N432 Newborn Care Plan

Lakeview College of Nursing

Shawn Weber

Demographics (10 points)

Date & Time of Clinical Assessment 05/20/21 @ 1945	**Patient Initials** N.K.	**Date & Time of Birth** 05/19/21 @22:53	**Age (in hours at the time of assessment)** 21 hours
Gender Male	**Weight at Birth** **(gm)** 3275 **(lb.)** 7 **(oz.)** 3.5	**Weight at Time of Assessment** **(gm)**3300 **(lb.)** 7 **(oz.)** 4.4	**Age (in hours) at the Time of Last Weight** 21 hours
Race/Ethnicity Caucasian	**Length at Birth** **Cm** 51 **Inches** 20.08	**Head Circumference at Birth** **Cm** 33.6 **Inches** 13.19	**Chest Circumference at Birth** **Cm** 33 **Inches** 12.99

There are times when the weight at the time of your assessment will be the same as birth

Mother/Family Medical History (15 Points)

Prenatal History of the Mother:

GTPAL: G2 T1 P0 A1 L1

When prenatal care started: 8 weeks.

Abnormal prenatal labs/diagnostics: Group Beta Streptococcus positive at 28 weeks. HGB 11.4, HCT 32.8, Spontaneous Membrane Rupture. Peripheral streaking on infant Chest X-ray.

Prenatal complications: Mother has complaints of iliac instability unrelated to the infant

Smoking/alcohol/drug use in pregnancy: Never smoked, denies alcohol or drug use during pregnancy.

Labor History of Mother:

Gestation at onset of labor: 37 weeks 1 day

Length of labor: 13 hours 19 minutes

ROM: Spontaneous membrane rupture with a partial leak at home, Artificial rupture of membrane performed in hospital.

Medications in labor: Oxytocin, Fentanyl & Ropivacaine epidural

Complications of labor and delivery: Slight right labial tear

Past Surgical History: Tonsillectomy

Family History: Asthma, depression, post-partum psychosis

Pertinent to infant: Post-partum psychosis prior pregnancy, potential withdrawal from mother's antidepressant medications.

Social History (tobacco/alcohol/drugs): Never smoked does not use alcohol or illicit drugs.

Pertinent to infant: N/A

Father/Co-Parent of Baby Involvement: Father is involved, has one other child with mother.

Living Situation: Father and mother married and live with 5-year-old-daughter.

Education Level of Parents (If applicable to parents' learning barriers or care of infant): The mother has some college education and has a background working as medical assistive personnel. She quit her job last year to become a full time stay at home mom. No information on father.

Birth History (10 points)

Length of Second Stage of Labor: O hr. 19 min

Type of Delivery: Induced vaginal delivery

Complications of Birth: Nuchal cord x1

APGAR Scores:

1 minute: 8 (blue/pale skin)

5 minutes: 9 (body pink, extremities blue)

Resuscitation methods beyond the normal needed: Suctioned clear liquid from the newborn's airway.

Feeding Techniques (10 points)

Feeding Technique Type: Currently NPO, mother intends to breastfeed as soon as she able to.

If breastfeeding: N/A

LATCH score: N/A

Supplemental feeding system or nipple shield: N/A

If bottle feeding: N/A

Positioning of bottle: N/A

Suck strength: N/A

Amount: N/A

Percentage of weight loss at time of assessment: Client is approximately 100.76 % of birth weight. Increase in weight is due to continuous IV 10% Dextrose. 3300gm/3275gm=100.76%

****Show your calculations; if today's weight is not available, please show how you would calculate weight loss (i.e. show the formula)****

What is normal weight loss for an infant of this age? Newborns can lose up to 10% of birthweight after 3 or 4 days (Ricci et al., 2020, p. 607), this client appears to have mostly maintained due to the infusion of fluids.

Is this neonate's weight loss within normal limits? N/A

Intake and Output (8 points)

<u>Intake</u>

If breastfeeding: N/A

Feeding frequency: N/A

Length of feeding session: N/A

One or both breasts: N/A

If bottle feeding: N/A

Formula type or Expressed breast milk (EBM): N/A

Frequency: N/A

Volume of formula/EBM per session: N/A

If EBM, is fortifier added/to bring it to which calorie content: N/A

If NG or OG feeding: Client has an orogastric tube inserted, however no feeding is being performed at this time.

Frequency: N/A

Volume: N/A

If IV:

Rate of flow: 9.6 mL/hr.

Volume in 24 hours: 230.4 mL once 24 hours of fluids has elapsed.

Output

Age (in hours) of first void: 0 hrs. 0 min.

Voiding patterns: Voiding approximately every 2-4 hours based off charting.

Number of times in 24 hours: 6

Age (in hours) of first stool: 2 hours 7 minutes (0100 on 05/20/21)

Stool patterns:

Type: Meconium

Color: Dark Green

Consistency: Thick

Number of times in 24 hours: 3

Laboratory Data and Diagnostic Tests (15 points)

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Name of Test	Why was this test ordered for THIS client? *Complete this even if these labs have not been completed*	Expected Results	Client's Results	Interpretation of Results
Blood Glucose Levels	This test is looking for hypoglycemia in the newborn (Ricci et al., 2020).	45-90mg/dL	56 mg/dL	Blood Glucose is within normal limits.
Blood Type and Rh Factor	This test is to assess for potential Rh incompatibility between the newborn and the mother. Screen for hemolytic disease of the newborn (Ricci et al., 2020).	O negative	O Rh-	Match in blood type between the mother and the newborn.
Coombs Test	To assess for foreign antibodies in the infant's blood attacking the newborn's erythrocytes, used to check for hemolytic disease of the newborn (Ricci et al., 2020).	Negative for immunoglobins attacking the newborn's erythrocytes.	N/A	The Coombs test has not been performed on this client.

Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	To assess for liver function and to check if newborn's RBC are going through hemolysis.	In adults typically no higher than 5 mg/dL, in neonates can be as high as 10 mg/dL due to short lifespan of RBC Ricci et al., 2020).	N/A	This test has not yet been performed
Newborn Screen (At 24 hours)	Performed shortly after birth to detect for birth defects undetectable prior to the infant's birth.	Unavailable until post-discharge. The client does not have any fatal birth defects that were undetectable prior to birth.	(If available—these may be not available until after discharge for some clients)	This screening is not available until post-discharge.
Newborn Hearing Screen	Hearing loss is a common birth disorder. This screening is to detect infant's that likely have hearing loss (Ricci et al., 2020).	The newborn has intact hearing.	N/A	This screening has not yet been conducted.
Newborn Cardiac Screen (At 24 hours)	To detect defects in the newborn heart/cardiac system.	No congenital defects of the cardiac.	N/A	This test has not yet been performed.

Lab Data and Diagnostics Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Newborn Medications (7 points)

Brand/Generic	**Vitamin K/ Aquamephyton**	**Illotycin/ Erythromycin Ointment**	**Recombivax/ Hepatitis B Vaccine**	**Omnipen/ Ampicillin**	**Instant Glucose/ Dextrose 10%**

Dose	0.5 mL = 1 mg	1 drop per eye	0.5 mL	219 mg/7.3 mL	9.5521 mL/ hr.
Frequency	1 @ 2322	2322	1 @ 2322	Q8H	Continuous infusion
Route	Intramuscular	Topical ointment	Intramuscular	Intravenous	Intravenous
Classification	Vitamin	Antibiotic	Viral vaccine, inactivated	Antibiotic	Carbohydrate
Mechanism of Action	Utilized by the body to create clotting factor, can be deficient in newborns.	Bactericidal to potential contact with gonorrhea or chlamydia during birth.	Gives active immunity against Hepatitis B by exposure to the newborns immune system.	Inhibits the synthesis of bacterial cell walls.	Increases circulating blood glucose while supplying the body with fluids and carbs.
Reason Client Taking	Prophylactic medication given to increase the coagulability of the newborn's blood.	Prophylactic given to newborns to prevent ophthalmia neonatorum which can cause blindness.	Vaccination to build immunity to Hepatitis B.	Group B Streptococcus positive in mother.	Client is currently on NPO.
Contraindications (2)	Hypersensitivity vitamin K, hypercoagulability.	Hypersensitivity to erythromycin or other macrolide antibiotics. Concurrent simvastatin therapy.	Newborns with a past reaction to a Hepatitis B vaccination should not receive following shots. Hypersensitivity to yeast.	Hypersensitivity to penicillin antibiotics, infection due to penicillinase producing organism.	Hyperglycemia, overhydration.
Side Effects/Adverse Reactions (2)	Hypercoagulation, tachycardia.	Hepatotoxicity, Jaundice.	Low fever, irritation at injection site.	Laryngeal stridor, diarrhea.	Hyperglycemia, hypotension.
Nursing Considerations (2)	Administer within 1 to 2 hours after birth.	Wear gloves and administer into the	The first dose is usually to be given within	Monitor closely for signs of anaphylaxis.	Assess infusion site for signs of irritation or

	Intramuscular into the outer third of the vastus lateralis muscle at a 90º angle.	conjunctival sac of the inner canthus or outer canthus. Be careful not touch the eye.	12 hours of birth, A total of 4 doses is acceptable for most clients.	Monitor renal/hepatic labs.	swelling. Can affect bodily fluid osmolarity leading to dehydration .
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor client's PT, and for client's platelet count.	Check for hepatic function before administrati on. Assess client heart rate/rhythm.	Confirm the hepatitis status of mother. Check client's surface antigen test.	Assess for baseline WBC count. Assess labs for client's renal function.	Assess baseline electrolytes and blood glucose levels.
Client Teaching needs (2)	Adverse reactions can happen very rapidly, report any signs of respiratory distress or rash. Medication is given to newborn to provide body with what it needs to produce clotting factor.	Inform caregivers, this medication is given as a universal prophylaxis to help prevent potential blindness. Inform healthcare personnel of any signs of irritation.	This disease is spreadable through bodily fluids and can be highly damageable to the liver.	Review signs of anaphylaxis with caregivers. Have caregivers report long term diarrhea.	Report any signs of IV site irritation. Monitor for signs of FVO or FVD with these fluids.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.).

Ricci, S. S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Newborn Assessment (20 points)

Area	Your Assessment	Expected Variations and Findings *This can be found in your book on page 623*	If assessment finding different from expectation, what is the clinical significance?
Skin	Smooth, dry, warm, good perfusion, pink with some jaundice undertones seen in client's ears. 1 cm oval shape, slightly darker discoloration on clients left forearm.	Smooth, flexible, good skin turgor, well hydrated, warm, skin color consistent with client race/ethnicity.	Jaundice undertones is not abnormal for newborns, as their liver has just begun normal function.
Head	Soft, normocephalic.	Varies with age, gender, ethnicity. Symmetrical and normocephalic.	No abnormal findings.
Fontanels	Soft and flat anterior fontanel open with diamond shape, and posterior fontanel with triangular shape.	Diamond-shaped anterior fontanel, triangular shaped posterior fontanel.	No abnormal findings.
Face	Symmetrical facial features with full cheeks.	Full cheeks with symmetrical facial features.	No abnormal findings.
Eyes	Clear, equal pupils, ears online with ears.	Clear symmetrical eyes lined up with ears.	No abnormal findings.
Nose	Small, narrow, midline of face, nares symmetrical and patent. Nasal canula in client's nares.	Small, midline and narrow, ability to smell.	No abnormal findings.
Mouth	Symmetrical, midline, lips intact. Oral mucosa moist	Midline, symmetric, intact soft and hard	No abnormal findings.

	with hard and soft palate intact.	palate.	
Ears	Pliable with quick recoil, online with eyes. Patent ear canals.	Soft and pliable with quick recoil when folded and released.	No abnormal findings.
Neck	Creased, moves freely in all directions, no webbing of neck noted.	Short, creased, moves freely, baby holds head midline.	No abnormal findings.
Chest	Round, symmetric, slightly narrower than head with barrel shape.	Round, symmetric, smaller than head.	No abnormal findings.
Breath Sounds	Fine crackles in bilateral lower lobes. Bronchovesicular breath sounds in all other lobes.	Bronchovesicular breath sounds in bilateral lungs.	Client was brought to the NICU for monitoring due to some respiratory distress.

Heart Sounds	Audible S1 and S2 with regular rhythm.	S1, S2 heart sounds. Absent S4, S4 or murmurs. Regular rate/rhythm.	No abnormal findings.
Abdomen	Protuberant, contour, and soft. Belly movements with respirations.	Protuberant, contour, soft. Abdominal movements with respirations.	No abnormal findings.
Bowel Sounds	Auscultated bowel sounds in all 4 quadrants.	Bowel sounds in all 4 quadrants.	No abnormal findings.
Umbilical Cord	Large umbilical vein and 2 smaller arteries visible in umbilicus	Three vessels in the umbilical cord. Large vein and 2 small arteries.	No abnormal findings.
Genitals	Client is uncircumcised at this time, testes firm and equal size in both sides of scrotal sac.	Smooth glans, meatus centered at tip of penis.	No abnormal findings.
Anus	Patent due to passing of meconium, no redness.	Normal position, patency evidenced by passing meconium.	No abnormal findings.
Extremities	20 digits intact. Hands arms, legs, feet all symmetrical. Full range of motion.	Symmetrical with free movement. All 20 digits intact. Full range of motion.	No abnormal findings.
Spine	Symmetrical, midline, no signs of abnormal spinal curvature.	Symmetrical and palpable along entire length. Nor curvature.	No abnormal findings.
Safety • **Matching ID bands with parents** • **Hugs tag** • **Sleep position**	Matching parental bands, HUGS tag present on left foot, client is swaddled and sleeping supine.	Matching parental bands hugs tag on client's foot. Sleeping on back swaddled.	No abnormal findings.

Complete the Ballard Scale grid at the end to determine if this infant is SGA, AGA, or LGA—be sure to show your work

What was your determination? Client scored a 40. Appropriate for client's gestational age. (AGA)

Are there any complications expected for a baby in this classification? No expected complications.

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	98.1 ºF (36.7)	152	48
4 Hours After Birth	98.7 ºF (37.1)	130	38
At the Time of Your Assessment (1943)	98.3 ºF (36.8)	132	79

Vital Sign Trends: Respirations have fluctuated and were higher during assessment due to client crying/distress. Temperature has been stable and consistent since birth. Pulse was highest at birth and seems to have stabilized around 130.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1945	NIPS (Neonatal Infant Pain Scale)	N/A	0 Fascial Expression: 0 Cry: 0 Arms: 0 Legs: State of Arousal: 0	Client appears to be comfortably sleeping, no crying/grimacing/ or flailing of extremities.	No interventions at this time.

Summary of Assessment (4 points)

Discuss the clinical significance of the findings from your physical assessment:
****See the example below****

This neonate was delivered on 5.15.14 at 0522 by normal spontaneous vaginal delivery (NSVD). Nuchal cord x1. Apgar scores 1/3/9. EDD 5.10.14 by US. Dubowitz revealed neonate is 39 2/7 weeks and LGA. Prenatal hx complicated by PIH and GDM (diet controlled). Birth weight 9 lbs 4 ozs (4440 grams), 21" long (53.34 cms). Upon assessment all systems are within normal limits. Last set of vitals: 38.4/155/48. BS x3 after delivery WNL with lowest being 52. Neonate is breastfeeding and nursing well with most feedings 20"/20" q2-3 hrs. Bilirubin level at 24 hours per scan was 4.9. Neonate expected to be discharged with mother later today and to see pediatrician in the office for first well baby check within 48 hours.

This neonate was delivered on 05.19.21 at 2253 by induced vaginal delivery. Nuchal cord x1. APGAR scores of 8/9. EDD 06.06.21 by US Dubowitz reveals neonate is 37 1/7 weeks and AGA. Prenatal hx was uncomplicated. Birth weight 7 lb. 3.5 oz (3275 gram), 20.08" (51 cm). Upon assessment all systems are within normal limits. Last vitals: 36.8/132/79. BS x1 after delivery within normal limit at 56g/dL. Receiving 10% Dextrose intravenously at 9.6mL/hr. Bilirubin level scan at 24 hours has not been conducted at this time. Neonate is expected to discharge with mother in one week's time and is to FU with family practice physician one business day post discharge.

Nursing Interventions and Medical Treatments for the Newborn (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
HR, RR, and temperature on monitor "N"	Continuous	Client brought to NICU for respiratory distress, vital monitor allows for assessment of improving/worsening condition.
Assessment/ auscultation of lungs sounds every 2-4 hours. "N"	Q4H	To assess for improvement of lung sounds.
Supplemental airflow and oxygen. "T"	Continuous	Nutritional/carb replacement while neonate is on NPO status.
IV ampicillin every 8 hours "T"	Q8H	Mother tested positive for Beta Streptococcus; neonate shows signs of respiratory distress.

Discharge Planning (2 points)

Discharge location: Infant will be discharged to home with parents once he is cleared of symptoms of respiratory distress.

Equipment needs (if applicable): None implicated at this time.

Follow up plan (include plan for newborn ONLY): Plan to follow up with family practice physician the day following discharge.

Education needs: Client may need refresher on breastfeed. Education on warning signs of post-partum depression and psychosis as mother has a history of postpartum psychosis in previous pregnancy.

Nursing Diagnosis (30 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (2 pts each)** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for impaired gas exchange related to episode of acute respiratory distress as evidenced by being placed on	The client suffered an episode of respiratory distress. Newborns are under high susceptibility	**1.** Monitor effectiveness of supplemental air with O2 sat monitoring. **Rationale** Client was put on supplemental air flow to help promote lung	Newborn maintained O2 sat above 98%. Client's lung sounds become clearer upon auscultation.

airflow via NC in the NICU.	to respiratory complications.	expansion and gas exchange. **2.** Perform Auscultation of lung sounds every 2-4 hours. **Rationale** Crackles can be heard bilaterally in the base of the lungs.	
2. Ineffective feeding pattern as evidenced by newborn being unable to latch to mother's breast and related to being placed on an NPO status.	The client being put on NPO status without being able to feed puts him at a higher risk of malnutrition.	**1.** Provide refresher teaching to mother on proper breast feeding. **Rationale** Infants require a lot of nutrition to grow, and have very small stomach capacity, which means they require feedings every 2-4 hours (Ricci et al., 2020). **3.** Encourage mom to hold newborn in breastfeeding position. **Rationale** This can simulate how the newborn will be held while he is being fed. The contact can also help the client bond with the mother.	Client's mother verbalizes the importance of regular feedings every2-4 hours while the infant is awake. Mother bonds with her newborn.
4. Risk for injury related to mental health issues/depression suffered by mother as evidenced by mother experiencing post-partum psychosis (PPP) with previous pregnancy.	Post-partum psychosis is a rare emotional disorder that can potentially lead to suicide or infanticide (Ricci et al., 2020). As the client had it once before it is more likely to happen again.	**1.** Assess mother for signs of PPD or PPP and try to help her identify what could be warning signs of it happening again. **Rationale** Acknowledging signs of postpartum psychosis could help prevent the child from being put in any danger. **2.** Teach the importance of the client maintaining good nutrition, adequate rest, and good family/partner	Mother states the importance of recognizing the warning signs of PPP episodes as well as understands the teaching on good coping mechanisms.

		support systems to help her improve her coping mechanisms. **Rationale** Reducing the stress as much as possible for the client can reduce the likelihood of exacerbation of PPD.	
5. Risk for impaired skin integrity related to HUGS tag and nasal canula being placed on client as evidenced by erythema.	NC and HUGS tag being placed for extended periods of time may lead to erythema/skin breakdown.	**1.** Inspect for redness around the nostrils, back of ears and on the limb with the HUGs tag every 2-4 hours. **Rationale** Detecting skin irritation early on can prevent further breakdown or infection. **2.** Frequently readjust Nasal Cannula as needed. **Rationale** The newborn frequently moves the cannula, either knocking it out of position. Frequent adjustments keep it in the correct position and not too tight on the client.	Neonate is free of any skin breakdown and the Nasal Cannula stays in the correct positioning.

Teaching Topics:

1. The newborn is at an increased risk of ineffective infant feeding patterns due to failure to initially latch on mothers' breast at birth and being placed on NPO status shortly after. Seeing as mother had a child previously, she would likely only need brief refresher on proper breastfeeding technique and the child's feeding regiment. The goal of the teaching is to improve the neonate's nutritional status as soon as is taken off NPO.

2. The mother suffered from post-partum psychosis with her last child, which as a rare but potentially dangerous emotional disorder. Discussing with her emotional/stress triggers can help

her identify potential risk factors to predict negative on coming symptoms. Also discussing coping mechanisms and making a support system to help her handle stress may prevent exacerbations of the mental disorder. The goal of this training is to promote better mental health which will in turn promote better safety for the client and the mother.

Other References (APA): N/A

Ballard Gestational Age Scale

Neuromuscular Maturity

Score	−1	0	1	2	3	4	5
Posture							
Square window (wrist)	> 90°	90°	60°	45°	30°	0°	
Arm recoil		180°	140–180°	110–140°	90–110°	< 90°	
Popliteal angle	180°	160°	140°	120°	100°	90°	< 90°
Scarf sign							
Heel to ear							

Physical Maturity

Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; rare veins	Parchment, deep cracking; no vessels	Leathery, cracked, wrinkled
Lanugo	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	
Plantar surface	Heel-toe 40–50 mm: −1 < 40 mm: −2	> 50 mm, no crease	Faint red marks	Anterior transverse crease only	Creases anterior 2/3	Creases entire sole	
Breast	Imperceptible	Barely perceptible	Flat areola, no bud	Stippled areola, 1–2 mm bud	Raised areola, 3–4 mm bud	Full areola, 5–10 mm bud	
Eye/Ear	Lids fused loosely: −1 tightly: −2	Lids open; pinna flat; stays folded	Slightly curved pinna; soft; slow recoil	Well curved pinna; soft but ready recoil	Formed and firm, instant recoil	Thick cartilage, ear stiff	
Genitals (male)	Scrotum flat, smooth	Scrotum empty, faint rugae	Testes in upper canal, rare rugae	Testes descending, few rugae	Testes d good rugae	Testes pendulous, deep rugae	
Genitals (female)	Clitoris prominent, labia flat	Clitoris prominent, small labia minora	Clitoris prominent, enlarging minora	Majora and minora equally prominent	Majora large, minora small	Majora cover clitoris and minora	

Maturity Rating

Score	Weeks
−10	20
−5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

Ballard Score: 40

CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE [1,2]

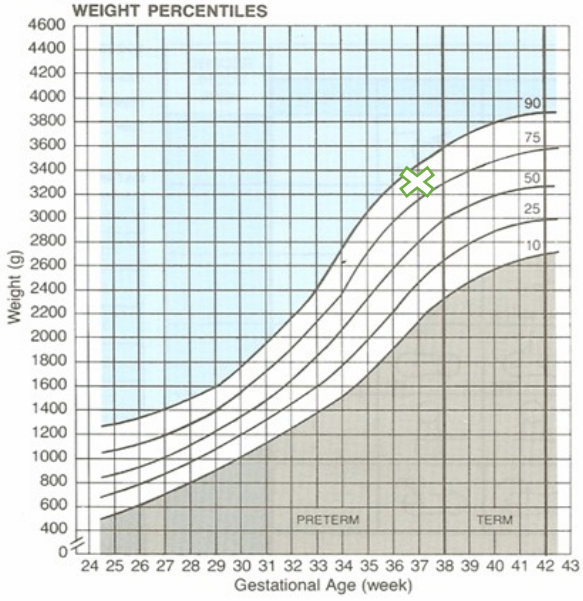
NAME _____ DATE OF EXAM _____ LENGTH _____

HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

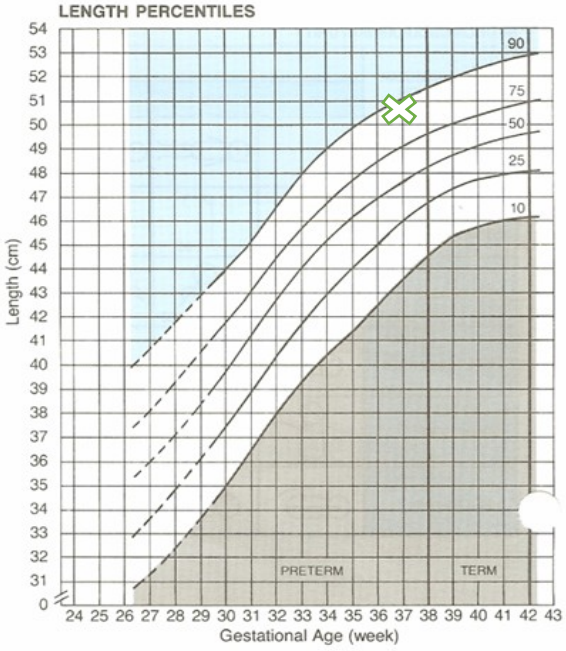
RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____

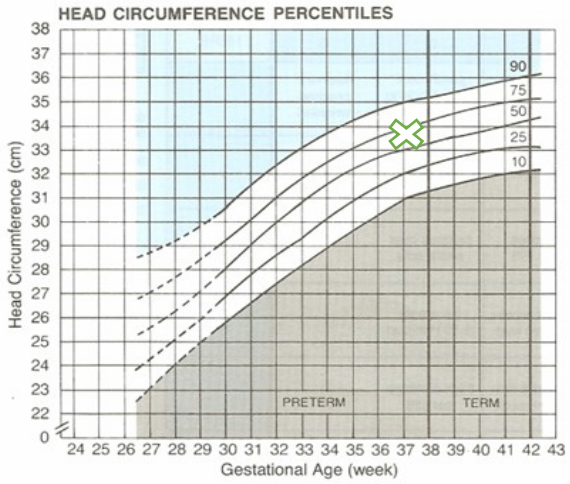
WEIGHT PERCENTILES



LENGTH PERCENTILES



HEAD CIRCUMFERENCE PERCENTILES



CLASSIFICATION OF INFANT*	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)			
Appropriate for Gestational Age (AGA) (10th to 90th percentile)	X	X	X
Small for Gestational Age (SGA) (<10th percentile)			

*Place an "X" in the appropriate box (LGA, AGA or SGA) for weight, for length and for head circumference.

References
1. Battaglia FC, Lubchenco LO: A practical classification of newborn infants by weight and gestational age. J Pediatr 1967; 71:159-163