfer to other hospital and Name of other hospital: _____ □ Child and Family Services Apprehension □Other unit, same hospital

Reason for Neonatal Transfer: □ Bed needed for sicker baby □ Condition improved □ Lack of physician coverage □ Lack of RN coverage □ No bed available □ Requires further investigation □ Requires higher level of care □Keeping baby and mother together □Care closer to home □Other □Unknown

Neonatal Transfer Date: dd/mmm/yyyy **Neonatal Transfer Time**: hours **Discharge Weight: _____** grams

If Discharged to Home or CAS: Discharge Date: dd/mmm/yyyy Time: hours **Neonatal Death:** □ No □ Yes
Death Date: dd/mmm/yyyy Death Time: hours

Additional Transfer: Newborn Transfer Back/Readmission Date: dd/mmm/yyyy **Newborn Transfer Back/Readmission Time:** hours
Newborn Discharged or Transferred To: □ Home □ Transfer to NICU/SCN other hospital
Name of hospital transfer to: _____□ Transfer to NICU/SCN same hospital □ Transfer to Pediatric unit □ Child and Family Services Apprehension

Reason for Neonatal Transfer: □ Bed needed for sicker baby □ Condition improved □ Lack of physician coverage □ Lack of RN coverage □ No bed available □ Requires further investigation □ Requires higher level of care □ Keeping baby and mother together □ Care closer to home □ Other □ Unknown

Neonatal Transfer Date: dd/mmm/yyyy **Neonatal Transfer Time**: hours **Discharge Weight: _____** grams
If Discharged to Home or Child and Family Services: Discharge Date: dd/mmm/yyyy Time: hours
Neonatal Death: □No □Yes Death Date: dd/mmm/yyyy Death Time: hours

MIDWIFERY TAB

Was care of the maternal client transferred back to Midwifery: □ Yes □ No □ Unknown
Infant discharged with Mother: □ Yes □ No □ Unknown

Newborn Feeding at 3 days: □ breastmilk only □ combination of breast milk and breask milk substitute □ breast milk substitute **-** fomula only □ breast milk substitute -other □ None □ unknown **Newborn Feeding at discharge from midwifery care:** □ breastmilk only □ combination of breast milk and breask milk substitute □ breast milk substitute **-**fomula only □ breast milk substitute -other □ None □ unknown	**Newborn Feeding at 10 days:** □ breastmilk only □ combination of breast milk and breask milk substitute □ breast milk substitute **-** fomula only □ breast milk substitute -other □ None □ unknown
Was newborn admitted to hospital in postpartum period for a postpartum complication? □ Yes □ No □ Unknown	
Was there Neonatal transport to hospital in the postpartum period □ Yes □ No □ Unknown **Was EMS used to transport to hospital?** □ Yes □ No □ Unknown **Did EMS attend in during postpartum (not the immediate postpartum)** □ Yes □ No □ Unknown	***Reason(s) for Transport:*** □ Respiratory Distress □ Other neonatal clinical indication □ other ***Primary Reason for Transport:***_____ ***(indicate)*** ***Barrier to Transport:*** □ None □ Delayed arrival time of EMS □ Delayed Departure of EMS □ Delay on rout □ other
Where there any consults, transfers of care, or use of hospital/outpatient/emergency services? Yes_____ No_____	**2 consultation records provided. If additional are needed, please attach to record**
Reason(s) for consultation/transfer of care? **Infant Consult with Physician?** Yes_____ No_____ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Infant Transfer of Care?** Yes_____ No_____	**Reason(s) for consultation/transfer of care?** **Infant Consult with Physician?** Yes_____ No_____ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Infant Transfer of Care?** Yes_____ No_____

Rationale for Transfer of Care: College/regulatory body___Hospital/physician protocol___Midwife discretion___ Parental request___Other, specify_____ **Infant Transfer of Care returned?** Yes_____ No_____ Infant Outpatient (plus emergency) Hospital Services: Yes_____ No_____	**Rationale for Transfer of Care:** College/regulatory body___Hospital/physician protocol___Midwife discretion___ Parental request___Other, specify_____ **Infant Transfer of Care returned?** Yes_____ No_____ Infant Outpatient (plus emergency) Hospital Services: Yes_____ No_____