

N432 Newborn Care Plan
Lakeview College of Nursing
Patricia East

Demographics (10 points)**Date & Time of Clinical Assessment:**

Date & Time of Birth 6/17/2020 0835	Patient Initials A.D	Age (in hours at the time of assessment) 31 hours old	Gender Male
Race/Ethnicity Caucasian	Weight at Birth 3590 grams 7 lbs. 14.6 oz.	Weight at Time of Assessment 3530 grams 8 lbs. 0 oz.	Age (in hours) at the Time of Last Weight 37 hours old
Length at Birth 52 cm. 20.472 inches	Head Circumference at Birth 35 cm 13.78 inches	Chest Circumference at Birth 34 cm. 13.39 inches	

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:**

When prenatal care started: November 21, 2019

Abnormal prenatal labs/diagnostics: Mom of baby tested seropositive for Herpes Simplex Virus (HSV). The mom has no history of active outbreak.

Prenatal complications: Mixed hyperlipidemia, increase nuchal translucency space on fetal ultrasound, borderline macrosomia.

Smoking/alcohol/drug use in pregnancy: Former smoker. No current smoking or drug use. The mom has had alcoholic beverages prior to pregnancy, but not during pregnancy.

Labor History of Mother:

Gestation at onset of labor: 39 weeks 0/7 days

Length of labor: 11 hours and 35 minutes

ROM: AROM done at 0757 on 6/17/2020. Fluid clear with no odor.

Medications in labor: Epidural (Fentanyl ropivacaine) and lactated ringer

Complications of labor and delivery: No complication noted.

Family History:

Pertinent to infant: Maternal grandfather has hx of cancer and hypertension. Maternal grandmother has hx of hypertension, and paternal grandmother has a hx of diabetes.

Social History (tobacco/alcohol/drugs):

Pertinent to infant: No tobacco, alcohol, or drug use during pregnancy.

Father/Co-Parent of Baby Involvement: Father is involved

Living Situation: The parents of baby are married and live in Arcola, IL. The patient has a little sister who is three and is excited to have a little brother.

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

Mom and dad are both well educated. They are attentive and are active in baby care. There are no learning barrier's or care of infant.

Birth History (10 points)

Length of Second Stage of Labor: 34 minutes

Type of Delivery: Spontaneous, vaginal birth

Complications of Birth: None

APGAR Scores:

1 minute: 8

5 minutes: 8

Resuscitation methods beyond the normal needed: No resuscitation needed.

Feeding Techniques (10 points)

Feeding Technique Type: The patient is currently receiving feeds by NG tube/syringe feeding. The patient was put to breast and latched, but due to fatigue and increase respiratory will be receiving feeds to help reserve energy. Mom is pumping and planning to breast feed. TTOF once respiratory rate remains in stable ranges.

If breastfeeding:

LATCH score: N/A

If bottle feeding:

Positioning of bottle: 90 degrees

Suck strength: Strong and coordinated

Amount: 25 oz.

Percentage of weight loss at time of assessment: 1.7%

$3590 \text{ g} - 3530 \text{ g} = 60 \text{ g} / 3590 \text{ g} = 0.0167 * 100 = 1.67\% \rightarrow 1.7\% \text{ weight loss}$

What is normal weight loss for an infant of this age? No more than 10%

Is this neonate's weight loss within normal limits? Yes, the weight loss is within normal limits.

Intake and Output (8 points)

Intake

If breastfeeding: N/A

Feeding frequency: N/A

Length of feeding session: N/A

One or both breasts: N/A

If bottle feeding:

Frequency: Q3 hours

Volume of formula per session: 25 oz

If NG or OG feeding:

Frequency: If patient's respiratory rate is too high, feeds will be given through NG. The first feed patient's respirations were 58/min. The patient's feed was given over 30 minutes

Volume: 25 oz.

If IV:

Rate of flow: 8 mL/hr.

Volume in 24 hours: 296 mL

Output

Age (in hours) of first void: 9.5 hours old

Voiding patterns:

Number of times in 24 hours: 5

Age (in hours) of first stool: 7.5 hours old

Stool patterns:

Type: Meconium

Color: Green

Consistency: tarry

Number of times in 24 hours: 5

Laboratory Data and Diagnostic Tests (15 points)

Chest X-ray: Chest x-ray was performed on 6/17/2020. The neonate had an increase in neutrophils, respiratory rate, and decrease in heart rate. Doctors wanted to rule out suspected

pneumothorax. The x-ray showed no findings of pneumothorax. All findings were in normal limits.

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	Upon admission to Special Care Nurse, patient's blood glucose was taken and was 41 on 6/17 at 1303. Patient was NPO with a low blood sugar and D10 was initiated. Blood glucose was rechecked at 1440 and was 72. Per policy, blood sugar will be checked Q12 hours.	45-99	1303: 41 1440: 72 0220: 70 1440: 74	The neonate's blood glucose level was low but remains stable with eating and D10.
Blood Type and Rh Factor	To know the blood type and Rh factor are.		O positive	The neonate does not have the same blood type as mom. Mom is O negative.
Coombs Test	This test is performed to help identify autoimmune hemolytic anemia	Negative	Negative	The Coombs test is negative which means that there are no antibodies in the neonate's serum
Bilirubin Level (All babies at 24 hours)	This lab is performed to see the total of bilirubin levels.	Below 6	6.8	The neonate is high-intermediate risk and could develop hyperbilirubinemia.

Utilize bilitool.org for bilirubin levels	If it is too high it can lead to jaundice and other complications.			
Newborn Screen (At 24 hours)	This screen is performed to help diagnosis birth defects that were not founded via ultrasound or at birth.	Pass	N/A	This screening was not performed yet.
Newborn Hearing Screen	This screen is performed to help diagnose an hearing disabilities	Pass	N/A	This hearing screen was not performed yet.
Newborn Cardiac Screen (At 24 hours)	This test is performed to help diagnose and detect any cardiac defects	Pass	Wrist (Right): 100% Foot: 100%	The neonate's pulse remained within normal limits. No cardiac defects were found.

Lab Data and Diagnostics Reference (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing (11th ed)* Assessment

Technologies Institute, LLC.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.)* Wolters Kluwer.

Newborn Medications (7 points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin Ointment)	Hepatitis B Vaccine	Ampicillin (Omnipen)	Gentamicin (Cidomycin)
Dose	1 mg/ 0.5 mL	1 tube (½ tube in each eye)	0.5 mL/ 10 mcg	240 mg	14.9 mg
Frequency	Once	Once	Once	Q8 hours	Q24 hours
Route	IM	Topical	IM	IV	IV
Classification	Vitamin	Antibiotic	Vaccine	Antibiotic	Antibiotic
Mechanism of Action	Enhances clotting factor	Inhibits protein synthesis by binding to the ribosomal of infectious organism and kills it	Promotes antibodies against hepatitis B	Inhibits the growth of bacteria	Disrupts the integrity of membrane and binds to the ribosomal and causes cell death
Reason Client Taking	To prevent hemorrhagic event in neonate	To treat or prevent infection of the eye	To prevent infection of Hepatitis B	To treat potential bacterial infection	To treat potential bacterial infection
Contraindications (2)	Hypersensitivity Liver disease	Hypersensitivity Liver disease	Hypersensitivity Severe illness with a fever	Hypersensitivity to ampicillin Hypersensitivity to other penicillin	Hypersensitivity to gentamicin Hypersensitivity to aminoglycosides
Side Effects/Adverse Reactions (2)	Flushing Redness or swelling at injection site	Eye redness Hives	Fever Soreness at injection site	Epistaxis diarrhea	Ototoxicity Rash
Nursing Considerations (2)	Avoid rapid infusion of this medication Educate the	Wash hands and don gloves before administering	Do not give vaccine if neonate is experiencing a fever.	Expect to give Ampicillin for 48 to 72 hours.	Know that this drug is best absorbed given IV.

	<p>mom that Vitamin K is not a vaccine, but a natural vitamin needed to prevent bleeding disorder.</p>	<p>medication to eye</p> <p>Squeeze a ribbon of ointment into each eyelid and prevent the tip from touching the eyes</p>	<p>Administer this medication intramuscular</p>	<p>Monitor patient for anaphylaxis</p>	<p>For IV use. Dilute each dose with 50-200 mL of normal saline or D5W</p>
<p>Key Nursing Assessment(s)/ Lab(s) Prior to Administration</p>	<p>Monitor for bleeding</p> <p>Monitor for anaphylaxis while administering</p>	<p>Monitor for adverse effects.</p> <p>Wipe off excess ointment after 1 minute</p>	<p>Monitor for anaphylaxis</p> <p>All consents are signed before administration of medication</p>	<p>Monitor for diarrhea</p> <p>Monitor for superinfection</p>	<p>Administer slowly over 30 to 60 minutes</p> <p>Monitor for nephrotoxicity</p>
<p>Client Teaching needs (2)</p>	<p>Educate the parents of risk if vitamin K is not given</p> <p>Educate the parents of side effects of injection</p>	<p>Educate parents about the eye treatment</p> <p>Educate parents that instillation should be done as soon as possible after birth.</p>	<p>Educate parents to follow up with doctor for the two of serious of the three series.</p> <p>Educate parents of side effects of injection</p>	<p>Educate parents the importance of taking full course of medication</p> <p>Educate parents the signs/symptoms of allergic reaction</p>	<p>Educate parents the importance of taking full course of medication</p> <p>Education parents the signs/symptoms of allergic reaction</p>

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.)* Wolters Kluwer.

<i>Newborn Assessment (20 points)</i> 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	Skin is pink, warm, and dry. No signs of jaundice or rashes. Skin turgor is less than 2 seconds. Temperature is 99.3 axillary.	Skin is smooth, flexible, good turgor, well hydrated, and warm.	The neonate's findings were within normal limits.
Head	Normocephalic. No enlarged fontanel, microcephaly, macrocephaly noted.	Varies with age, gender, and ethnicity.	The neonate's findings were within normal limits.
Fontanel	Anterior fontanelles are open, soft, and flat. Posterior fontanelles are open and triangular.	Anterior fontanelles are open, soft, and flat. Posterior fontanelles are open and triangular.	The neonate's findings were within normal limits.
Face	Facial features are symmetrical. Cheeks are full.	Cheeks are full, facial features symmetric	The neonate's findings were within normal limits.
Eyes	PERRLA, eyes are symmetric. Red reflex noted. No drainage. Ears are in line with eyes.	Clear and symmetrically placed on face, in line with ears.	The neonate's findings were within normal limits.
Nose	No deviated septum noted or nasal drainage. No malformation or blockage.	Small, placement in the midline and narrow, ability to smell	The neonate's findings were within normal limits.
Mouth	Pink, moist mucosa. Symmetrical movement. Soft and	Aligned in midline, symmetric, intact soft and hard palate.	The neonate's findings were within normal limits.

	hard palate intact.		
Ears	Ears quick recoil when folded and released. No low-set ears noted.	Soft and pliable with quick recoil when folded and release	The neonate's findings were within normal limits.
Neck	Moves freely noted. Holds head midline. No clavicular fractures noted.	Short, creased, moves freely, body holds head in midline.	The neonate's findings were within normal limits.
Chest	Chest is smaller than head. Symmetrical. No engorgement of nipples or drainage.	Round, symmetric, smaller than head. Barrel shaped.	The neonate's findings were within normal limits.
Breath Sounds	Breath sounds clear bilaterally. No presence of crackles or wheezes. No diminished breath sounds noted.	Clear breath sounds bilaterally. No crackles or wheezes. No diminished breath sounds.	The neonate's findings were within normal limits.

Heart Sounds	S1 and S1 noted. No murmur or gallops noted. The point of maximal impulse presence at the fourth intercostal space lateral to mid-clavicular line.	S1 and S2 present. The point of maximal impulse is lateral to mid-clavicular line at the fourth intercostal space.	The neonate's findings were within normal limits
Abdomen	Three vessels noted in umbilical cord. Protuberant contour.	Protuberant contour, soft, three vessels in umbilical cord	The neonate's findings were within normal limits
Bowel Sounds	Normoactive bowel sounds in all four quadrants. No masses or tenderness noted.	Bowel sounds presents in all four quadrants. No masses or tenderness.	The neonate's findings were within normal limits
Umbilical Cord	Two veins and one artery noted. No bleeding, redness, swelling noted. No erythema present around umbilical cord.	No bleeding, redness, swelling.	The neonate's findings were within normal limits
Genitals	Smooth glans and meatus center at tip of penis noted. No edematous scrotum. Testes are palpable.	Smooth glans, meatus centered at tip of penis	The neonate's findings were within normal limits
Anus	Anus is in normal position. The patient has passed 5 meconium stools which indicates patency. No anal fissures or fistulas noted.	Patency, position.	The neonate's findings were within normal limits
Extremities	All extremities are symmetrical and are free moving.	Symmetrical and free movement	The neonate's findings were within normal limits
Spine	Spine is palpable.	Symmetric, no tuft	The neonate's

	No tuft or dimple on spine. Symmetrical throughout.	or dimple on spine.	findings were within normal limits
Safety <ul style="list-style-type: none"> • Matching bands with parents • Hugs tag • Sleep position 	The neonate and parents have matching bands. A hugs tag is attached to the left ankle. Identification band is around left wrist. All sides of Omni are latched and secure. Omni is locked. Oxygen/suction is available at bedside. The neonate is in a supine position and swaddled. All cords are off the floor and off the skin of baby.	Matching bands with parents, hugs tag, supine position, oxygen and suction available. Bed is locked and rails of bed are locked. Identification band. Cords are off the floor and not a tripping hazard.	All safety precautions are in place.

Reference (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing (11th ed.)* Assessment Technologies Institute, LLC.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd 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?

This neonate scored a 45, his maturity level rating is 42 weeks.

Weight: 3530 grams and 39 weeks puts the neonate in 75th percentile which is appropriate for gestational age.

Length: 52 cm and 39 weeks puts the neonate in the 80th percentile which is appropriate for gestational age.

Head circumference: 35 cm and 39 weeks puts the neonate in the 75th percentile which is appropriate for gestational age.

Are there any complications expected for a baby in this classification? No, the neonate's findings were appropriate for gestational age.

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	98 axillary	160 bpm	70/min
4 Hours After Birth	98.4 axillary	118 bpm	76/min
At the Time of Your Assessment	99.3 axillary	108 bpm	58/min

Vital Sign Trends: The neonate's vitals remain within normal limits. Respiration rate has increased but has started to remain within normal limits. The normal range of vitals for neonates are a temperature between 97 degrees to 99 degrees, apical pulse 110-160 bpm, and respirations 30-60 breaths/min (Ricci et al., 2017). There are a few vital signs that are slightly out of normal limits, but have fallen back into normal limits.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	NIPS	N/A	0	N/A	N/A

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 6.17.2020 at 0835 by normal spontaneous vaginal delivery (NSVD). Apgar scores 8/8. EDD 5.24.2020 by US. Fitton revealed neonate is 39 0/7 weeks and AGA. Prenatal hx complicated by HSV seropositive, but no lesions present during birth. Birth weight 7 lbs. 14.6 oz. (3590 grams), 20.47” long (52 cm). Upon assessment all systems are within normal limits. Last set of vitals: 37.4/108/58. BS upon Special Care admission was not within normal limits. The first BS was 41. D10 was initiated and the follow up BS was 72. Q12 BS ordered and remain within normal limits. Neonate is receiving feeds through NG tube when respirations are above 60/min. If respirations are within normal limits, the neonate will receive feedings through bottle feeds and breastfeeding. Neonate is eating q3 hours. Bilirubin level at 24 hours per scan was 6.8. Neonate expected to be discharged within a few days when respiratory status stabilizes. The neonate will follow up with pediatrician in the office for first well baby appointment within 48 hours after 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.
Monitor pulse ox (N)	Continuous	This intervention is monitoring the arterial oxygenation to prevent hypoxia. The neonates heart rate decreased in low range when respiratory rate increases.
Monitor respiratory rate (N)	Q1 hour	The neonate respiratory rate increases out of normal range. This intervention is to monitor to make sure that the respiratory rate is in recommended ranges before feeds. If the respirations are too high, it can cause incoordination when eating.
Administer Ampicillin/Gentamicin (M)	Q8/Q24 hour	This neonates’ neutrophils increased along with increase respiratory rate and decreased heart rate. This can indicate infection.
Monitor TCB/TSB (N)	Q24 hour	The bilirubin level at 24 hours was 6.8. This puts the neonate at high intermitted

		risk to develop hyperbilirubinemia.
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Discharge Planning (2 points)

Discharge location: The neonate will discharge home with mom and dad.

Equipment needs (if applicable): N/A

Follow up plan (include plan for newborn ONLY): The neonate will follow up with a pediatrician for well-baby checkup 48 hours after discharge.

Education needs: Mom and dad will need circumcision care education. Mom will need further education about breastfeeding.

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.***

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>Evaluation (1 pt each) <ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan. </p>
<p>1. Risk for impaired</p>	<p>The neonate</p>	<p>1. Monitor</p>	<p>The neonate’s</p>

<p>gas exchanged related to ineffective breathing as evidence by increased respiratory rate of 76 breaths per minute.</p>	<p>respiratory rate is increasing while his heart rate is decreasing. It is important to monitor pulse ox to see how well the neonate's heart is pumping oxygen throughout the body.</p>	<p>respiratory rate, depth, and use of accessory muscles Q1hr. Rationale: Monitoring breathing patterns will help identify if neonate is having ineffective breathing</p> <p>2. Monitor oxygen saturation with continuous pulse ox. Rationale: Monitoring oxygen saturation shows the amount of oxygenated blood being delivered to the body.</p>	<p>parents understand the interventions set in place. The neonate is not using accessory muscles and respiratory rate has started to decrease and remain in normal limits.</p>
<p>2. Risk for imbalanced nutrition: less than body requirement related to uncoordinated during feeds as evidenced by hypercapnic.</p>	<p>The neonate respiratory rate is above normal limits at 58 breaths per min. This causes the neonate to be uncoordinated with breathing, sucking, and swallowing.</p>	<p>1. Daily weight to assess caloric intake Rationale: Monitoring daily weight will show if the neonate is receiving enough calories to survive.</p> <p>2. Administer feedings through nasal gastric tube when respirations are above 60 breaths per minute. Rationale: If</p>	<p>The neonate's parents understand the interventions set in place. The neonate received his feeding through NG tube at 1500 but was able to receive 1800 and 2100 feed through bottle. Daily weight was obtained, and baby weight loss was within normal limits.</p>

		respirations are too fast, the neonate can have difficulty coordinating breathing and swallowing.	
3. Risk for injury: hypoglycemia related to hyperbilirubinemia as evidenced by lethargy and disinterest in eating.	The neonate scored in the high-intermediate zone and is at risk for developing hyperbilirubinemia. He is lethargic and not wanting to eat. This neonate will need prevention prior to discharge to help manage and lower his bilirubin levels.	<p>1. Educate mom and dad to increase feedings and exposure to sun to help manage bilirubin</p> <p>Rationale: Healthy food and exposure to sun will help maintain and promote healthy liver function which will remove toxins and turn bilirubin into bile to be excreted</p> <p>2. Educate mom and dad to monitor skin temperature to make sure skin is warm and dry to prevent bilirubin levels from increasing.</p> <p>Rationale: Cold temperatures increases circulating bilirubin. Keeping neonate warm and dry will help maintain bilirubin levels and lower it.</p>	The parents have verbalized that they understand the cause/treatment of this condition. The mom feels confident in the education that was provided to help her recognize the signs and symptoms of hyperbilirubinemia.
4. Minimize post circumcision complications	The neonate is the parent's first boy. This teaching	1. Educate the parents to monitor signs	The parents understand they need to monitor for

<p>related to circumcision as evidenced by teaching proper care of circumcised neonate.</p>	<p>diagnosis is important to prevent any further complications with the neonate's circumcision.</p>	<p>and symptoms of infection: persistent redness, yellow discharge, foul-smelling</p> <p>Rationale: Parents of neonate should know signs/symptoms incase an infection develops.</p> <p>2. Use gentle, unscented soap with warm water to clean area with each diaper change.</p> <p>Rationale: Washing with unscented soap and warm water will help remove microorganisms and prevent infection.</p>	<p>signs and symptoms because if the area of circumcision is not properly taken care of it can become infected. Both parents were taught and taught back how to properly clean the area of circumcision.</p>
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Other References (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing (11th ed)* Assessment

Technologies Institute, LLC.

Ladwig, G. B., & Ackley, B. J. (2014). *Mosby's guide to nursing diagnosis*. Maryland Heights,

MO: Elsevier.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.)* Wolters

Kluwer.

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							

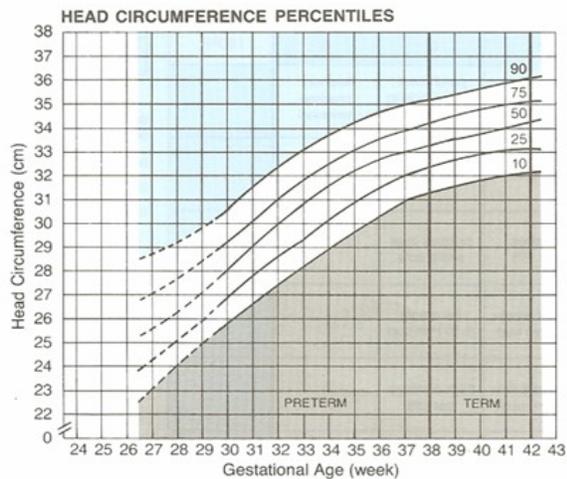
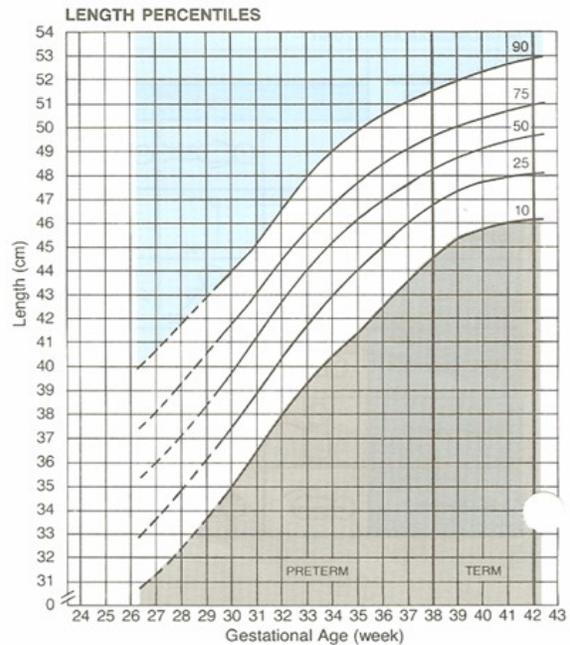
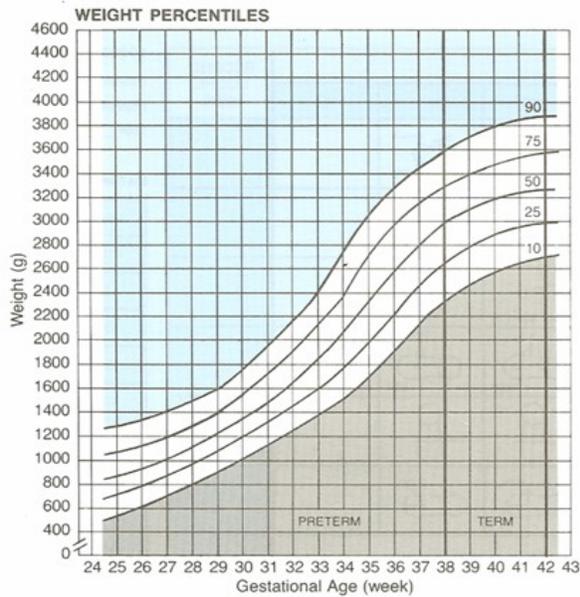
Physical Maturity

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	Maturity Rating
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	-10 20
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	-5 22
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	0 24
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	5 26
							10 28
							15 30
							20 32
							25 34
							30 36
							35 38
							40 40
							45 42
							50 44

This neonate scored a 45, his maturity level rating is 42 weeks.

**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)			
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; 71:1-10-123

Weight: 3530 and 39 weeks puts the neonate in 75th percentile which is appropriate for gestational age.

Length: 52 cm and 39 weeks puts the neonate in the 80th percentile which is appropriate for gestational age.

Head circumference: 35 cm and 39 weeks puts the neonate in the 75th percentile which is appropriate for gestational age.