

# INITIAL EXAMINATION

V2009

Date:..... Time:..... hr.

Age at examination: .....

SGA <10% Yes ☐

Family history: .....

Identification or Patient identity sticker for **BABY**

Surname .....

Forename(s) .....

Hospital No. ....

Referral to NOC: Yes ☐ No ☐

Referral to Audiology: Yes ☐ No ☐

BCG Required: Yes ☐ No ☐

Reason: .....

Date given:..... Site: .....

By:..... BLOCK CAPITALS Batch No:.....

Hepatitis B vaccination required: Yes ☐ No ☐

Date given:..... Site: .....

Jaundice: Yes ☐ No ☐

By:..... BLOCK CAPITALS Batch No:.....

OFC: ..... cms

|                | Normal                   | Abnormal                 | Details                                                                                |
|----------------|--------------------------|--------------------------|----------------------------------------------------------------------------------------|
| Skin           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Skull          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Sutures        | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Fontanelles    | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Facies         | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Palate         | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Ears           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Eyes           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Red reflex     | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Mouth          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Chest          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Heart          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Femoral pulses | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Abdomen        | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Umbilical Cord | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Genitalia      | <input type="checkbox"/> | <input type="checkbox"/> | Both testes in scrotum? Yes <input type="checkbox"/> No <input type="checkbox"/> ..... |
| Anus           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Hips           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Spine          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Hands          | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |
| Feet           | <input type="checkbox"/> | <input type="checkbox"/> | .....                                                                                  |

Malformation: Yes ☐ No ☐ Specify .....

Birth Trauma: Yes ☐ No ☐ Specify .....

Passed Urine: Yes ☐ No ☐

Passed Meconium: Yes ☐ No ☐

Feeding: Breast ☐ Bottle ☐ Combined ☐

Other relevant issues: .....

Can be discharged without any further examination: Yes ☐ No ☐

If NO please specify reasons: .....

Examination discussed with the parents Yes ☐ No ☐

Examined by: Surname:..... Forename:..... Signature:.....  
please print

ANNP/Midwife/Paediatrician (delete as appropriate)

# RESUSCITATION

V2009

Nil required ☐

Facial Oxygen only ☐

Meconium below cords Yes ☐ No ☐  
(do not visualise if baby active and crying)

Heart rate at 1st assessment: ☐ Slowing  
☐ Accelerating  
☐ Constant

IPPV GIVEN: ☐ Face mask for.....min  
☐ Intubation at .....min

Identification or Patient identity sticker for **BABY**

Surname .....

Forename(s) .....

Hospital No. ....

Comments:

## Times from moment of delivery:

First Gasp or Cry < 1 min ☐  
or specify ..... mins

Time to Regular respiration  
..... mins

Please put any other details on Sheet 2.9.4

## Assessment 1 min 5 min 10 min

### Heart Rate:

>100 ☐ 2 ☐ 2 ☐

<100 ☐ 1 ☐ 1 ☐

Absent ☐ 0 ☐ 0 ☐

### Respiratory Effort

Regular ☐ 2 ☐ 2 ☐

Irregular ☐ 1 ☐ 1 ☐

Absent ☐ 0 ☐ 0 ☐

### Muscle Tone

Normal with movt. ☐ 2 ☐ 2 ☐

Normal no movt. ☐ 1 ☐ 1 ☐

Limp ☐ 0 ☐ 0 ☐

### Colour of Trunk

Pink ☐ 2 ☐ 2 ☐

Blue ☐ 1 ☐ 1 ☐

White ☐ 0 ☐ 0 ☐

### Response to Stimuli

Cry ☐ 2 ☐ 2 ☐

Grimace ☐ 1 ☐ 1 ☐

None ☐ 0 ☐ 0 ☐

APGAR SCORE ☐ ☐ ☐

## UMBILICAL BLOOD GASES

## ARTERY

## VEIN

pH

pCO<sub>2</sub>

pO<sub>2</sub>

BE

No. Vessels

Hard copy filed in CTG Envelope

Names of all present at Resuscitation  
(please print)

## NAME

## POSITION