Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby’s HCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s HCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*HCP: Healthcare Provider*

**Baby**

**Birth Weight: Length at Birth:**

**[]** Active/Good Color **[]** Sleeping, Good Color **[]** Jaundiced, Lethargic **[]** Other

**Mother**

**[]** Good **[]** OK **[]** Fair **[]** Poor

**Interval History: Questions for Mother:**

Gestation age at delivery: \_\_\_\_\_\_\_\_\_\_ How are you feeling?

APGAR Score: 1 min 5 Max How did the delivery go?

Medication(s) for Baby: Delivery Location:

 **[]** Hospital **[]** BS

**[]** Home **[]** Other

Injury or Illness: \_\_\_\_\_\_\_\_\_\_ Type of Delivery:

 **[]** Vaginal  **[]** Cesarean Section

Special Health Care Needs: Length of Baby’s Hospital Stay:

 | Routine | Non-Routine (< one week) |

|One week to one Month | Over one Month|

Visit to Health care Providers or facilities: What do your children think about the new baby?

Changes/stressors in family or home: What are your questions about feeding the baby?

Notes: Questions or concerns?

Weight: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Head Circumference: \_\_\_\_\_\_\_\_\_\_\_ BMI %: \_\_\_\_\_\_\_\_\_\_\_

**[]** Birth Control **[]** 6 Week Postpartum Follow-up

**Anticipatory Guidance**

**Healthy Habits Family Relationships**

**[]** Car Seat **[]** Shaken Baby Syndrome **[]** Partner Involvement

**[]** Crib Safety **[]** Rest, Fatigue, Depression

**[]** SIDS/Tummy Time **[]** Support from Family/Friends

**[]** Water Temperature <120 degrees **[]** Sibling’s Reactions:

**[]** Keep Hand on Baby

**[]** Smoke-free Environment

**[]** Hot Liquids, Cigarettes

**[]** Signs of Illness

**[]** Emergency Procedures

**Nutrition Other Needs**

**[]** Successful Breastfeeding Practices **[]** Offer Materials for Reviews at Home on Child

 (Positioning, Latching on, Feeding on Cue) Safety, Childproofing Home, Breastfeeding

**[]** 6 or 8 Wet Diapers per Day **[]** Suggest Resources to Help with Breastfeeding

**[]** Maternal Care (Rest, Nipple Care, Eating Properly, **[]** Provide Information about Parenting Classes or

 Following-up Support) Support Groups

**[]** Formula (Preparation, Equipment, Semi-Sitting Position) **[]** Suggest Community Resources

**[]** No Bottle in Bed or Microwave **[]** Discuss How to Access Health Care

**Infant Care Referrals**

**[]** Cordially, Intact Penis or Circumcision Care **[]** Health Insurance/Medicaid

**[]** Vaginal Discharge, Bleeding **[]** SSI

**[]** Skin, Nails **[]** Part C

**[]** Crying **[]** Immunizations **[]** WIC

**[]** Sneezing, Hiccups **[]** Food Stamps

**[]** Burping, Spitting Up **[]** Social Services

**[]** Thumb Sucking, Pacifiers **[]** Housing

**[]** Sleep Patterns, Arrangements **[]** Other:

**[]** Thermometer Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[]** Layers of Clothing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Infant Interaction**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[]** Baby’s Temperament \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[]** Console Baby \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[]** Hold, Cuddle, Rock \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[]** Talk, Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Signature & Date:**

**EHS Health Staff Signature & Date:**