Gastrointestinal Assessment

Determine presence of abdominal distention—increase in circumference, shiny skin, evidence of abdominal wall erythema, visible peristalsis, visible loops of bowel, status of umbilicus.

Determine any signs of regurgitation and time related to feeding; describe character and amount of residual if gavage fed; if nasogastric tube is in place, describe type of suction and drainage (color, consistency, pH).

Describe amount, color, consistency, and odor of any emesis.

Palpate liver margin (1 to 3 cm below right costal margin).

Describe amount, color, and consistency of stools.

Describe bowel sounds—presence or absence (must be present if feeding).

Genitourinary Assessment

Describe any abnormalities of genitalia.

Describe amount (as determined by weight), color, pH, lab stick findings, and specific gravity of urine.

Check weight.

Neurologic–Musculoskeletal Assessment

Describe infant's movements—random, purposeful, jittery, twitching, spontaneous, elicited; describe level of activity with stimulation; evaluate based on gestational age.

Describe infant's position or attitude—flexed, extended.

Describe reflexes observed—Moro, sucking, Babinski, plantar, and other expected reflexes.

Determine level of response and consolability.