

USNH ROTA, SPAIN PEDIATRICS/FAMILY PRACTICE SERVICES

NMCRS VISITING NURSE NEWBORN ASSESSMENT

IDENTIFYING INFORMATION:

Last Name: _____ First Name: _____ SSN: _____
 Mother's Name: _____ Age: _____ Gravida: _____ Para: _____ Current Live: _____ Abs: _____
 Type of Delivery: _____ Associated Problems: _____
 DOB: _____ Apgars: _____ / _____ Sex: _____ Weeks Gestation: _____ Breast Bottle
 Obstetrician/FP Provider: _____ Pediatrician/FP Provider: _____
 Source of Contact: Patient Request / Routine MNB Contact / Referred by: _____

BIRTH WEIGHT: _____	LENGTH: _____	HC: _____
DATE OF DISCHARGE: _____	DISCHARGE TCB: _____	
DISCHARGE WEIGHT: _____	% WEIGHT LOSS: _____	

DATE OF HOME VISIT: _____ **VITAL SIGNS: (T) (P) (R)** _____

CURRENT WEIGHT: _____ **% WEIGHT LOSS:** _____

CURRENT TCB: _____ **COMMENTS:** _____

BREASTFEEDING WELL? YES NO N/A **FREQUENCY:** _____ **AMT/TIME:** _____

WET DIAPERS/DAY: _____ **STOOLS/DAY:** _____ **COLOR:** _____ **TEXTURE:** _____

DATE : _____ **WEIGHT:** _____ **%WT. LOSS:** _____ **TCB:** _____ **VS:(T) (P) (R)** _____

COMMENTS: _____

DATE : _____ **WEIGHT:** _____ **%WT. LOSS:** _____ **TCB:** _____ **VS:(T) (P) (R)** _____

COMMENTS: _____

Signature of Visiting Nurse **Date**

Signature of Physician **Date**

PATIENT'S IDENTIFICATION (Use this space for Medical Imprint)

RECORDS MAINTAINED AT:		
PATIENTS NAME		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSORS NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH
CHRONOLOGIC RECORD OF MEDICAL CARE		STANDARD FORM 600 (REV.1-05) USNHR OP FP600-7/7-08