

Birth Summary - Baby

Attach computer
printout if available

Mother's Name

Unit number

NHS number

Baby Details

Number of babies

Birth order	Date of Birth	Time	Sex	Birth weight (g)	Centile	Mode of Delivery	Outcome	Apgars			Congenital Anomaly	Unit Number	NHS Number
								1	5	10			
1													
2													

Apgar Score

	0	1	2	Baby 1			Baby 2		
				1	5	10	1	5	10
Heart rate	absent	< 100	> 100						
Respiratory effort	absent	weak cry	good strong cry						
Muscle tone	limp	some flexion of extremities	well flexed						
Reflex irritability	no response	some motion	cry						
Colour	blue / pale	body pink, limbs blue	pink						
Total									

Cord Gases

	Baby 1		Baby 2	
	Arterial	Venous	Arterial	Venous
pH				
Base excess / deficit				
Other				

Resuscitation

	Baby 1			Baby 2		
	None	Basic	Advanced	None	Basic	Advanced
Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IPPV : Face mask	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
ETT	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac massage	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Intubated	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Age intubated (mins)						
Drugs						
Name						
Grade						

Initial Examination

	Baby 1	Baby 2
Head circumference (HC, cm)		
Temperature (°C) / Route		
Identification / security labels		
Physical examination		

Vitamin K

	Baby 1		Baby 2	
	Yes	No	Yes	No
Administered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Route				
Requires further dose	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signature				

Contact & Feeding

	Yes	No	Comments	Baby 1		Baby 2	
				Time		Time	
Skin-to-skin	<input type="checkbox"/>	<input type="checkbox"/>					
Offered	<input type="checkbox"/>	<input type="checkbox"/>					
Accepted	<input type="checkbox"/>	<input type="checkbox"/>					
Intended method of feeding	Breast			<input type="checkbox"/>		<input type="checkbox"/>	
	Artificial			<input type="checkbox"/>		<input type="checkbox"/>	
	Undecided			<input type="checkbox"/>		<input type="checkbox"/>	
Feed offered	Method						
	Time feed started						
	Duration of feed						

Neonatal Comments

Plans for Transfer after Birth

	Destination	Date and time of transfer	Signature *
Mother			
Baby(ies)			
Summary of care			

Signature

Date / Time