N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment 10/11/21 1458	**Patient Initials** C.W.	**Date & Time of Birth** 10/11/21 12:15pm	**Age** 4 hours and 43 minutes
Gender Male	**Weight at Birth** 4695 grams 10 (oz.) 5.6	**Weight at Time of Assessment** Patient's weight is unchanged from the time of delivery. 4695 grams 10 (oz.) 5.6	**Age (in hours) at the Time of Last Weight** 4 hours and 43 minutes
Race/Ethnicity Caucasian	**Length at Birth** 54.6 cm 21.5 inches	**Head Circumference at Birth** 37 cm 14.57 inches	**Chest Circumference at Birth** 39 cm 15.35 cm

Mother/Family Medical History (15 Points)

Prenatal History of the Mother:

GTPAL: 1 gravida, 0 para, 1 term, 0 abortions and 1 living

When prenatal care started: 8 weeks gestation (12/26/20)

Abnormal prenatal labs/diagnostics: The patient's WBC was elevated at 11.47. Her absolute neutrophils was also elevated at 10.36. Her monocytes was also elevated during her prenatal labs at 0.56.

Prenatal complications: The patient did not have any prenatal complications.

Smoking/alcohol/drug use in pregnancy: Patient reports she has never smoked or used smokeless tobacco. Patient denies alcohol or drug use.

Labor History of Mother:

Gestation at onset of labor: 41 weeks and 2 days

Length of labor: 2 hours and 15 minutes

ROM: 0 hours and 1 minute (clear in color)

Medications in labor: bupivacaine 0.7% in dextrose 8.25% (intrathecal), ephedrine injection, morphine sulfate injection and oxytocin (Pitocin) injection

Complications of labor and delivery: Patient was full term and large for gestational age. There were no complications of labor and delivery.

Family History: The patient's father is deceased and has a history of heart disease and hypertension. The patient's mother had a history of hypertension, diabetes, and heart disease. The patient's paternal grandmother had a history of lung cancer. The patient's maternal grandmother had a history of cancer. The patient's maternal grandfather has a history of prostate cancer.

Pertinent to infant: The patient has a history of diabetes which can affect the newborn. The combination of high blood glucose levels from the mother and high insulin levels in the fetus results in large fat deposits, which causes the fetus to grow excessively large (The Children's Hospital of Philadelphia, 2018). Birth injury may occur due to the baby's large size and difficulty being born.

Social History (tobacco/alcohol/drugs): Patient denies use of any tobacco, alcohol, and drugs.

Pertinent to infant: N/A

Father/Co-Parent of Baby Involvement: Father is involved and present at birth and the bedside of the mother.

Living Situation: Patient lives with her husband and two other dogs.

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

Both the patient and the father have a college degree. The patient is a police officer, and the father is a teacher. He teaches high school special education students. The patient and husband deny any learning barriers or care of infants.

Birth History (10 points)

Length of Second Stage of Labor: N/A (Patient had a c-section).

Type of Delivery: Cesarean section without labor

Complications of Birth: No complications occurred during birth for this patient.

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: None utilized beyond the normal needed.

Feeding Techniques (10 points)

Feeding Technique Type: Breastfeeding

If breastfeeding:

LATCH score: 9

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: N/A %

The patient's current weight is still the same as his birth weight. The calculation I would have done is one hundred percent times the difference between grams at birth weight minus grams at current weight divided by birth weight equals percentage.

100% X [(birth weight – current weight) / birth weight] = percentage of weight loss

What is normal weight loss for an infant of this age? A newborn should lose up to 7- 10% of their birth weight within the first week.

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

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency: Encourage on demand (every 2-3 hours)

Length of feeding session: Varys according to patient's willingness; patient breastfeed for 30 minutes on first attempt

One or both breasts: Both the left and right breast

If bottle feeding:

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:

Frequency: N/A

Volume: N/A

If IV:

Rate of flow: N/A

Volume in 24 hours: N/A

Output;

Patient has not voided or had a bowel movement at the time of this assessment.

Age (in hours) of first void: N/A

Voiding patterns: N/A

Number of times in 24 hours: N/A

Age (in hours) of first stool: N/A

Stool patterns: N/A

Type: N/A

Color: N/A

Consistency: N/A

Number of times in 24 hours: N/A

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	The patient's birth weight was 10 pounds and 5.6 ounces. With this, he is at risk for abnormal blood glucose. The patient's mother also has a history of diabetes.	40-99	50	According to the patient's value, it is within normal range.
Blood Type and Rh Factor	Knowing the patient's blood type is essential because it can aid in a blood transfusion if medical emergency treatment is required. The Rh factor was not drawn due to the mother being A blood type.	A, B, AB and O	N/A	N/A
Coombs Test	This test is done to find specific antibodies that attack the red blood cells. It helps detect antibodies that act against the surface of your red blood cells.	Negative	N/A	N/A
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	This test is ordered to assess the baby's bilirubin levels and liver function, especially if the newborn displays jaundice, dark urine, or stomach pain. All of these signs can be indicative of hepatitis, cirrhosis, or other liver diseases. Newborns are also at risk for elevated bilirubin. It has to do with the immaturity of the liver.	03-5.7mg/dL	N/A	N/A
Newborn Screen (At 24 hours)	This is ordered to detect conditions or disorders in newborns soon after birth.	Within in Normal Limits	N/A	N/A
Newborn Hearing Screen	To identify newborns who are likely to have hearing loss and who require further evaluation.	No deficits noted	N/A	N/A
Newborn Cardiac Screen (At 24 hours)	To identify newborns with critical congenital heart defects before signs or symptoms are evident.	No deficits noted	N/A	N/A

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

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

Newborn Medications

Brand/Generic	**Aquamephyton (Vitamin K)**	**Ilotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**		
Dose	1 mg	One thin strip per eye inside and outside			
Frequency	once	once	N/A		
Route	IM (injection)	Ophthalmic Ointment (bilateral)	N/A		
Classification	Vitamin	Macrolide Antibiotic	N/A		
Mechanism of Action	Vitamin used for the synthesis of clotting factors	Binds to bacterial ribosomes. Used for prophylaxis of conjunctivitis.	N/A		
Reason Client Taking	For to prevent damage from intracranial bleeding or any bleeding	For preventative measures from injection during delivery	N/A		
Contraindications (2)	Hypersensitivity Concurrent use of blood thinners	Hypersensitivity Concurrent use of astemizole	N/A		
Side Effects/Adverse Reactions (2)	Metabolic acidosis Cardiac arrest	Diarrhea Anaphylaxis	N/A		
Nursing Considerations (2)	Use normal saline for dilution. Takes 1-2 hours to take effect	Use 1cm ribbon for each eye. Do not administer directly into eye with tip	N/A		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor bleeding Monitor platelets	Monitor for hypersensitivity. Monitor heart rate and rhythm.	N/A		
Client Teaching needs (2)	Report rashes Teach side effects	Monitor for seizures and epilepsy. Review the reason for the use of ointment	N/A		

Medications Reference (1) (APA):

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

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

Newborn Assessment (20 points)

Area	Your Assessment		If assessment finding

		Expected Variations and Findings ***This can be found in your book on page 622 in Ricci, Kyle, & Carman 4th ed 2020.**	**is different from expectation, what is the clinical significance?**
Skin	Normal color; even tone; no bruises. No jaundice noted	Smooth & flexible with color consistent with genetic background	**N/A**
Head	Normocephalic, molding at birth, within normal limits, symmetrically rounded	Varies with gender, age, and ethnicity. Symmetrical and normocephalic	**N/A**
Fontanels	Overriding sutures present in Anterior and Posterior fontanelles. Soft, non-bulging	Diamond shaped anterior fontanelle, triangular shaped posterior fontanelle.	**N/A**
Face	Full cheeks with no abnormalities	Full cheeks, symmetrical facial features	**N/A**
Eyes	Normally set, pupils equal, red reflex present bilaterally and patent canals	Clear and symmetrical may have uncoordinated movement or strabismus	**N/A**
Nose	Nares patent, no septal deviation	Small, midline, narrow and able to smell.	**N/A**
Mouth	Oral mucosa moist, palate normal shape and intact; no lesions noted. Ankyloglossia noted.	Intact with symmetrical movement. Gums pink, moist, natal teeth may be present	
Ears	Normally set with patent canals, soft, resets wen placed against head	Soft, pliable and recoil quickly. Aligned with outer canthus of eye	
Neck	Supple without masses, able to support the heart. Clavicles are intact to	Supple, without masses	

	palpate		
Chest	Symmetrical with no abnormalities, nipples parallel to armpits	Barrel shaped, symmetric	
Breath Sounds	Bronchovesicular breath sounds in all fields. Clear and equal bilaterally and no signs of respiratory distress	Bronchovesicular breath sounds in all fields. Symmetric and slightly irregular	

Heart Sounds	Normal S1 and S2, no S3 noted. No murmurs noted. Heart rate within normal range. Femoral pulses normal	Point of maximal impulse lateral to midclavicular line located at the fourth intercostal space, audible S1 and S2 Variations: heart murmurs (foramen ovale closure)	
Abdomen	Protuberant contour, soft three vessels in umbilical cord; no distention noted, symmetrical, no masses or organmegaly	Protuberant contour, soft, three vessels in umbilical cord	
Bowel Sounds	Bowel sounds heard in all four quadrants (normoactive)	Bowel sounds heard in all four quadrants	
Umbilical Cord	Umbilical vein larger than two arteries. Cord is clean, drying, clamps intact	Umbilical vein larger than two arteries	
Genitals	No bleeding or redness. Normal term genitals. Testes descended bilaterally.	Testes descended bilaterally, no bleeding or redness	
Anus	Normal position and patency indicated by passing of meconium	Normal position and patency indicated by the passing of meconium	

Extremities	Extremities symmetric with free movement; No deficit in upper or lower extremities; ten digits to toes and fingers, which appear normal; 3 palmar creases noted in hands; no clubfoot noted. Extremities normally perfused. Barlow and Ortolani maneuvers are negative. Moro, grasp (palmar and plantar), rooting and sucking reflexes	Extremities symmetric with free movement	
Spine	Spine symmetrical and palpable along entire length; no deformity noted	Spine palpable along entire length with not lateral curvature	
Safety · **Matching ID bands with parents** · **Hugs tag** · **Sleep position**	ID and alarm bands on ankle; ID band matched mother's ID band. Sleep position was on her back.	Matching parental bands, hugs tag on foot, baby sleeps on back and swaddled	

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

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? LGA; The patient scored above 90% in all three categories.

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

Complications with a baby with a Ballard Scale of LGA include risk for hypoglycemia, birth injuries, and lung problems. This particular patient does not currently have any of these issues. It is said that later on, these newborns are at an increased risk for obesity and heart disease.

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth 12:15pm	**99.5 (axillary) (37.5 c)**	**190 bpm**	**44 breaths per minutes**
4 Hours After Birth 1458	**98.9 (axillary)**	**133 bpm**	**42 breaths per minute**
At the Time of Your Assessment 1415	**98.9 (axillary) (37.2 c)**	**140 bpm**	**52 breaths per minutes**

Vital Sign Trends:

All of which are within normal range for a newborn of this size. Heart rate tachycardic at birth; later became within normal limit (110 – 160 beats per minute); temperature is steady and is within normal limits (36.5 – 37.5); respirations are normal and within normal range (30 – 60).

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1212	N-PASS	N/A	N/A	N/A	N/A
1458	N-PASS	N/A	N/A	N/A	N/A

The patient's pain goal was met. According to the patient's nurse, the patient at the time of this assessment shows no signs of pain and appears to be comfortable. The patient's facial expression is relaxed, restful, and neutral. The patient is not crying. He is quiet. The patient's breathing pattern is within normal limits for a newborn. His breathing is not labored or slowed down. He has relaxed breathing patterns. The patient's arms and legs are also relaxed. No signs of muscular rigidity were noted. The patient does have occasional random movements of his arms which are within normal levels. The patient's state of arousal is between sleeping and awake. He is quiet and peaceful while sleeping and alert and settled when he is away.

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 10/11/21 by cesarean section. Apgar's score at 1 minute was 8 and at 5 minutes it was 9. EDD 10/2/21 by US. It was revealed neonate is 41 weeks and 2 days and LGA. Patient does not have a prenatal history that was complicated. Birth weight 10 lbs 5.6 ozs (4695 grams), 21.5" long (54.6 cms). Upon assessment all systems are within normal limits. Last set of vitals: 37.5/190/44. BS x3 after delivery WNL with lowest being 44. Neonate is breastfeeding and nursing well with most feedings 20"/20" q2-3 hrs. Bilirubin level was not taken for this patient yet. Neonate expected to be discharged with mother later in around 2-3 days and to see a pediatrician in the office for the first well baby check within 48 hours.

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.
Cord care (N)	Routine, continuous	Keeping the cord clean and dry helps with decreasing the baby's risk for infection. It will also help the umbilical cord stump to fall off and the navel to heal more quickly. This patient's chart was also encouraged to use soap and water to base only if needed.
Swaddling (N)	Continuous (when the mother is not doing skin to skin)	Swaddling helps with increasing the baby's comfort, security, and supporting sleep. It also helps to protect the baby against its natural startle reflex. Most importantly, though, it helps protect the baby from overheating and decreases their risk for SIDS.
Erythromycin (M)	Once	Erythromycin is ordered for newborns within a couple of hours of birth because it helps with preventing a baby from getting an infection during delivery.
Vitamin K Injection (M)	Once	Vitamin K injections are given to newborns because decreased levels can lead to dangerous bleeding in newborns. With this injection given shortly after birth, it protects against bleeding.

Discharge Planning (2 points)

Discharge location: The patient is going to be discharged home with the parents.

Equipment needs (if applicable): No equipment will be required upon discharge for this patient.

Follow up plan (include plan for newborn ONLY): The patient is expected to follow up with a pediatrician in the office for the first well baby check within 48 hours of discharge.

Education needs: The patient's parents will require education on breastfeeding and proper techniques to help with latching. They will also need education on the use of the car seat, how to monitor the patient's blood glucose levels, and safe sleeping practices.

Nursing Diagnosis (30 points)

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 hypoglycemia **related to** large for gestational age, making too much insulin **as evidence by** birth weight being 10 pounds and 5.6 ounces, mother has history of diabetes pre pregnancy	This patient is at an increased risk for hypoglycemia due to	**1.** Monitor accuchecks routinely throughout shift on 10/11/21 from 1300 to 1500. **Rationale: The measurement of blood glucose provides information on the effectiveness of blood glucose metabolism and guides interventions to achieve optimal glucose control within the body (Wayne, 2019).** **2.** Monitor for clinical signs of neonatal hypoglycemia such as bluish color or pale skin, apnea, irritability, poor feeding or vomiting throughout shift on 10/11/21 from 1300 to 1500. **Rationale: Monitoring for signs of hypoglycemia can help with early intervention for the treatment of it (Wayne, 2019). If ignored for too long or left untreated, it can result in seizures.**	Goal met. The patient's blood sugar was checked routinely on 10/11/21 by 1500. His blood sugar was checked when he was born as well as four hours after ways, both within the normal limits of 40-99. The patient's blood sugar at the time of the assessment was 50. Goal met. The patient did not display signs of hypoglycemia during my shift on 10/11/21 from 1130 to 1500. The patient's assessment was within normal limits.
2. Knowledge deficit **related to** breastfeeding **as evidenced by** first time breastfeeding, desire to want to learn, first child	This is this patient's first child, and she had never breastfed before. She is educated on the use of a breast pump and verbalizes her desire to want to breastfeed. The newborn is tolerating feedings well. The newborn's latch score was 9. The mother has attempted to breastfeed on both her right and left breast and the baby has	**1.** Assess patient knowledge of breastfeeding throughout shift on 10/11/21 by 1500. **Rationale: Educate mother and husband about breastfeeding techniques to improve chance of success (Martin, 2019).** **2.** Educate mother and husband about breastfeeding techniques to improve chance of success by 1500 on 10/11/21.	Goal met. This patient was able to verbalize and demonstrate understanding of correct breastfeeding techniques, concepts such as demand vs scheduled feeding, indicators of successful feeding by 1500 on 10/11/21. The patient also verbalized and was educated on the proper position for breastfeeding. The staff educated on how the patient can utilize pillows to elevate

	tolerated both well.	**Rationale: Correct positioning and getting the infant to latch on is critical for breastfeeding to get off to a good start and contributes to breastfeeding success (Martin, 2019).**	her arm as well as the newborns in order to have the baby at an angle.
3. Risk for infection **related to** break in her skin, invasive procedure, exposure to pathogens **as evidenced by** cesarean section	This particular nursing diagnosis for chosen for this patient due to her having a cesarean section. This puts her at an increased risk for obtaining an infection due to the break of her skin being a portal of entry for pathogen to enter and spread throughout her body.	**1.** Assess for signs and symptoms of infection such as elevated temperature, pulse, WBC; abnormal odor or color of vaginal discharge, or fetal tachycardia throughout shift on 10/11/21 from 1130 to 1500. **Rationale: To monitor for classic signs of infection to intervene early (Wayne, 2019).** **2.** Wash hands and encourage the patient to do the same throughout shift on 10/11/21 from 1130 to 1500. Dry hands with a paper towel after washing. **Rationale: Handwashing is an effective technique to prevent the spread of infection. Dry surfaces are better in preventing the transfer of microorganisms. (Wayne, 2019).**	Goal met. The patient was did not show signs and symptoms of infection throughout shift on 10/11/21 by 1500. The patient's vital signs and labs were within normal limits. Goal met. The patient was able to verbalize the importance of hand hygiene by 1500 on10/11/21. The patient displayed hand hygiene when she utilized hand sanitizer.
4. Risk for acute pain **related to** break in her skin, invasive procedure, epidural wearing off, psychological reaction **as evidenced by** cesarean section	This nursing diagnosis is important for this patient because she has had a c-section and she has verbalized feeling pressure and the epidural wearing off. It is important to help this patient know what pain methods she can utilized to decrease pain and increase comfort.	**1.** Educate proper relaxation techniques; position for comfort as possible. Use Therapeutic Touch, as appropriate throughout shift on 10/11/21 from 1130 to 1500. **Rationale: May help in decreasing anxiety and tension, promote comfort, and enhance sense of well-being (Wayne, 2019).** **2.** Drop anxiety-producing circumstance (loss of control), give accurate information, and encourage presence of partner	Goal met. The patient used relaxation techniques by 1500 on 10/11/21. She was positioned for comfort. Her head of the bed was elevated per the patient's comfort. Goal met. The patient's partner was present throughout the shift on 10/21/21 from 1130 to 1500. The patient's room light was

		throughout shift on 10/21/21 from 1130 to 1500. **Rationale: Levels of pain tolerance are individual and are affected by various factors. Extreme anxiety following an emergency situation may develop discomfort due to fear, tension, and pain affecting the patient's ability to cope (Wayne, 2019).**	also decreased to help both her and the baby get some rest.

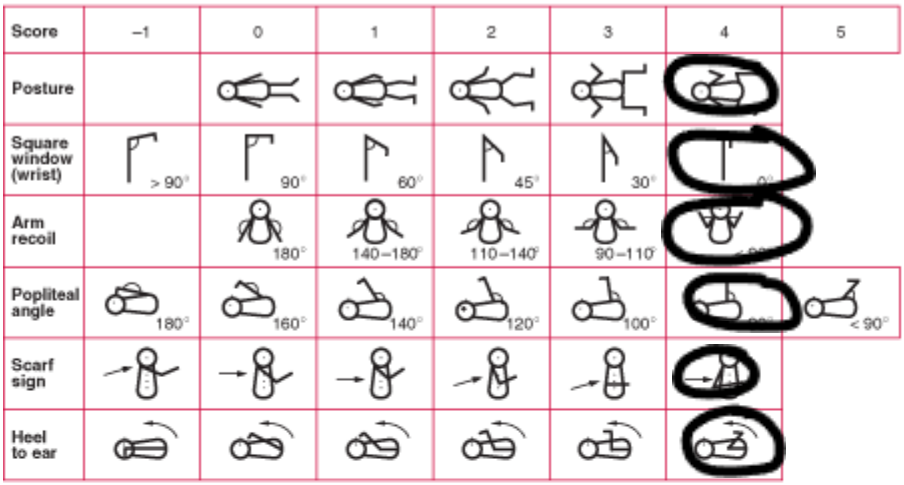
Other References (APA):

Martin, P. (Ed.). (2019, September 1). *36 Labor Stages, Induced and Augmented Labor Nursing Care Plans - Nurseslabs - Page 2*. Nurseslabs. https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/2/#b1

Wayne, G. (2019, September 25). *10 Cesarean Birth Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/cesarean-birth-nursing-care-plans/6/

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°	0°	
Popliteal angle	180°	160°	140°	120°	100°	0°	< 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

Name: C.W.
Race: Caucasian
DOB: 10/11/21

Date of Exam: 10/11/21
Sex: Male
Birth Weight: 10 pounds and 5.6 ounces

Length: 54.6 cm
Head Circumference: 37 cm
Gestational Age: 41 weeks and 2 days

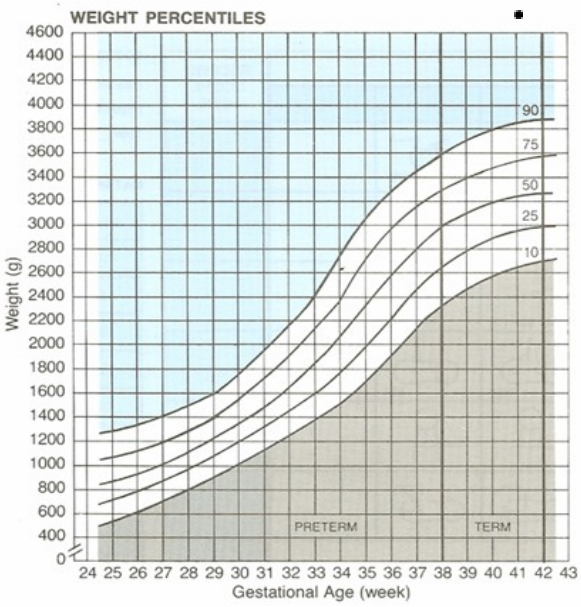
CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE [1,2]

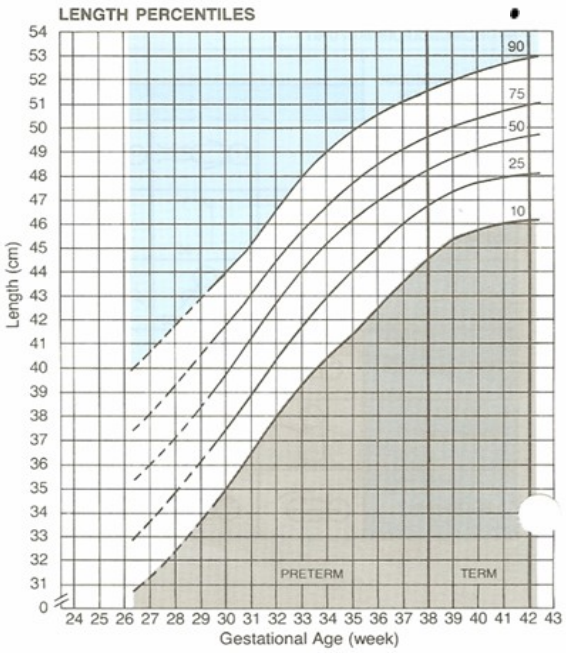
NAME _____ DATE OF EXAM _____ LENGTH _____

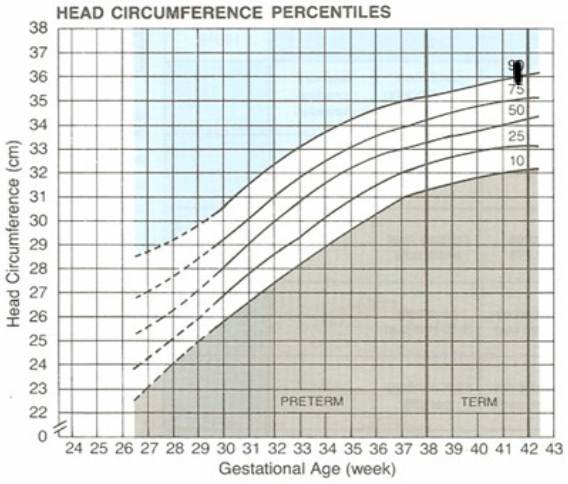
HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____







CLASSIFICATION OF INFANT*	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)	X	X	X
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