MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
ADMISSIONS	NAVHOSPPNCLAINST 6010.9W	03 Dec 2012

LOCAL FORM TITLE *(Optional)*
NEWBORN ADMISSION ORDERS

Date: _____ Time: _____

1. **Admit:** Newborn
   ☐ Peds ☐ Family Medicine Dr. _____
2. **Diagnosis:** ☐ Term ☐ Pre-Term ☐ Post Dates ☐ SGA ☐ LGA ☐ Other _____
3. **Condition:** ☐ Good ☐ Other: _____
4. **Vital signs:** After birth, then Q 30 min x4, then Q 1 hr x2, then Q 8 hr. If mother is GBS+, then Q 4 hrs for 48 hrs.
5. **Call Parameters:** Temp (rectal) > 100.4 (39.0) or < 97.5 (36.4) RR > 60 or < 20 HR > 180 or < 100 dex < 40
   Urine output < 0 ml over 24 hours or no stool in 48 hours.
6. Record weight, length, and head circumference and plot on growth curves. If SGA, IUGR, or < 37 WGA, perform Dubowitz/Ballard scoring.
7. **Bathe:** per protocol when temperature stable. After bath, leave on radiant warmer until temp stable, then move to open crib.
   Check temp after 1 hour. If < 97.5, initiate hypothermia protocol.
8. Daily weights on same scale; length and head circumference day of discharge
9. Record all stools and voids
10. Newborn / Parent teaching per protocol
11. **Medications:** Phytonadione (Vitamin K) 1 mg IM x1
    Erythromycin ophthalmic ointment to both eyes x 1
    Hepatitis B vaccine, 0.5 ml IM x1
12. **Diet:** Breastfeed on demand, at least Q 5 hours, using hunger cues, **OR** Bottle feed 20 cal formula with iron Q 3-4 hours or on demand.
13. **Labs:** **IF** chorioamnionitis **and** asymptomatic; blood culture, CBC / CRP. Notify MO.
14. **Initiate Hypoglycemic Protocol Order Set for:** IDM, GDM, LGA, SGA, < 37 or > 42 WGA, < 2500 or > 4000 gm, post asphyxia, polycythemia, cold stress/hypothermia.
15. If mother Rh negative or blood type O, obtain infant's type and coombs. Notify Mo if DAT+
16. IMS (newborn screen) > or = 24 hours **AFTER** birth
17. Infant Hearing Screen prior to discharge

DAY OF DISCHARGE:

18. Transcutaneous bilirubin. If > 95 percentile for age, draw serum level.
19. Schedule Newborn Care Clinic appt

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	