N432 Newborn Care Plan

Lakeview College of Nursing

Nikki Brown

Demographics (10 points)

Date & Time of Clinical Assessment:

Date & Time of Birth 06/11/21 1400	**Patient Initials** M	**Age** **(in hours at the time of assessment)** 25 hours old	**Gender** Male
Race/Ethnicity Caucasian	**Weight at Birth** **(gm) __**3220____ **(lb.) __**7__ **(oz.) _**1.6__	**Weight at Time of Assessment** **(gm) ___**3170_____ **(lb.) __**6__ **(oz.) _**15.8	**Age (in hours) at the Time of Last Weight** 6 hours
Length at Birth **Cm _____**53.3_____ **Inches ___**21_____	**Head Circumference at Birth** **Cm ___**83.8_____ **Inches __**33_____	**Chest Circumference at Birth** **Cm _____**34_____ **Inches __**13.4___	

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: Gravida 3, Term 2, Preterm 0, Abortion 1, Living 2

When prenatal care started: December 24, 2020.

Abnormal prenatal labs/diagnostics: Varicella non-immune, GBS positive

Prenatal complications: None

Smoking/alcohol/drug use in pregnancy: Marijuana occasionally

Labor History of Mother:

Gestation at onset of labor: 39 weeks

Length of labor: N/A

ROM: Repeat cesarian section

Medications in labor: Sodium citrate-citric acid, Metoclopramide (Reglan), Cefazolin (Ancef).

Complications of labor and delivery: None

Family History:

Pertinent to infant: Dextrocardia and hearing loss

Social History (tobacco/alcohol/drugs):

Pertinent to infant: Mother smokes marijuana occasionally.

Father/Co-Parent of Baby Involvement: Dad visits, not at bedside at this time.

Living Situation: Unable to obtain information.

Education Level of Parents (If applicable to parents' learning barriers or care of infant):

Birth History (10 points)

Length of Second Stage of Labor: No second stage of labor due to repeat cesarian section.

Type of Delivery: Repeat cesarian section.

Complications of Birth: None

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: None

Feeding Techniques (10 points)

Feeding Technique Type: Breast feeding with supplemental formula.

If breastfeeding:

LATCH score: N/A

If bottle feeding:

Positioning of bottle: Upright

Suck strength: Strong

Amount:

Percentage of weight loss at time of assessment: ___1.6**_____%**

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

Formula (pounds lost/starting weight x 100)

3220-3170= 50

50/3220= 0.0155

0.0155*100=1.55 rounded 1.6%

What is normal weight loss for an infant of this age? Normal birth weight can range from 2,500 g to 4,000 g. Newborns usually lose up to 10% of their birth weight within the first few days of life but regain it in approximately 10 days (Ricci et al., 2021).

Is this neonate's weight loss within normal limits? Yes

Reference

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency: Every 2 to 3 hours

Length of feeding session: 20 minutes on both sides

One or both breasts: Both

If bottle feeding:

Frequency: one time

Volume of formula per session: 5ml

If NG or OG feeding: N/A

Frequency: N/A

Volume: N/A

If IV: N/A

Rate of flow: N/A

Volume in 24 hours: N/A

Output

Age (in hours) of first void: 12 minutes (0.2 hour)

Voiding patterns:

Number of times in 24 hours: Three times

Age (in hours) of first stool: Six hours

Stool patterns:

Type: Meconium

Color: Black

Consistency: Soft

Number of times in 24 hours: Two

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 lab is ordered during the first 24 to 48 hours of life, as a normal newborns transition from intrauterine to extrauterine life, their plasma glucose levels are typically lower than later in life (Ricci et al., 2021). Most newborns experience transient hypoglycemia and are asymptomatic (Ricci et al., 2021). If hypoglycemia is prolonged or is left untreated, serious, long-term neurological effects can occur (Ricci et al., 2021).	>45	Not obtained	Not obtained
Blood Type and Rh Factor	Blood types are A, B, AB, and O. Blood types are determined by the types of antigens on the red blood cells (RBC) (Ricci et al., 2021). Antigens are	A, B, AB, or O.	O-negative	O-negative

	proteins on the surface of RBC that can cause a response from the immune system. Mothers who are Rh-negative blood type who have given birth to an infant that has Rh-positive should receive an injection of Rh immunoglobulin within 72 hours after birth to prevent a sensitization reaction in the Rh-negative woman (Ricci et al., 2021). By getting the blood type it can determine Rh status and any incompatibility of the newborn (Ricci et al., 2021).			
Coombs Test	The Coombs test identifies hemolytic disease of newborns; positive results indicate that the newborns RBC have been coated with antibodies thus are sensitized. (Ricci et al., 2021).	Neg	Neg	Negative results are good.
Bilirubin Level (All babies at 24 hours)	Some jaundice in newborns is quite	<5.2 mg/dL in the first 24 hours	5.3 mg/dL	Using the Bili tool, it says this newborn is

Utilize bilitool.org for bilirubin levels	common, although it could be due to severe hyperbilirubinemia that could potentially lead to neurodevelopmental complications (Ricci et al., 2021). This is tested because pathologic jaundice is manifested within the first 24 hours of life and the bilirubin levels increase more than 5 mg/dL/day in a full-term infant. Pathologic jaundice is an unconjugated hyperbilirubinemia that occurs after the first postnatal day and can last up to 1 week (Ricci et al., 2021). Bilirubin concentrations peak in the first 3-5 days (Ricci et al., 2021).			at low intermediate risk for developing severe hyperbilirubinemia based off his value of 5.3 mg/dL.
Newborn Screen (At 24 hours)	Used to detect dozens of metabolic disorders from a single drop of blood. A child who tests positive will have to have additional testing to confirm the diagnoses (Ricci et	Neg	No results back while on unit	No results back

	al., 2021).			
Newborn Hearing Screen	Hearing loss is a common condition in newborns, and even mild hearing loss can cause serious delays in social and emotional development, language acquisition, and cognitive function (Ricci et al., 2021). A hearing screening should be done before discharge from the birthing unit, if not the newborn needs to be screened before 1 month of age (Ricci et al., 2021).	Pass	Referred	Testing will need to be repeated.
Newborn Cardiac Screen (At 24 hours)	Pulse oximetry screening of newborns should occur within the first 24 hours of life (Ricci et al., 2021). This is a simple, non-expensive test that can assist with identifying congenital heart disease. It allows for a timely workup and optimal treatment of the defect prior to the infant's circulatory	Pass	97 on wrist 100 on foot	Pass

	system collapsing (Ricci et al., 2021). To perform this test, you put the pulse oximeter on the wrist and then the foot. The numbers can only be three away from each other to pass and they can have three tries to pass.			

Lab Data and Diagnostics Reference (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**		
Dose	1 mg	5 mg/g	10 mcg/ 0.5 ml		
Frequency	One time	One time	One time		
Route	IM	Both eyes	IM		
Classification	Vitamin	Macrolide antibiotic	Vaccine		
Mechanism of Action	Vitamin K replacement indicated for the treatment of coagulation disorders which are due to faulty	Exerts effect only against multiplying organisms; penetrates cell wall of gram-positive bacteria more	Active immunization with hepatitis B vaccine stimulates the immune system to produce anti-HBs without		

	formation factors of II, VII, IX, and X when caused by vitamin K deficiency or interference with vitamin K activity (Haynes, 2021).	readily than that of gram-negative bacteria, and thus, gram-positive organisms may accumulate 100 times more erythromycin than gram-negative organisms do (Schmerin, 2019).	exposing the patient to the risks of active infection (Ricci et al., 2021).		
Reason Client Taking	Low levels of vitamin K can lead to dangerous bleeding in newborns and infants (Haynes, 2021). The vitamin K given at birth provides protection against bleeding that could occur because of low levels of this essential vitamin (Haynes, 2021).	To prevent bacterial eye infection (Schmerin, 2019).	Hepatitis B vaccine is recommended at birth, preferably within the first 12 hours (Ricci et al., 2021).		
Contraindications (2)	Hypersensitivity to phytonadione or other components of this medication (Lee, 2018).	History of hypersensitivity (Schmerin, 2019).	Contraindicated if hypersensitivity or severe reaction. If parent strongly objects to an immunization. Known yeast hypersensitivity.		

Side Effects/Adverse Reactions (2)	Hypersensitivity or cutaneous reactions (Lee, 2018).	Eye stinging, burning, redness, and temporary blurred vision (Schmerin, 2019).	Soreness, redness, or swelling in the injection site. Fever (Ricci et al., 2021).		
Nursing Considerations (2)	Observe for generalized ecchymosis or bleeding from umbilical cord, circumcision site, and GI tract (Lee, 2018).	Observe for irritation. Do not rinse, ointment may be wiped from the outer eye after 1 minute (Ricci et al., 2021)	First dose should be given within the first 12 hours. Administer intramuscularly (Ricci et al., 2021).		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patient for severe reactions and inflammation. Give before circumcision procedure. Monitor for therapeutic effectiveness (Lee, 2018).	Be alert for chemical conjunctivitis for 1-2 days. Do not touch the tip of the eye (Ricci et al., 2021).	Get baseline vital signs before administration. Find placement for injection in vastus lateralis (Ricci et al., 2021).		
Client Teaching needs (2)	Inform caregiver why the newborn is getting this medication. Explain how it works to caregiver.	Teach parents that any discharge from the eyes, especially if it is purulent, they should alert the nurse because of the possibility of infection. Inform parents of possible reaction and the infant may experience a rash (Schmerin, 2019).	Explain to parent that pain and inflammation at injection site are common side effects. Instruct parent to immediately report signs of allergic response (Ricci et al., 2021).		

Medications Reference (APA):

Haynes, B. (2021, January 1). *FAQs About Vitamin K Deficiency Bleeding*. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/vitamink/faqs.html#:~:text=Low%20levels%20of%20vitamin%20K%20can%20lead%20to%20dangerous%20bleeding,levels%20of%20this%20essential%20vitamin.

Lee, J. (2018, June 5). AquaMEPHYTON (Phytonadione Injection)*: Uses, Dosage, Side Effects, Interactions, Warning*. RxList. https://www.rxlist.com/aquamephyton-drug.htm#clinpharm.

Schmerin, A. (2019, September 28). (erythromycin ophthalmic) dosing, indications, interactions, adverse effects, and more. https://reference.medscape.com/drug/ilotycin-ophthalmic-erythromycin-ophthalmic-343573#10.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Newborn Assessment (20 points)

Area	Your Assessment	Expected Variations and Findings *This can be found in your book on page 645*	If assessment finding different from expectation, what is the clinical significance?
Skin	**Appropriate skin color for race. Nail beds, conjunctiva, soles of feet, and palms of hands appear pink. Skin is uniformly warm, fairly dry, moist in creases, and smooth in texture. Skin turgor is normal.**	**Skin variations could include vernix caseosa, stork bites or salmon patches, milia, Mongolian spots, erythema toxicum, harlequin sign, nevus flammeus, and nevus vasculosis. None of the variations listed were seen.**	**Assessment findings match expected findings.**
Head	**Head is symmetrical, hair is evenly distributed. Head does not have overriding sutures, lumps, or deformities.**	**Variations for the head consist of molding, caput succedaneum, and cephalhematoma. None of these variations were seen.**	**Assessment findings match expected findings.**
Fontanels	**Anterior and posterior fontanelles are palpable.**	**Abnormal findings in fontanelles include microcephaly, macrocephaly, large fontanelles, and small or closed fontanelles. None of the abnormalities were seen.**	**Assessment findings match expected findings.**
Face	**Face is symmetrical. Eyes line up with top of ear lobe. Face is relaxed.**	**If forceps were used during birth, it is possible to see bruising and reddened areas over**	**Assessment findings match expected findings.**

		both cheeks and parietal bones. This variation was not seen.	

Eyes	**Eyes are symmetrical and evenly spaced. Free of discharge, inflammation, and swelling.**	**It is possible to see marked edema of the eyelids and subconjunctival hemorrhages due to pressure during birth. This variation is not seen.**	**Assessment findings match expected findings.**
Nose	**Nose is symmetrical. No obstruction in the nares. Uniformly pink, free from edema and polyps.**	**A slight mucous discharge may be present but not actual drainage. Neither was seen in this infant.**	**Assessment findings match expected findings.**
Mouth	**Lips are pink in color. Mouth is symmetrical. On the inside of the mouth, it is pink and moist. Tongue lies within the mouth at rest. Hard and soft palate are intact. When finger in mouth infant preforms sucking reflex.**	**Variations involving the lip might include cleft upper lip, or thin upper lip associated with fetal alcohol syndrome. Normal variations include Epstein pearls, erupted natal teeth that may need to be removed to prevent aspiration, and thrush. None of these variations were seen upon assessment.**	**Assessment findings match expected findings.**
Ears	**Ears are symmetrical and are no lower than the eyes. No drainage or cerumen inspected.**	**Inspect the size, shape, skin condition, placement, and patency of auditory canal. Findings are normal.**	**Assessment findings match expected findings.**
Neck	**Neck is symmetrical and has full range of motion. No masses or palpable lymph nodes.**	**The neck should move freely in all directions and should be capable of holding head in**	**Assessment findings match expected findings.**

		midline position. Findings are normal.	
Chest	**Chest is symmetrical, smooth, and round. Clavicle is straight and intact.**	**The newborn chest is usually barrel shaped with normal anteroposterior and lateral diameters. Findings are normal.**	**Assessment findings match expected findings.**
Breath Sounds	**Breath sounds clear throughout. Breathing pattern irregular. Belly rises and falls symmetrically.**	**Bilateral equal breath sounds. Assessment findings are normal.**	**Assessment findings match expected findings.**

Heart Sounds	**Clear S1 and S2, no extra heart sounds. Normal heart rate at 110.**	**S1 and S2 heart sounds are auscultated with no extra heart sounds or murmurs.**	**Assessment findings match expected findings.**
Abdomen	**Abdomen is symmetrical and even in size and shape. Abdomen rounded and protuberant.**	**Inspect shape and movement of abdomen will be protuberant but not distended. Assessment findings are normal.**	**Assessment findings match expected findings.**
Bowel Sounds	**Bowel sounds are present and normoactive.**	**Bowel sounds in all four quadrants are heard. No masses or lumps palpated. Assessment findings are normal.**	**Assessment findings match expected findings.**
Umbilical Cord	**Umbilicus is green, yellow, and black. No bleeding, odor, or drainage.**	**Inspect for signs of bleeding, infection, inflammation, redness swelling, or purulent drainage. Assessment findings of umbilical cord were normal.**	**Assessment findings match expected findings.**
Genitals	**Penis and scrotum normal in size, shape, and symmetry. No discharge or lesions. Foreskin still intact during assessment. Testes are palpable, smooth, similar in size, and freely moveable.**	**Inspect for size, symmetry, color, and location of testes. Findings are normal.**	**Assessment findings match expected findings.**
Anus	**Normal findings. No fissures, rash, hemorrhoids, prolapse, or skin tags.**	**Check for position and patency. This infants' anus is symmetrical, and he passed 3 meconium stools. Findings are**	**Assessment findings match expected findings.**

		normal	
Extremities	**Can move extremities spontaneously. Symmetrical in size, movement, warmth, contour, and color. Infant feet and legs bowed secondary to utero positioning but can be straightened through passive range of motion. There are 5 fingers on each hand and 5 toes on each foot. Primitive reflexes present such as plantar, palmer grasp, step, and Babinski. Plantar creases on both soles of feet.**	**Check for appearance, movement, and symmetry. Assessment findings are normal.**	**Assessment findings match expected findings.**
Spine	**Spine is aligned in the center with no deformities.**	**Should be aligned. Findings are normal.**	**Assessment findings match expected findings.**
Safety • **Matching bands with parents** • **Hugs tag** • **Sleep position**	**Infant matching band with parent, and hug tag were seen, checked, and accurate. The infant was sleeping supine wrapped in a swaddle.**	**They should be properly identified when leaving and returning room, bracelets remain on. Bracelets accurate and on baby and mom.**	**Assessment findings match expected 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? Appropriate for gestational age (AGA). Based on Sex, gestational age, and birth weight.

Are there any complications expected for a baby in this classification?

No

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	**37.3 Celsius (99.2 F)**	**145**	**50**
4 Hours After Birth	**37.2 Celsius (99 F)**	**114**	**52**
At the Time of Your Assessment	**37.4 Celsius (99.4 F)**	**110**	**54**

Vital Sign Trends: Heart rate has slowed down since birth as well as the pulse rate. Respirations are consecutively in the 50's. Vital signs are stable.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0722	**N-PASS**	**No pain**	**No pain**	**No pain**	**No pain**

Summary of Assessment (4 points)

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

This newborn was delivered on 06/10/21 at 1240 by cesarian section. Apgar scores are 8 and 9. Infant is 39 weeks gestation. Birth weight is 7 lbs 1.6 oz (3220 grams), 21" long (53.3 cm). Upon assessment all systems were within normal limits. Last set of vitals: 99.4/110/54. Infant is breastfeeding and using supplemental formula feeding every 20"/20" q2-3 hrs. Bilirubin level at 24 hours was 5.3. Infant expected to be discharger with mother in 2 days and to see pediatrician for first well baby visit within 2 weeks.

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.
Swaddling	**As often as possible**	**Swaddling the baby helps to comfort him, sooth crying, and keep him warm.**
Assessments	**BID per facility protocol**	**To assess any changes and ensure proper health.**
Bathe	**After 12 hours of birth**	**Waiting until at least 12 hours after birth to bathe the infant helps strengthen his immune system.**

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): May need a breast pump.

Follow up plan (include plan for newborn ONLY): Follow up visits are typically in 2 weeks after discharge.

Education needs: Mother may need some refreshing on how to swaddle baby, how to use a breast pump properly, and how often to feed the baby.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client."

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 (1 pt 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 infection related to decreased immune system as evidence by birth.	Newborns are at an increased risk for infection due to exposure to bacteria after womb, as well as being immunocompromised.	**1.**Assess for signs and symptoms of infection. **Rationale:** Looking for changes in vital signs and labs can be an indication of infection. **2.**Observe for behavior changes. **Rationale:** Behavior changes can be a sign of infection.	Patient is free from infection and does not have complications.
2. Sensory/perceptual alterations related to multiple environmental stimuli as evidence by emotional responses.	When the baby is moved, woken up while sleeping or unwrapped from the swaddle he cried.	**1.** Examine environmental factors causing sensory overload. **Rationale:** Keep the nursery quiet with dim lighting when infant is sleeping can help. **2.** Eliminate additional personnel from the room. **Rationale:** More	Patient appears appropriately relaxed.

		peaceful and relaing.	
3. Anxiety related to not being held as evidence by crying.	When patient was put down after being held, he would cry, and he was in the nursery for hours.	**1.** Remain with patient and help stay calm. **Rationale:** Help reduce anxiety. **2. R**edirect coping mechanisms **Rationale:** Finding another way to relax baby that is not being held.	Patient appears relaxed and comfortable.
4. Acute pain related to circumcision as evidence by healing.	Patient had circumcision and may express pain during the healing process.	1. Observe for behavior cues of pain Rationale: This can help to determine if further action needs to be taken 2. Assess circumcision site for infection or swelling. Rationale: Infection and swelling can cause pain.	Patient is comfortable and does not show behavioral clues of pain or any infection and swelling.

Other References (APA):

Martin, P. (2021, June 11). *Nursing Guides, Care Plans, NCLEX Practice Questions*. Nurseslabs. https://nurseslabs.com/.

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 over 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 down, 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

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

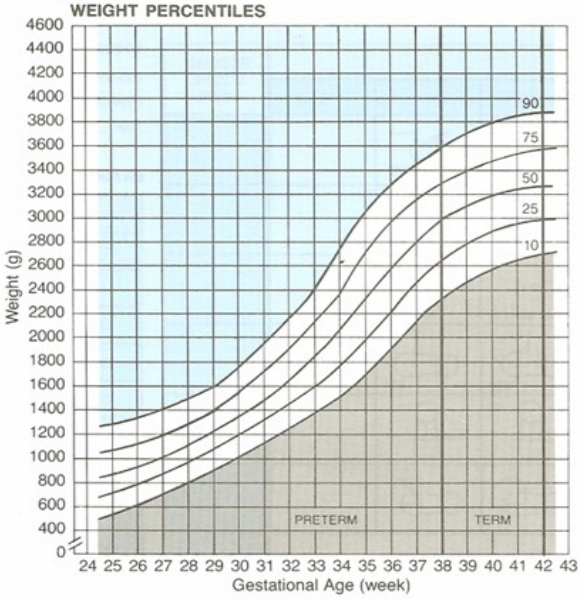
NAME _____ DATE OF EXAM _____ LENGTH _____

HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

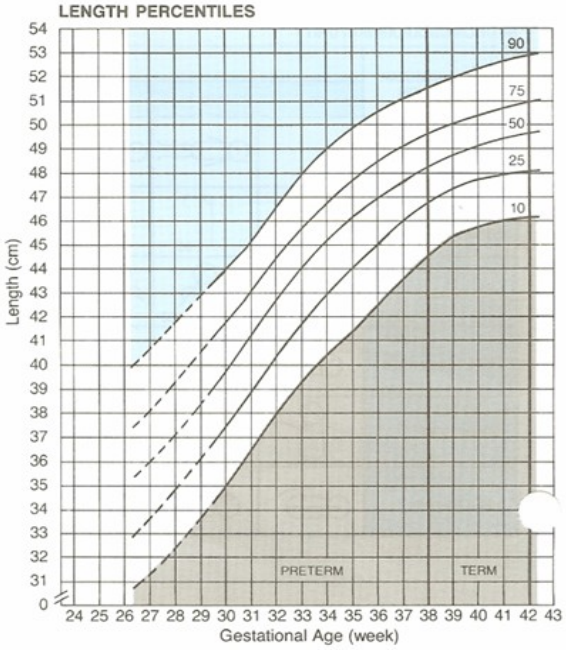
RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____

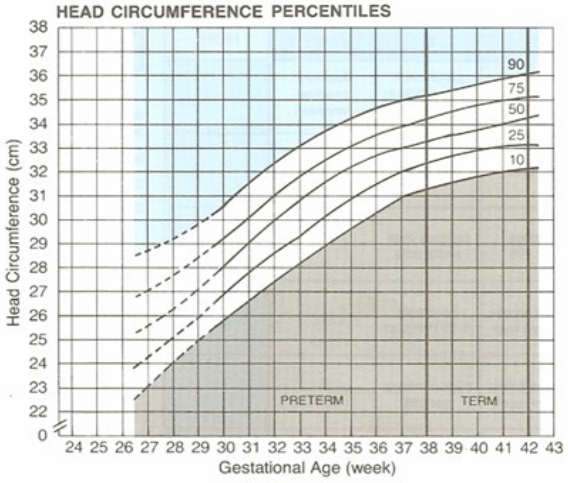
WEIGHT PERCENTILES



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)			
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