"Admission Date: [**2122-3-16**]   Discharge Date: [**2122-4-1**]

Date of Birth: [**2122-3-16**]   Sex: M

Service: Neonatology

This is an interim dictation covering the dates of [**2122-3-16**] through [**2122-4-1**].

HISTORY: A 1755 gram male infant, twin #1, born at 34-2/7 weeks gestational age to a 39-year-old G2 P0-2 mother via C section for worsening PIH. Maternal prenatal screens included blood type A positive, rubella immune, RPR nonreactive, hepatitis B surface antigen negative, and GBS unknown. Pregnancy was conceived via IVF and was complicated by PIH.

Patient emerged vigorous. Was given blow-by O2 in the delivery room and facial CPAP secondary to grunting. APGAR 8 at one minute and 8 at fuve minutes. He was transported to the NICU secondary to respiratory distress and prematurity.

PHYSICAL EXAM ON ADMISSION: Temperature 97.5, heart rate 170, respiratory rate in the 50s, blood pressure 54/39 with a mean of 50. Anterior fontanel open and flat. Palate intact. Heart with a regular rate and rhythm, no murmur. Normal pulses. Chest with a mild pectus. Patient retracting with fair air exchange. Abdomen is soft, bowel sounds present, anus patent. Normal male external genitalia. Testes

descended. Normal tone for gestational age.

HOSPITAL COURSE BY SYSTEMS:

1. Respiratory: Initially placed on CPAP, then intubated and received one dose of Surfactant. Rapidly extubated to CPAP and transitioned to room air on day of life one. Subsequently breathing comfortably in room air. Infrequent episodes of apnea and bradycardia of prematurity. At the time of this dictation, the patient is six days without a spell.

2. Cardiovascular: Patient with a soft murmur noted on day of life one. Murmur persisted through day of life three. An echocardiogram was obtained, which revealed a PDA with left to right flow. Patient was started on Indocin. Completed one course of Indocin. Follow-up ECHO with small residual PDA, not clinically significant. Murmur subsequently resolved. Patient maintained normal blood pressures throughout admission.

3. FEN: Initially NPO and on IV fluids. Feeds were initiated on day of life one and were advanced as tolerated. Patient was made NPO on day of life three when he was started on a course of Indocin for a PDA. He remained NPO throughout his Indocin course. His feeds were restarted on day of life six, and advanced without difficulty. Patient reached full feeds on day of life 10, and then calories were then advanced. Advanced to 150 cc/kg/day of PE24 or breast milk 24. Has taken all of his feeds p.o. for two days. On [**3-31**] was switched to an

adlib feeding regimen of NeoSure 24 calories/ounce in preparation for discharge home. He was started on Vi-Daylin and iron supplements. Electrolytes monitored and last checked on day of life seven with a sodium of 140, potassium of 4.3, chloride of 108, and a bicarb of 20.

4. GI: Bilirubin levels monitored. Phototherapy was initiated for hyperbilirubinemia with a peak bilirubin of 9.7/0.2. Phototherapy was discontinued on day of life six for a bilirubin of 5.3/0.2 and rebound bilirubin the following day was 6.0/0.2.

5. ID: CBC and blood cultures sent on admission. White count of 12 with 30 polys and no bands. Started on ampicillin and gentamicin. Blood cultures had no growth at 48 hours and antibiotics were discontinued. No further ID issues. Patient does have an umbilicus that we are monitoring since his cord came off. It is continuing to heal well with no signs of infection.

6. Hematology: Hematocrit on admission 48.2, platelets of 352. Patient required no blood products during this hospitalization.

7. Sensory: Audiology: Hearing screen was performed automated auditory brain stem responses and patient passed bilaterally on [**3-30**].

8. Routine healthcare maintenance: Patient received

hepatitis B vaccine on [**3-30**]. Patient will need a car seat test prior to discharge home. Parents are requesting a circumcision prior to discharge home. Newborn state screens sent on day of life three. Repeated on day of life 14, and results are pending at this time.

PRIMARY PEDIATRICIAN: Dr. [**First Name4 (NamePattern1) **] [**Last Name (NamePattern1) 37243**] in [**Location (un) 17927**].

CONDITION AT TIME OF THIS DICTATION: Stable.

MEDICATIONS:

1. Vi-Daylin.
2. Fer-In-[**Male First Name (un) **].

DISCHARGE DIAGNOSES:

1. Prematurity at 34 weeks gestational age.
2. Status post mild surfactant deficiency.
3. Status post patent ductus arteriosus.
4. Status post hyperbilirubinemia.
5. Status post rule out sepsis.
6. Status post feeding immaturity.

[**Name6 (MD) **] [**Name8 (MD) 38353**], M.D. [**MD Number(1) 38354**]

Dictated By:[**Last Name (NamePattern1) 50027**]

MEDQUIST36

D: [**2122-4-1**] 07:22

T: [**2122-4-1**] 07:30

JOB#: [**Job Number 55226**]

"

"Admission Date: [**2122-3-16**]   Discharge Date: [**2122-4-6**]

Date of Birth: [**2122-3-16**]   Sex: M

Service: NEONATOLOGY

ADDENDUM: This is an Addendum to the dictation performed on [**4-1**].

Discharge weight was 2155 grams. Brainstem auditory evoked responses examination passed. Hepatitis B vaccine given. At the time of discharge, the infant was taking a minimum of 130 cc/kg per day of breast milk with a 24-calorie per ounce formula and was tolerated well. Circumcision performed before discharge with good results.

Reviewed By: [**Doctor Last Name **] [**Last Name (NamePattern5) 36094**], M.D. [**MD Number(1) 36250**]

Dictated By:[**Name8 (MD) 54816**]

MEDQUIST36

D: [**2122-4-7**] 13:38

T: [**2122-4-7**] 13:53

JOB#: [**Job Number 55227**]

"

"PATIENT/TEST INFORMATION:

Indication: Congenital heart disease.

Status: Inpatient

Date/Time: [**2122-3-20**] at 09:31

Test: Portable TTE (Congenital, complete)

Doppler: Complete pulse and color flow

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

Conclusions:

Pediatric study. Report will be generated by [**Hospital3 485**].

"

"Neonatology note

3 d.o

in RA

mild jaundice

AFOF, L era skin tag.

clear lungs

rr soft murmur, no pounding pulse

bili= 4.6

wt= 1720 gm -10,100 cc/kg/d with feeding at 60 cc/kg/d with PE 20

abdomen soft.

A: ex 34 [**2-7**] wks GA, resolved RDS, jaundice, intermittent murmur.

P: advance feeding.

"

"Clinical Nutrition

O:

34 [**2-7**] wk gestational age BB, AGA, now on DOL 3.

Birth wt: 1755 g (~10th to 25th %ile); current wt: 1720 g (-10)(down ~2% from birth wt)

HC: 31 cm (~25th to 50th %ile)

LN: 42 cm (~10th to 25th %ile)

Labs not due

Nutrition: TF @ 120 cc/kg/day. EN started on DOL 1; currently on 60 cc/kg/day PE 20, advancing 15 cc/kg/[**Hospital1 **]. Remainder of fluids D10 w/ 1 meq NaCl and 1 meq KCl per dl via PIV. Projected intake for next 24 hrs from EN ~50 kcal/kg/day and ~1.5 g pro/kg/day.

GI: Abdomen benign.

A/Goals:

Tolerating feeds without GI problems so far; advancing feeds slowly and monitoring closely for signs of intolerance. Infant taking most of feeds po. IVF being weaned as EN advances. Labs not due. Initial goal for EN is ~150 cc/kg/day PE 24, providing ~120 kcal/kg/day and ~3.6 g pro/kg/day. Appropriate to start Fe supps when feeds reach initial goal. Further increases in feeds as per growth and tolerance. Growth goals after initial diuresis are ~15 to 20 g/kg/day for wt gain, ~0.5 to 1 cm/wk for HC gain, and ~ 1 cm/wk for LN gain. Will follow w/ team and participate in nutrition plans.

"

"NPN 0700-1900

Addendum to note above:

ECHO done today showed PDA. Pt. made NPO. Indocin ordered. [** **] notified by fellow.

"

"NPN 1900-0700

1. RESP

O: Remains in RA. Breathing 40-60s, sats >93%. Mild SCR noted. LSC/=. No spells/desats. A: Stable in RA. P: Cont to monitor for s/s resp distress.

3. FEN

O: BW 1755g. Current wgt= 1725g (+5). TF 120cc/kg/day. NPO for tx of PDA. Receiving D10 w/1:1 via PIV in L foot @ 8.8cc/hr. Abd exam benign, +BS, no loops. A/G 21.5cm. Asps 0.2-1.4cc, nonbilious. No spits. UO x24hrs= 3.3cc/kg/hr. Stooled x2. D/S 93. See flowsheet for lab results. A: Tolerating fluids. P: Cont to monitor FEN status, monitor for changes in exam.

4. G&D

O: [**Known lastname **] is alert/active with cares. Irritable @ times, calms w/pacifier. Temps borderline (97.7-98.0), isolette temp increased. Swaddled in low air isolette. [**Last Name (LF) 33**],[**First Name3 (LF) 120**]. Sm skin tag noted on L ear. Likes pacifier. A: AGA. P: Cont to provide dev appropriate care.

5. [**First Name3 (LF) **]

O: [**First Name3 (LF) **] in to visit @ [**2118**]. Updated @ bedside. Very

loving and appropriate. Asking lots of questions but appear comfortable w/infant's status. Mom may be D/C'ed today, family meeting needs to be scheduled. A: Attentive, loving family. P: Cont to support and educate family.

6. CV
O: Soft murmur persists. PDA by ECHO yesterday. Started Indocin course this shift: Dose #[**1-3**] given @ [**2118**] as ordered. HR 130-160s. BP 56/31 (45). Ruddy. Pulses WNL. Brisk cap refill. A: Infant w/PDA. P: Cont to monitor for changes in exam, administer Indocin as ordered.

See flowsheet for details.

"

"NPN [**7-/2018**]

#1. O: [**Known lastname **] remains in RA. RR 30-60. LS cl/=. Mild sc/IC retractions. SAting 96-100%. Occas drifts to the 80's. No A+B's or desats today. A: Stable in RA. P: Cont to monitor closley.

#2. O: Temp WNL. Bl cultures neg to date. Antibx d/c'd. No overt S&S sepsis. A&A w/cares. A: Resolved.

#3. O: TF 100cc/k/d. IVF D10 w/1na/1kcl infusing at 55cc/k

via PIV w/o incident. Enterally rec 45cc/k BM/PE20 (13cc). Mom BF this am, latched but not very interested. Took nothing by bottle. PG tube inserted and feeding gavaged. Since then he has taken 8-25cc po. Abd soft w/active BS, 1 sm spit, min asp, no loops, AG stable, voiding 4.5cc/k/hr x12hrs, passing meconium. A: Learning po skills. P: Adv enteral feeds 15cc/k [**Hospital1 55**] [**12-13**]. Assess tol.

#4. O: Temp stable swaddled in low air isolette. A&A w/cares. Not waking for feeds. MAEW. Likes pacifier. AF soft and flat. A: AGA P: Cont to support dev needs.

#5. O: Mom up for 08 and 1600 cares. Learned temp, diaper, bottle and BF techniques. Very nervous w/twins because of their size. Asking approp questions. Updates on infant's progress given at the bedside. A: Involved parent. P: Cont support, keep updated and educate.

#6. O: Heard soft murmur x1 this am. HR 130-150. BP WNL. Pink sl jaundiced and perfused. Pulses good w/brisk cap refill. Percordium quiet. A: Stable w/intermittent murmur. P: Cont to monitor closely.

"

"NPN 0700-1900

#1Resp: Pt. remains on RA, RR 30-60's, Sats > 94%. Pt. has

mild SC retractions. No spells or desats. Lungs clear bialterally. P: continue to monitor resp status.

#3Nutrition: TF increased to 120cc/kg/day of D10 1:1 & PE 20. IVF @ 45cc/kg infusing well through PIV. Enteral feeds @ 75cc/kg alt PO/PG Q 4hrs. Pt. took full volume when po fed. Feeds are being increased 15cc/kg [**Hospital1 55**]. Abd soft & round, +BS, no loops. Voiding & stooling meconium. Max asp 3cc of non-bilious, partially digested formula. No spits. P: continue on current feeding plan.

#4DEV: Temps stable swaddled in air isolette. Have not been able to wean isolette temp today. Awake & alert for cares. Putting hands to face, MAE's approp, sucking on pacifier. Fontanelles soft & flat. P: continue to support dev needs.

#5Parenting: Mom in @ 1200 today for cares. Mom not feeling well when holding pt. Mom stated her vision was blurry. Had nurse [**First Name (Titles) **] [**Last Name (Titles) 3436**] come bring mom back downstairs. Mom had high BP earlier this am. Mom [**Name (NI) 366**] that she couldn't stay longer. Mom plans on being d/c'd tomorrow. Updates given. Scheduled lactation consult for next tuesday @ 1pm. Mom will be talking w/ dad to see when family meeting can be held, preferrably tomorrow. P: continue to support & update.

#6CV: Soft intermittent murmur heard today @ cares. HR 140-150's. BP 63/29(43). Pt. sl. jaundice, well-perfused,

brisk cap refill, palpable pulses. P: continue to monitor CV status.
See flowsheet for further details.

"

"Nursing NICU Note

#3. FEN O: TF Min 130cc/kg/d of BM24/ Neosure 24 =45cc Q 4hrs. He has taken all PO feeds, ~60cc this am then breastfed x15+ min w/30cc bottle afterward this afternoon. Abdomen is soft, pibk,+BS, no loops/spits noted. He is voiding/ no stool noted this shift thus far. A: Pt. is tolerating current nutritioanl plan. P: Continue w/ current feeding plan. Monitor for s/s of intolerance. Continue to encourage PO feeds.

#4. Growth/Development O: Pt. remains in an open crib, swaddled and co-bedding, temps stable. He is [** **] and active w/ cares, sleeps well in between. Fontanelle soft/flat. He loves to use his pacifier, brings hands to face. A: AGA P: Continue to provide environment appropriate for growth and development.

#5. [** **] O: Mom in to visit this afternoon and was updated at bedside on pt's current status and daily plan of care. Mom is active and independent in cares, asking appropriate questions. A: Family is loving and involved.

P: Continue to update, support and educate.

"

"physical exam

anterior fontanelle soft, open and flat. pink. breath sounds clear with equal air entry. Regular rhythm with no murmur. Abdomen soft with normal active bowel sounds. Normal tone for gestational age. 2+ femoral pulses bilaterally

"

"NPN 1900-0700

3 Nutrition

Current weight 2.085 kg, up 10 grams. PO feeding well

BM/Neosure 24. Total enteral intake for previous 24 hrs was

146cc/kg/day plus breast feeding. Small spit x's 1. Abd

soft, bs +. Voiding and stooling.

4 Dev

Temp stable in open crib. Wakes for feeds. Sleeps well

between feeds. Sucks vigorously on pacifier.

5 [**Name (NI) **]

Dad called for update. Mom will be in for visit in am.

"

"Neonatology

4 d.o

in RA, isolette

AFOF

pink, jaundice

RR with soft murmur (less than yesterday), pulses not bounding, s/p 2 doses of indocin

clear chest mild retraction

Abdomen soft

normal tone

wt= 1725 gm +5, 120 cc/kg/d, NPO

bili= 9.7

A: ex 34 [**2-7**] wks GA, RDS, PDA, jaundice

P: continue course of Indocin, start PN, start phototherapy, f/u bili

"

"NPN [**7-/2018**]

#1. O: [**Known lastname **] remains in RA. RR 40-60. Sating >92%. No drifts or desats. LS cl/=. Mild SC retractions.

#3. O: Infant remains NPO. TF 120cc/k D10W w/1na/1kcl infusing via PIV w/o incident. Abd soft w/active BS, min asp, no psits, no loops, AG stable, voiding 2.8cc/k/hr, trace mec stools. P: Change to PN this eve.

#4. O: Temp 97 in low air isolette despite increasing temp and adding blanket and hat. Changed to servo control when starting photo therapy. Acting well w/cares. A&A w/cares. MAEW. AF soft and flat. Sucks on pacifier.

#5. O: Both in at 1130. Stayed to do cares. Mom d/c'd to
home today. They felt a family meeting unnecessary today.
Plan on meeting this w/e. Mom to have lac consult on tues.

#6. O: Infant conts to have murmur (PDA) 2nd dose indocin
given w/o incident. HR 120-140. BP 59-40 48. Infant is ruddy
pink and perfused. Pulses good. Percordium quiet.

#7. O: Infant started on single photo therapy for bili of
9.7/0.2. Protective eye [**Doctor Last Name 739**] in place. Infant is ruddy.
Passing sm amts meconium.

"

"7 Hyperbili

REVISIONS TO PATHWAY:

7 Hyperbili; added
Start date: [**2122-3-20**]

"

"NPN 1900-0700

3 FEN
Current weight is 2.145 kg, up 60 grams. TF remain at min
of 130cc/kg/day. Total intake for previous 24 hrs was
104cc/kg/day plus breast feedings. Abd soft, bs +.

Continues to spit after feedings. Voiding and stooling.

4 DEV

Temp stable in open crib. Wakes for feeds. Awake and

active with cares. Sleeps well between cares. Sucks

vigorously on pacifier.

5 Parenting

Mom called for update. Will be in to visit in am.

"

"Neonatology Attending Note

Exam:

Resting comfortably in open crib. [** 33**]. Lungs CTA, =. CV RRR, no murmur, 2+FP. Abd soft. Ext warm, pink, and well perfused with full ROM.

"

"Neonatology Attending Note

Day 20

CGA 37 1

RA. RR30-60s. BS cl and =. Pink. Well perfused. No murmur. HR 150-160s. BP 61/42, 51.

Wt 2145, up 60 gms. Min 130 cc/k/day BM24 w NeoSure or Neosure 24. TFI: 104 +BF. Nl voiding and stooling.

In open crib.

A/P:

Growing preterm infant with plan for discharge in am. Cont to monitor, no changes to current medical plan.

"

"Nursing

#3O: Ad lib demand, wakes on own bottles well, 24 cal

breast milk or neosure, occ. spits. Belly soft, voids qs, no

stool.

#4O: Co-bedding with brother, active with cares. Brings

hands to mouth. Had bath today.

#5O: Mom in, gave bath and reviewed tcg. Mom set to take

son home [**Name2 (NI) 172**].

"

"NPN

#3 F/N- Abd soft,+bs, no loops.Tolerating feeds of BM24 cals

w/o spits. Bottles well ad lib demand taking 80cc q4-5 hrs.

Voiding+ stooling in adeq amts.Wt up 10gms.

#5 [**Name (NI) 9**] Mom called x1. Updated.

"

"NPN 1900-0700

1. RESP

O: Remains in RA. Breathing 40-70s, sats >95%. Mild IC/SCR noted. Lungs wheezy upon auscultation x2, NNP/RT aware. RT suctioned infant @ 2400 for large plug - LSC/= now. No spells or drifts noted. A: Stable in RA. P: Cont to monitor for s/s resp distress.

3. FEN

O: BW 1755g. Current wgt= 1720g (-10). TF 100cc/kg/day. Currently receiving 40cc/kg of D10 (w/1+1) @ 2.9cc/hr. Infusing well via PIV. Enteral feeds of PE20 @ 60cc/kg (18cc q4h PO/PG). Infant has received all feeds PG this shift d/t resp status (wheezing). Advancing feeds by 15cc/kg [**Hospital1 **] @ 1200+2400 as tolerated. Abd exam benign, +BS, no loops. A/G 21-22.5cm. No spits. Asps= 1.4-3cc, all nonbilious and refed. UO x24hrs= 3.9cc/kg/hr. Lg mec x1. Will check D/S with next care. A: Tolerating current regime. P: Cont to monitor for s/s feeding intolerance.

4. G&D

O: [**Known lastname **] is alert/active with cares. Temps stable swaddled in low air isolette. PKU done. Sm skin tag noted on infant's L ear. Roots and sucks on pacifier. A: AGA. P: Cont to provide dev appropriate care.

5. [**Known lastname **]

No contact w/family thus far this shift. Unable to assess.

6. CV

O: Soft intermittent murmur heard x1 this shift. HR

140-160s. BP 62/36/48. Pulses WNL. Brisk cap refill. Color

remains ruddy, well perfused. A: Stable CV status. P: Cont

to monitor for changes in exam.

See flowsheet for details.

"

"CLINICAL NUTRITION

O:

~36 [**1-2**] WK CGA BB ON DOL 17.

WT: 2020G(+5)(~10 %ile); birth WT: 1775g. Average wt gain over past wk ~11g/kg/day.

HC: 31cm([**10-26**] %ile); last wk: 31cm

LN: 45cm(~25 %ile); last wk: 43cm

Meds include Fe & vidaylin.

Labs not needed.

Nutrition: Min. 130cc/kg/day as Neo/BM 24; all po's. Feeds just changed; Took ~154cc/kg/day past 24hrs; projected intake for next 24hrs based on past 24hrs ~154cc/kg/day, providing ~123kcal/kg/day & ~2.2-3.2g pro/kg/day.

GI: Abdomen benign.

A/Goals:

Tolerating feeds w/o GI problems, all po's. Labs not needed. Current feeds & supps meeting weaned recs for kcal/pro/vits/mins. Growth is not meeting recs for WT/HC gains of ~15g/kg/day for WT gain & of ~0.5-1.0cm/wk for HC gain; feeds changed to adlib min. 130cc/kg/day, hopefully, will take larger volumes; will monitor & will increase calories PRN per growth. LN gain is exceeding recs of ~1cm/wk, ? accuracy of measurement. Will monitor long term trends. will continue to follow w/ team & participate in nutrition plans.

"

"NPN addendum

Noted that infant has white coating on tongue which does not wipe off. [** 41**] saw infant and ordered nystatin x6 days. Also Mom showed me her nails today and said that within the past few days they have been swollen and red around the cuticles. she does not wear artificial nails. Sugested she call her PCP. ?if she has fungal infection. Will suggest she wear gloves while visiting infants.

"

"Attending Note

Physical Exam

Gen very well appearing active and engaging

lungs clear bilaterally

CV regular rate and rhythm no murmur

Abd soft with active bowel sounds no masses or distention

Ext warm well perfused with brisk cap refill

"

"Attending Note

Day of life 19 CGA 37

RR 30-50 stable in room air

no murmur HR 140-160

weight 2085 up 10 min 130 cc/kg/day BM 24

does well with breast feeding

voiding and stooling

s/p circ yesterday

active and [** **]

Imp- doing really well

anticipate discharge to home Monday

car seat test today

"

"Nursing

#3O: On 24 cal Breast milk with neosure, changed to demand feeds. Belly soft, voiding and stooling. Breast fed x 1 very well and also bottled well with NUK nipple.

#4O: Car seat screen done and passed. Co-bedding with brother, active with cares.

#5O: Mom in this morning and handles son well and independently. Tlaked about when to call pedi, protection from infection, bowel and bladder habits and how often to feed. Mom feels comfortable giving vitamins and iron as well as circ care. Will do bath [**Doctor First Name 172**].

"

"Discharge Physical Exam

normal male genitalia with circ nonerythematous; testes high in canal with mild right hydrocele

"

"Discharge Physical Exam

Anterior fontanelle soft, open and flat; palate intact with normal suck. clavicles intact. symmetric air entry bilaterally with clear breath sounds. Regualr rhythm with no murmur. Abdomen soft with no distension; normal active bowel sounds. 2+ femoral pulses bilaterally. warm, well perfused; normal tone, 2+ DTRs. Normal grasp and moro reflexes.

"

"Neonatology Attending

DOL 21

[**Known lastname **] remains in room air with no cardiorespiratory events.

No murmur.

Wt 2155 (+10) on min 130 cc/kg/day BM24/Neosure24 ad lib demand with intake well above minimum, in addition to breastfeeding. Voiding and stooling normally.

Temperature stable.

A&P

34-2/7 week GA infant

-For discharge home today.

-Hearing screen passed, HB administered, car seat testing passed, parental education completed

-Will continue iron and vidaylin at home

-Ped follow-up with [**First Name4 (NamePattern1) 734**] [**Last Name (NamePattern1) 2580**] on Wed

Discharge time > 30 minutes

"

"Nsg note

[** **] attended a cpr class. Watched the video first. Reviewed infant cpr and choking and demonstrated on doll . Parent returned [**Last Name (un) 26**] without difficulty. Handout given to them.

"

"NICU nursing note

3. FEN=O/Current wt=2075g (^55g). TF cont at min of 130cc/k/d of BM24/Neosure24. All po's. Fed Q4hours. Abd benign. (Please refer to flowsheet for assessment and po vols.) Lg spit x1 so far this shift. Voiding. Lg stool x1. Cont on Vidaylin and iron. A/Tolerating current regime. Bottlefeeding well. P/Cont to monitor for feeding intolerance. To start oral Nystatin once up from pharm.

4. G&D=O/Temp stable swaddled cobedding in open crib. [** 25**] and active with cares. Sleeping well between feeds. Circ healing well. Slightly edematous. Scant serosang dng noted on gauze. Vaseline gauze applied with Qcare. Tylenol given at 2200. A/Alt in G&D. Pain/discomfort r/t circ well managed. P/Cont to monitor and support G&D.

5. [** **]=O/Dad called x1. Updated by this nurse. P/Cont to support and educate [** **].

"

"Neonatology Attending

DOL 18 / CGA 36-6/7 weeks

Remains in room air with no distress. No cardiorespiratory events.

No murmur noted today. BP 81/47 (59).

Wt 2075 (+55) on min TFI 130 cc/kg/day BM24/Neosure24, with intake above this minimum. Voiding and stooling.

Temperature stable in open crib. Concern re: oral thrush overnight.

A&P

34 week GA infant with resolving respiratory immaturity

-Continue to await 5-day period without apnea prior to anticipated discharge on Monday

-Nystatin started for oral thrush; will discuss with mother re: breastfeeding and need for monitoring of the twin

"

"NPN 1900-0700

1. RESP

O: Remains in RA since 0800 yesterday. Breathing 50-70s,

sats >93%. Occ periods of tachypnea noted w/grunting around

care times. Self-resolves. Mild IC/SCR noted. LS clr/=. Occ

drifts to mid-high 80's noted throughout shift, self

-resolved. No spells. A: Stable in RA. P: Cont to monitor

for s/s resp distress.

2. SEPSIS

O: Remains under 48hr r/o for sepsis. BC pending. CBC benign

@ birth. Receiving ampi/gent as ordered. A: Infant

w/possible sepsis. P: Cont to monitor for s/s sepsis,

administer abx as ordered.

3. FEN

O: BW 1755g. Current wgt= 1730g (-25). TF 100cc/kg/day. Currently receiving 70cc/kg of D10 (w/1NaCl & 1KCl) @ 5.1cc/hr via PIV. Infusing well. Enteral feeds @ 30cc/kg (9cc PE20 q4h). Infant is bottling, taking 10cc q4h this shift. No plans to advance this shift. Abd exam benign, +BS, no loops. A/G 22-23cm. No spits. D/S 119. UO x24hrs= 3.1cc/kg/hr. Lg mec x1. A: Tolerating current regime. P: Cont to monitor for s/s feeding intolerance.

4. G&D

O: [**Known lastname 3435**] is alert/active with cares. Temps stable swaddled in low air isolette. Weaned air temp x1. [**Last Name (LF) 33**],[**First Name3 (LF) 120**]. Roots and brings hands to face. Sm skin tag noted on infant's L ear.

A: AGA. P: Cont to provide dev appropriate care.

5. [**First Name3 (LF) **]

No contact w/family thus far this shift. Unable to assess.

6. CV

O: Soft murmur heard throughout shift. HR 140-150s. BP 55/34/45. Pulses WNL. Brisk cap refill. Infant is ruddy. NNP aware of murmur. A: Alt in CV status. P: Cont to monitor for changes in exam.

See flowsheet for details.

"

"Social Work

Mother of twins known to me from her antepartum admission on 6s.

Saw her briefly yesterday, she was exhausted and needing to sleep. she is delighted with how well babies are doing. Plans to visit again when she is feeling more rested. Doing well.

"

"Neonatology note

2 d.o

in RA, no spells.

RR with soft murmur

abdomen soft

jaundice

on amp+gent

wt= 1730 gm -25, 100 c//kg/d with feeding at 30 cc/kg/d with EBM/PE 20

AFOF

clear lungs, mild retraction

normal tone

A: ex 34 [**2-7**] wks GA, resolved RDS, sepsis evaluation

P: d/c antibiotics, f/u bili, advance feeding.

"

"Fellow note; Physical exam

Alert and active. Skin pink. AFOF, sutures overriding. Left ear tag. Lungs clear with good aeration bilaterally. RRR. NL S1, S2. No murmur appreciated on exam. Normal femoral pulses. Abd soft, ND, +BS. Extre WWP. Good tone.

"

"NPN 7p-7a

Fen: Wt tonoc 2.020kg (+5gms). Min 130cc/kg of neosure 24. Waking q3-4hrs for feeds. Po'ing above minimum. Po intake for 24hrs 153cc/kg. Abd soft. Active bs. Stool x1 thus far. Quaic neg. Voiding with each diaper change. Umbi sl oozing wiped with alcohol. Conts on fe and polyvisol. Cont to monitor.

Dev: Temp stable swaddled in open crib. [** 25**] and active with cares. Temp stable swaddled in open crib. Waking for feeds. Cont to support developmental milestones.

Parenting: NO contact from [**Name2 (NI) **] so far this shift.

"

"Neonatology Attending

DOL 17

[**Known lastname **] remains in room air with no cardiorespiratory events since yesterday.

No murmur.

Wt [**2138**] (+5) on min 130 cc/kg/day Neosure 24/BM24, tolerating well. Intake yesterday 153 cc/kg/day. Abdomen benign.

Circumcision this morning.

A&P

34 week GA infant with resolving respiratory immaturity

-Will be ready for discharge after 5 asymptomatic days (counted from yesterday).

-Otherwise continue current management as detailed above.

"

"Neonatology-[** 41**] Physical Exam

Infant remains in RA. Active, [** **] in an open crib, AFOF, sutures opposed, good tone. BBS clear and equal with good air entry. No murmur, pulses +2, pink, RRR. Abdomen soft, non-distended with active bowel sounds, no HSM, tolerating feeds. Circ today. Please refer to attending progress note for detailed plan.

"

"NPN [**7-/2018**]

#3. O: Infant conts on min 130cc/k BM/neosure 24 (44cc) on an adlib demand schedule. He has been waking about every 4hrs and taking 50cc by bottle. No bradys or immaturity noted w/bottling today. Abd soft w/active BS, conts to have spits (sm to medium) HOB elevated, voiding and stooling heme-. A: No immature feeding pattern so far today. Taking over min requirement. P: Cont to monitor w/feeds.

#4. O: Temp stable swaddled in OC, cobedding w/sibling. R hydrocele soft. S/P circ, given sucrose and tylenol for procedure. Tol well. No bleeding from site. Vaseline gauze in place. Umbi site drying, cont to apply alcohol w/diaper

changes. AF soft and flat. MAEW. A&A w/cares. Sleeping

between cares. A/P: Cont tylenol for pain s/p circ x24hrs.

#5. O: [**Month/Year 1 **] in at 1200 today. Very affectionate

w/infants after circs done today. Holding for long periods

of time. Mom BF but infant slept and wouldn't latch. [**Month/Year 1 **]

signed up for CPR on mon 1530pm. Will bring car seat on sat.

Would like to do return bath [**Last Name (un) 26**] this w/e. A: INvolved

vested [**Last Name (un) **]. P: Cont d/c planning.

"

"NPN 0700-1900

#3 Alt. in Nutrition

O: TF=140cc/kg, IVF via PIV at 100cc/kg and feeds of BM/PE20 at 40cc/kg=12cc Q 4 Hrs. IVF currently D10W/lytes at 7.3cc/hr. Awaiting PN and IL from pharmecy. Abd. is round, soft with + BS, 23-24cm girth. No spits. Voiding QS and passing mec. stools. PO fed virously X 3. To breast X 1. Latched on briefly and suck only a couple of times.

A: Tolerating beginning feeds, adequate hydration

P: Increase feeds by 15cc/kg [**Hospital1 55**] and assess feeding tolerance. Follow daily wts. Change IVF to PN and IL as soon as available.

#4 Alt. in Development

O: Maintaining temp in weaning isolette, swaddled, positioned supine, HOB elevated. Awake and irritable at times. Acting very hungry, sucking on fingers and IV. Calms with pacifier. No spells. All POs thus far.

A: Maturing behaviors, appropriate for GA

P: Continue to support developmental needs.

#5 Alt. in Parenting

O: Mom in for 1200 with grandfather. Updated. [**Name2 (NI) **] infant and put him to breast. Questions answered.

A: Involved, loving mom

P: [**Name2 (NI) 181**] informed and support.

#7 Hyperbilirubinemia

O: Rebound bili today 6/0.2. Up only slghtly. Color is resolving jaundice.

A: Resolving hyperbilirubninemia

P: D/C problem.

"

"#5 PARENT

s/o: dad called x1 and updated. A: Invested family. P: cont

support, reinforce teaching.

#4 DEV

s/o: Remains in heated isolette- air mode. TEmp stable in

swaddling. Alert with cares. Po feeds his 40cc/k of PE20

with eagerness. A: dev AGA P: cont dev supportive cares

#3 FEN

s/o: Wt down 10 gms tonight. TF remains at 140cc/k with IVF

at 100 and enterals at 40. PN an IL infusing well via PIV.

Po feeding PE20 well. Abd exam benign. A: Diuresing over

past days. P: To adv 15cc/k [**Hospital1 55**]- as per adv plan at- 12a-12p

To offer 55cc/k at 12midnight- assess tolerance.

"

"NPN:

RESP: Sats 95-98% in RA. RR=40-60 w/SC retraction. BBS =/clear. No A&Bs thus far tonight; none over past 24 h.

CV: No audible murmur. HR=150s. BP=72/36 (45). Color pink w/jaundice. Perfusion good.

FEN: Wt=1745g (- 65g). TF=140cc/kg/d. Enteral fdgs at 55cc/kg/d; tolerating 16cc PE-20 q 4 h PO. Bottled slowly w/good coordination. PN (D-10) & IL at 85cc/kg/d. Abd benign. U/O=3.3cc/kg/h over 24-h period yesterday. No stool since yesterday. To increase enteral feeds 15cc/kg [**Hospital1 55**] as tolerated.

G&D: CGA=35 [**3-8**] wk. Temp stable in air-controlled isolette. Active and alert w/cares. Swaddled, nested and resting well.

SOCIAL: No contact w/[**Name2 (NI) **].

"

"Neonatology note

8 d.o

in RA, no spells.

AFOF

mild jaundice

RR with no murmur

clear lungs

abdomen soft

wt= 1745 gm -65, 140 cc/kg/d with feeding at 55 cc/kg/d with PE 20

A: ex 34 [**2-7**] wks GA, closed PDA, jaundice

P: advance feeding.

"

"npn 1900-0700

#1 resp

pt continues on nasal prong cpap6, fio2 21%. lsc=. rr

30-70's. sc/ic and +pectus noted. occational grunting

noted with cares, then quiets when settled. no spells or

drifts thus far this shift.

#2 sepsis

bc pending. cbcd benign. amp and gent continued for

48hours. pt a/a with cares. stable temps

#3 fen

tf 80cc/kg of d10w via piv. npo. wt. 1.755kg. abd flat with

+bs. u.o thus far this shift has been 2cc, nnp aware. ag

18.5cm. no spits.

#4 g&d

pt in servo control isolette with stable temps. alert and

awake with cares. maew. loves binki. fontanelles soft and

flat. bruising noted to heels.

#5 parenting

[** **] up briefly at beginning of shift. updated at

bedside on both infants condition. [** **] asking

appropriate questions. loving towards infants.

"

"Respiratory Care Note

Pt. is a 34 wk. twin born [**3-16**]. Pt. was intubated and surfed x1 per report. Pt. received on 6cmH2O of nasal prong CPAP. Pt. sx'd for mod.white secretions. To follow

"

"Neonatology note

1 d.o

on CPAP now in RA this am, s/p 1 dose of surfactant yesterday.

mild retraction, clear lungs

RR with no murmur

abdomen soft

pink.

AFOF.

wt= 1755 gm, 80 cc/kg/d with IV, NPO

A: 34 [**2-7**] wks GA, RDS, sepsis evaluation.

P: continue antibiotics for 48h, start feeding, observe for immaturity of breathing.

"

"Nursing NICU Note

1. Resp. O/Pt remains in RA since this am. No evidence of

increased WOB noted. A/Resp status stable in RA at this

time. P/Cont. to monitor.

2. Sepsis. O/Remains on Amp and Gent for 48hour R/O sepsis.

A/At risk for sepsis. P/Cont. to follow bld cx results.

Cont. to monitor for s/s of sepsis.

3. F/N. O/TF remain at 80cc/k/d Enteral feeds initiated at

30cc/k/d PO. IVF D10W running via intact PIV at 50cc/k/d.

Please see flowsheet for examinations of pt from this shift.

Voiding. No stool passed. A/Appears to be tolerating present

feeding regime. P/Cont. to monitor for s/s of feeding intolerance.

4. Dev. O/Weaning air controled isolette temp gradually, as pt tolerates. PT swaddled. Awake and alert with care times and sleeping well in between. A/Alt. in G/D. P/Cont. to support pt's growth and dev. needs.

5. [** **]. O/Mother and father in today. [** **] updated on pt's status and plan of care. Mother stated that she felt light headed and would be up for the 4pm feeding to hold pt. A/[** **] are involved in pt's care. P/Cont. to support and educate [** **].

"

"NPN days

Nutrition: Total fluids MIN of 130cc/k/d ad lib. of (now) Neosure 24 or Bm 24 made with Neosure powder. All bottles today ,taking 60cc per feeding. spit x2 (one small and one med.) both spits with burping in the middle of feeding. Abdomen is soft,pink, no loops, active bowel sounds. Minimal residuals. continues on Iron supplements and starting on Vidaylin today. Voiding Qdiaper change, no stool this shift. Will continue to monitor closely,

encourage po feedings.

Dev: Continue to co-bed with twin in open crib with HOB at 45degrees due to spits. temps are stable. Active and [** **] with cares, sleeeping well between cares. MAE. Umbi with some yellow drainage -small amt, cleaned Q4hours with alcohol wipes with diaper changes, keeping open to air. R hydrocele is soft and pink. Dr. [**Last Name (STitle) 91**] [**Name (NI) 415**] for possible circumcision - he will evaluate tomorrow. Will continue to support developmental needs.

Parenting: Mother called today for update, updated on progress. Will be in tomorrow to visit infants. Mother to bring in car seats for testing. Wants to bathe [**Known lastname **] tomorrow. will continue to update and support family.

"

"Fellow note; physical exam

[** 25**] and active in open crib. Breathing comfortably in RA. Skin pink. AFOF. Eyes clear. Lungs clear. RRR. No murmur. Normal femoral pulses. Abd soft, ND, +BS. Umbilicus still healing in center, no signs of infection. Extrem WWP. Good tone.

"

"NPN 7p-7a

Fen: Wt tonoc 2.015kg (+55gms). Conts on min 130cc/kg of neosure 24. Po'ing 40-55cc. Po intake for 24hrs 160cc/kg. Abd soft. Active bs. Stool x1 thus far. Voiding with each diaper change. Conts on fe and polyvisol. Umbi slightly oozing. Drying with alcohol. Rt hydrocele soft. HOB elevated. No spits thus far. Well coordinated with feeds this shift. Cont with current plan.

Dev: temp stable swaddled in open crib. [** 25**] and active with cares. Sleeps well between. Wakes for feeds. Cont to support developmental milestones.

Parenting: Mom called x1 for update. Cont to support and update.

"

"NPN 1900-0700

3.FEN: Infant's weight tonight 1925g (up 5g). He remains on TF 150cc/kg/day of PE/BM 24cal/oz. Infant offered bottle q feed, took full bottle twice thus far this shift. He is tolerating feeds with two spits, maximum aspirate 2.0cc of non-bilious, partially digested formula. Abdomen is soft and round with active bowel sounds, no loops. Abdominal girth consistent at 23.5-24.5cm. He is voiding and stooling (heme neg). On Fe+ dietary supplement. Continue to monitor

FEN status, weight gain, and encourage po feeds as
tolerated.

4.DEV: Infant remains cobedded in open crib with twin. He is
swaddled with stable temps, HOB elevated 45 degrees. He is
alert and active with cares, wakes early for feeds.
Umbilical granuloma present, healing well. Plan to
administer Hep B vaccine when 2kg. Plan for hearing screen,
circumcision, and car seat test prior to d/c. Continue to
monitor, support growth and development.

5.[** **]: Mom called x 1 this shift. This nurse unable to
speak with mother due to timing of call. Plan for lactation
consult tomorrow (Monday [**3-30**]) at noon. Continue to support
[**Month/Year (2) **] and keep informed.

"

"NPN Addendum

Infant exhibits drifts in HR with feeds to 80s attributed to uncoordinate suck and swallow, quickly self resolved.

"

"Neonatology note

14 d.o

in RA, no spells

clear lungs

RR with no murmur

abdomen soft

wt= [**2043**] gm +5, 150 cc/kg/d with PE/EBM 24, po/pg

AFOF

pink

normal tone

A: ex 34 [**2-7**] wks GA, growing preemie.

P: encourage po nippling.

"

"PCA Note:

FEN: O: TF 150cc/kg BM24 or PE24. PO/PG feeds q4h as tolerated. Infant bottled this morning taking in 60cc; brady'd to 74 beats/min - resolved with mild stim. (no O2). Infant breastfed (<5min) this afternoon, bottled 43cc and was further supplemented by gavage. Infant's abdomen is soft, nontender, pos bowel sounds, no loops. Medium spit this morning after bottling. Minimal aspirates. Infant is voiding, no stool thus far. Right hydrocele, small and soft. A: Infant tolerating feeds well. Strong suck, eager to bottle, lacking coordination. Uninterested at breast this afternoon, sleepy. P: Continue to encourage PO feeds. Continue to support nutritional needs of infant.

DEV: O: Infant is swaddled, cobedded in an OAC; maintaining stable temps. Infant sleeps well between cares. Beginning to stir for feeds. A/A with cares. Green to yellow drainage from umbi., treated with alcohol swabs. A: Developmentally appropriate. P: Continue to support developmental needs of infant. Continue to watch umbilical drainage.

[** **]: O: Mom in this afternoon for 12:30 cares. Breastfed infant (<5min), supplemented infant with bottle and gavage. Lactation consult this afternoon. A: Mom appears appropriate, comfortable; gaining confidence and independance in caring for infants. P: Continue to support and teach [** **].

"

"Nursing Progress Note

1 Alt. in Resp. Function
6 Alt. in CV

#3. O: Infant remains on TF's of 140cc/k/d. Feeds of BM/PE20 continue at 20cc/k/d. IVF's of D10PN and IL's infusing well via PIV at 120cc/k/d. Abd soft and flat with active bowel sounds. No loops. Voiding 4.3cc/k/hr. No stools. Wgt is down 55gms tonight to 1810gms. A: Tolerating feeds. P: Continue to monitor feeding tolerance. Send elec's this a.m.

#4. O: Infant remains in air mode isolette, dressed and swaddled with stable temp. He is alert and active with cares. MAEW. Sucking on pacifier intermittently. A: AGA. P: Continue to assess and support developmental needs.

#5. O: Dad called x1 for update. Asking appropriate questions. A: Involved [** **]. P: Continue to inform and support.

#7. O: Phototherapy lights off. Rebound bili to be sent this

a.m. A: Hyperbili. P: Check RBIL.

REVISIONS TO PATHWAY:

1 Alt. in Resp. Function; resolved

6 Alt. in CV; resolved

"

"Neonatology note

7 d.o

in RA, no spells.

RR with no murmur

clear lungs

pink, jaundice

Abdomen soft

abdomen soft

AFOF, normal tone

bili= 6

wt= 1810 gm -55, 140 cc/kg/d with feeding at 20 cc/kg/d with EBM/PE 20

A: ex 34 [**2-7**] wks GA, jaundice, closed PDA

P: continue to advance feeding

"

"Clinical Nutrition

O:

~35 [**1-2**] wk CGA BB on DOL 7.

WT: 1810 g (-55)(~10th %ile); birth wt: 1755 g. Average wt gain over past wk ~4 g/kg/day.

HC: 31 cm (~25th %ile); last: 31 cm

LN: 43 cm (~10th to 25th %ile); last: 42 cm

Meds include s/p indocin.

Labs noted

Nutrition: 140 cc/kg/day TF. Feeds currently @ 20 cc/kg/day PE/BM 20, increasing 15 cc/kg/[**Hospital1 **]. Remainder of fluids as PN via PIV; projected intake for next 24 hrs from PN ~67 kcal/kg/day, ~2.8 g pro/kg/day and ~2.4 g fat/kg/day. From EN: ~23 kcal/kg/day, ~0.4 to 0.7 g pro/kg/day, and ~1.2 to 1.3 g fat/kg/day. Glucose infusion rate from PN ~6.5 mg/kg/min.

GI: Abdomen benign.

A/Goals:

Tolerating feeds without GI problems; advancing slowly and monitoring closely for signs of PDA and/or feeding intolerance. Tolerating PN with good BS control. Labs noted and PN adjusted accordingly. Current feeds + PN meeting recs for kcal/pro/fat/and vits. Will not meet full mineral recs until feeds advanced to initial goal of ~150 cc/kg/day PE/BM 24. Growth should improve as enteral feeds advance to initial goal. Will continue to follow w/ team and participate in nutrition plans.

"

"Neonatology NP Exam Note

Please refer to Dr[**Name (NI) 348**] Note for details of evaluation and plan.

PE: small infant nestled in open crib with twin

HEENT: AFOF, eyes clear, MMMP

Chest is clear with comfortable resp pattern

CV: RRR, no murmur, pulses +2=

Abd: soft, active BS

GU normal male genitalia

EXT: MAE, WWP

Neuro: great tone, symmetric reflexes

"

"NPN 1900-0700

3.FEN: Infant's weight tonight 1920g (up 80g). He remains on
TF 150cc/kg/day of BM/PE 24cal/oz po/pg. Infant has been
offered bottle with [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] nipple q feed, took 32, 36, and
48cc respectively. He is tolerating feeds with 2 large
spits during feeds, maximum aspirate 5.0cc of non-bilious,
partially digested formula. Abdomen is soft and round with
active bowel sounds, no loops. Abdominal girth stable at
24-25cm. He is voiding and stooling. Continue to monitor
FEN status, weight gain/loss, and encourage po feeds as
tolerated.

4.DEV: Infant remains cobedded in open crib with twin, HOB
at 45 degreees. Infant is alert and active with cares,
wakes for feeds. Temps stable swaddled. He is coordinated
with bottle, has strong suck and is able to pace himself.
One brady overnight with bottle, attributed to
uncoordination, resolved with mild stim, no O2. Continue to
support growth and development.

5.[**Last Name (NamePattern4) **]: No contact from [**Name2 (NI) **] overnight. Continue to support [**Name2 (NI) **] and keep informed.

"

"Neonatology Attending
DOL 13

In room air with no distress and no spontaneous cardiorespriatory events.

No murmur. BP normal.

Wt [**2037**] (+80) on TFI 150 cc/kg/day BM24/PE24, bottling partial volumes.

A&P

34-2/7 week GA infant with feeding immaturity

-Continue to await maturation of oral feeding skills

-Discharge planning in progress

"

"NPN 0700-1900

3. FEN

O: TF 150cc/kg/day of BM24/PE24. Offered PO's qfeed this shift as infant appeared alert/awake and eager. Bottled full volumes x2. Breastfed well x30 mins @ 1230 and bottled 11cc of minimum thereafer; remainder gavaged. Abd exam benign. A/G 24.5-25cm. Lg spit x1. Max asp 3.6cc (nonbilious). Voiding and stooling (heme-). Receiving FeSO4 as ordered. Sm umbi granuloma noted; [** 41**] aware. A: Tolerating feeds. P: Cont to monitor for s/s feeding intolerance, encourage PO's.

4. G&D

O: [**Known lastname **] is alert/active with cares. Waking for feeds this shift. Temps stable cobedding in OAC. [**Last Name (LF) 33**],[**First Name3 (LF) 120**]. Awaiting circ, hearing screen, Hep B. A: AGA. P: Cont to provide dev

appropriate care.

5. [**First Name3 (LF) **]

O: Mom in to visit for 1230 care. Very loving and

appropriate w/[**Known lastname **]. Independent w/cares. Scheduled for

lactation app't tomorrow @ 1200. A: Attentive, loving

family. P: Cont to support and educate family.

See flowsheet for details.

"

"Neonatology NP EXam Note

PE: well appearing small infant cobedding with twin.

AFOF, eyes clear, ng in place, MMMP

Chest is clear, comfortable resp pattern

CV: RRR, no murmur, pulses +2=

Abd: soft active BS, granulating cord

GU normal male ext gentailia

EXT: [**Last Name (LF) **], [**First Name3 (LF) 120**], WWp

Neuro: active and responsive, symmetric tone and reflexes

"

"Neonatology admit note

Baby boy [**Known lastname **]-[**Known lastname 1755**], twin #1, was bborn today at 34 [**2-7**] wks GA to a 39 y.o mother [**Name (NI) 3431**] via c/s for worsening PIH with a BW of 1755 gm and an Apgar of */8.

Maternal prenatal screen included: A+/RI/RPR NR/HBSAg-/GBS unknown

Pregnancy was conceived via IVF and complicated by PIH.

He developped grunting in DR [**Last Name (STitle) **] was given BBO2 then facial and transported to NICU where he was noted to have retraction.

PE: T= 97.5 P= 170's RR= 50's BP= 54/39(50) D/S= 67

AFOF, no cleft lips, palate.

Heart: RR with no murmur. pulses equal.

Lung: mild pectus, retraction, air exchange fair

Abdomen soft, bowel sounds present.

anus patent, normal male genitalia, testes descended.

normal tone for preemie.

A: twin #1 at 34 [**2-7**] wks GA, respiratory distress, sepsis evaluation tthough low risk factors.

P: consider surfactant replacement, empirical antibiotics, NPO for now.

"

"NICU Admission Note

O: Baby [**Name (NI) 4**] [**Known lastname 3432**]-[**Known lastname 1755**], 34 [**2-7**] wk. twin #1, admitted to NICU at 1545 after C/S delivery to G-1 P-0 39 y.o. with worsening PIH. On admission infant with GFR receiving facial CPAP. WT-1755 gms ([**3-15**]) Placed on servo warmer, on cardio-resp. and 02 sat monitors with alarms set and audible. VS as noted on flow sheet. Intubated and received survanta. CBC and BC drawn. D/S=67. PIV placed with D10W at 80cc/kg=5.9cc/hr. IV Amp. and Gent. given. At 1800, infant self-extubated and was placed on prong CPAP 6cm. He currently remains on CPAP 21% with sats 91-95, RR in 60's with mild/mod IC/SC retractions. Baby care given. No contact with [**Name2 (NI) **]. Infant voided in DR. [**Last Name (STitle) **] void or stool since admission. Infant is nested with boundaries and positioned prone.

A: 34 [**2-7**] wk twin with resp. distress

P: Close observation and monitoring on CPAP. Continue NPO with I+O. Follow daily wts. and D/S. Antibiotics as ordered. Keep [**Month/Day (4) **] informed and support.

"

"Neonatology

Spoke with [** **] at bedside and updated.

They have given staff permission to share clinical information with paternal aunt- [**Name (NI) 3433**] [**Name (NI) 3434**], administrative director of OB/Gyn.

"

"Neonatology NP Procedure Note

Endotracheal Intubation

Indication: need for surfactant admininstration

3.0 ETT passed orally through cords under direct laryngoscopy. Tube secured with 7.5 at upper lip. Good chest wall movement and equal breath sounds present.

Infant tolerated procedure well. no complications.

"

"NPN 1900-0700

3.FEN: Infant's weight tonight 1840g (down 15g). He remains on TF 150cc/kg/day of PE/BM 24cal/oz po/pg. Infant took 20cc po in addition to breastfeeding well > 10 min. Mother has somewhat poor milk supply and infant has been losing weight so feeding supplemented via gavage. Infant is tolerating feeds with one small spit and maximum aspirate 4.6cc of non-bilious, partially digested breastmilk. Abdomen is soft and round with active bowel sounds, no loops. Abdominal girth consistent at 23.5cm. He is voiding, no stool thus far this shift. New NGT placed in right nare at 18cm. Continue to monitor FEN status, weight gain/loss, and encourage po feeds as tolerated.

4.DEV: Infant moved into open crib at 2100. Infant is cobedded with twin, swaddled with HOB elevated 15 degrees secondary to history of spits. Infant is alert and active with cares, stable temps. He brings hands to face and sucks vigorously on pacifier. Small reddened area noted on left

foot, continue to monitor. Continue to support growth and development.

5.[** **]: Mom and dad in this evening to visit with infants. They are loving and appropriate, very independent with cares and feeds. [** **] updated at bedside. Paternal aunt also called for update, permission to update given by mother and father. Lactation consult scheduled for tomorrow at 1130am. Mother given information regarding pumping, ways to stimulate milk production (specifically Mother's Milk tea). Continue to support [** **] and keep informed.

"

"NPN 07-1800

#3. O: Infant conts on TF 150cc/k BM/PE24 (52cc q4hr). Infant BF at 1300. Very sleepy during feeding. Did not latch at all. Offered bottle after BF, took 12cc. Gavaged remainder. Abd soft w/active BS, min asp, no spits, no loops, voiding and stooling heme-. A: Slow to BF and bottle today. P: Cont to support nutritional needs.

#4. O: Temp stable swaddled cobedding w/sibling in OC. A&A w/cares. Very passive personality. MAEW. AF soft and flat.

Hearing screen done/passed. Hep B consent signed. [**Last Name (un) **] bath given to Mom today. Mom to return bath on [**Known lastname **] on wed or thurs. A: AGA P: Cont to support dev needs. To call OB for circ evaluation.

#5. O: Mom in at 1200 today. Independent w/cares. BF both boys. Lac consult done. Updates on infant's progress given at the bedside. Asking approp questions. Dad in at 1500 to visit, held [**Known lastname 185**]. D/C teaching started. A: Involved vested [**Known lastname **]. P: Cont support, keep updated and educate.

"

"NPN [**7-/2018**]

Please disreguard above note, as it pertains to sibling.

I have examined infant and am in agreement w/above note by [**Initials (NamePattern4) **] [**Last Name (NamePattern4) 2486**]. In addition, infant had uncoordinated bottling at 1230 feeding. HR went to 79 and he was pale. QSR w/bottle being removed.

"

"Fellow note; physical exam

Alert and active in open crib. Breathing comfortably in RA. Skin pink. AFOF. Lungs clear. RRR. No murmur. Normal femoral pulses. Abd soft, ND, +BS. Umbilicus with cord off. Area in center still healing over. No signs of infection. Extrem WWP. Good tone.

"

"NPN 7p-7a

Fen: Wt tonoc 1.925kg (+35gms). Conts on tf 150cc/kg of
pe/bm 24cc. Po'ing full volume thus far. Po intake for 24hrs
154cc/kg. Abd soft. Active bs. Stool x1 thus far. Voiding
with each diaper change. Spit x1 thus far. Coordination
improved with po feeding. Hob elevated. Umbi with sm amount
of drainage wiping with alcohol. conts on fe. Cont to
encourage po feeding.

Dev: Temp stable swaddled cobedding with brother. [**Name (NI) 25**] and
active with cares. Sleeps well between. Not yet waking for
all feeds. Likes pacifier. Cont to support developmental
milestones.

Parenting: No contact from [**Name2 (NI) **] so far this shift.

"

"Neonatology note

15 d.o

in RA, no spells, occasional bradycardia with feeding

wt= [**2077**] gm +35, 150 cc/kg/d with EBm 24 all po nippling + breast-feding.

voiding, stooling

A: ex 34 [**2-7**] wks GA, growing preemie, closed PDA with indocin

P: continue preparation for d/c.

"

"Nursing Progress Note

#1. O: Infant remains in RA with O2 sats > 95%. RR 40's-50's. Breath sounds are clear and equal. No spells thus far tonight. A: Stable in RA. P: Continue to monitor resp status.

#3. O: Received infant on 20cc/k/d of feeds. Currently infant made NPO tonight due to persistant murmur. IVF's of D10PN, IL's and D10W with elec's infusing well via PIV. Abd soft and flat with active bowel sounds. No loops. Voiding 2.2cc/k/hr. Trace mec x1. Wgt is up 80gms tonight to 1865gms. A: NPO. P: Continue to monitor FEN status.

#4. O: Infant remains in servo control isolette with stable temp. He is alert and active with cares. MAEW. Sucking on pacifier intermittently. A: AGA. P: Continue to assess and support developmental needs.

#5. No contact from family thus far.

#6. O: Soft murmur heard tonight. Pulses 2+. Quiet precordium. No [**Location (un) 129**] pulses. BP 66/40 MAP 51. Infant made

NPO tonight. A: +murmur post one course indocin. P: ?Echo to

be done today.

#7. O: Infant remains under single phototherapy. Eye shields

in place. A: Hyperbili. P: Continue to monitor. Check bili

in a.m.

"

"Neonatology Attending

DOL 6 CGA 35 1/7 weeks

Stable in RA. R 40s-50s. No A/B.

Treated with indocin for PDA. Murmur recurred overnight therefore made NPO. BP 60/47 mean 51.

NPO. On 130 cc/kg/d with PN10/IL at 90 cc/kg and D10+lytes at 40 cc/kg. Voiding 2.2 cc/kg/hr. Stooling. 130/3.9/99/25 DS 104. Wt 1865 grams (up 80).

Bili 5.3/0.2. Phototherapy discontinued today.

Skin tag on L ear fell off yesterday.

[** **] visiting and up to date.

A: Stable in RA. Murmur has recurred-->? PDA. Hyperbili improved.

P: Monitor

Echo to check for PDA

If no PDA will start feeds

Follow lytes

Check rebound bili

"

"NPN 0700-[**2048**]

1. RA, O2 sat greater than 95%. LSC and equal, no retractions, no work of breathing noted. RR 30-50's. No spells, no desats. Continue to monitor resp status, monitor for spells.

3. TF 130cc/kg/day, will resume feeds at 20cc/kg/day with 4pm care. PN D10 with IL at 90cc/kg/day, D10 with 1Nacl, 1 KCL at 40cc/kg/day, infusing via left arm PIV. 8 hr u/o 3cc/kg/hr, no stool. Belly soft, +BS, no loops. Continue to monitor.

4. Temp stable in air isolette, swaddled and dressed in t shirt. Alert and active, slightly irritable at times. Continue to promote growth and development.

5. Mom called this AM, updated on progress and plan of care. [**Year (4 digits) **] will be in this afternoon for 4pm care. Continue to update, educate and support [**Year (4 digits) **].

6. Murmur not heard this AM or afternoon, yet echo

confirmed PDA. Infant asymptomatic, in [**Last Name (LF) **], [**First Name3 (LF) **] feedings restarted. HR 130-160's. BP 60/47 51. Infant pink, warm, well perfused. Continue to monitor.

7. Single phototherapy dc'd this AM for bili of 5.3/0.2.
Continue to monitor.

"

"Neonatology Attending

Day 12- CGA 36 0/7 weeks

Remains in RA. RR 30-50s. Clear breath sounds. No bradycardia, drifts. No murmur. HR 140-160s. BP mean 47. Pink, well-perfused. Weight 1840 gms (-15). TF at 150 cc/kg/d. On BM/PE 24. Alternating po/pg feeds. Occasional large spits. Put to breast. Benign abdomen. Passing heme negative stool. Alert, active.

Adequate breathing control. Monitoring closely. Tolerating feeds fairly well. Will start iron today. Following weight gain. Family up to date.

"

"NPN 0700-1900

3. FEN
O: TF 150cc/kg/day of BM24/PE24 po/pg. Bottled full volume x1 this shift. BF well x25 mins and bottled 30cc thereafter @ 1230. Abd exam benign. A/G 25cm. Lg spit x2 during bottles. Max asp= 4.8cc,nonbilious. Refed. Voiding, no stool

yet this shift. Starting on FeSO4. A: Tolerating feeds, occ
spits w/PO's. P: Cont to monitor for s/s feeding
intolerance, continued spits.

4. G&D
O: [**Known lastname **] is alert/active with cares. Temps stable cobedding
in OAC. [**Last Name (LF) 33**],[**First Name3 (LF) 120**]. Waking for feeds this shift. Will need
hearing screen, circ, Hep B, carseat test. A: AGA. P: Cont
to provide dev appropriate care.

5. [**First Name3 (LF) **]
O: [**First Name3 (LF) **] in to visit @ 1200. Both are very loving and
appropriate w/twins. Mom met briefly @ bedside w/Lactation
re: increasing milk supply. Scheduled for consult on Monday
@ 1200. A: Attentive, loving family. P: Cont to support and
educate family.

See flowsheet for details.

"

"#3FEN
Wt down 10g and checked x2. Wt 1.855. Baby took in 96cc/kg
plus breast feed. Hebottled 48cc at [**2148**] with a wet burp. he
bottled 45cc at 0030 with a small wet burp. Void but no
stool. Abd soft active bowel sounds. He cont to receive
PE22, no BM available
A. Tol feed with wet burp
P. cont to monitor tol to feed and weight gain

#4Dev

Temp stable in an off isolette. Waited on move to crib due

to decrease in weight. Awoken for feed

#5Parent

No contact.

"

"Neonatology Attending Note

Day 11

CGA 35 6

RA. RR30-50s. Mild sc rtxns. Cl and =. s/p indocin. No murmur. HR 130-150s. BP 62/43, 51.

Wt 1855, down 10 gms. PE/BM22 at 140 cc/k/day. pg/po. Tol well. Nl voiding and stooling.

In off isolette.

A/P:

growing preterm infant with immature po feeding skills

inc TF 150 cc/k/day

inc 24 cals

"

"Fellow note; physical exam

Alert and active in isolette. Spitty with exam. In RA. AFOF. Lungs clear. RRR. No murmur. Normal femoral pulses. Abd soft, ND, +BS. Extrem WWP. Good tone.

"

"NPN 0700-1900

#3 Alt. in Nutrition

O: TF increased to 150cc/kg=46cc Q 4 hrs. and cals increased to 24, BM or PE. Abd. is round, soft, with + BS, no loops. Girth stable at 24.5 cm. 1-5cc aspirates and frequent mod. to large spits after feeds. [** 41**] [**Initials (NamePattern4) **] [**Last Name (NamePattern4) 29**] notified of spits. Voiding and stooling, guaiac -. Infant is alert and active with cares, sucking on fingers and acting hungry. PO fed X 3, taking 30-45cc. NG tube reinserted D/T wt. loss and poor feeding at times.

A: Increased spits, some aspirates, benign abd. exam and acting well

P: Close observation and monitoring for feeding tolerance, increased aspirates/spits. Notify MD if any further s/s feeding intolerance. Follow daily wts.

#4 Alt. in Development

O: Maintaining temp in off isolette, swaddled, positioned supine with boundaries in place. Awake at feeding times, not crying but alert and acting hungry. (Sucking fingers, blanket, shirt sleeve, etc.) Appropriate tone. No spells. PO feeding well at beginning of feed, slow at end. Requires some gavage.

A: Immature feeding skills

P: Transfer to crib tonight if wt. up. Continue to support developmental needs.

#5 Alt. in Parenting

O: Mom called X 1. Updated. Stated she would visit later today.

A: Involved mom

P: [**Name2 (NI) 181**] informed and support.

"

"NPN/1900-0700

#1 RESP: Breathing RA w/ sats >93%. RR 30-60's. LSC w/ no

^ WOB. No spells. Cont. to monitor.

#3 FEN: NPO w/ TF at 120cc/k/d of PN(D10) and IL infusing

thru PIV. DS=131. Abd. benign. Girth=21.5cm.

Voiding/stooling. Lytes pending. Cont. to monitor.

#4 DEVELOPMENT: Infant nested in servo isolette. Temps

stable. Active/alert; awake after cares for short periods.

Sucks on pacifier when offered. AFOF. AGA. Cont. to

support developmental needs.

#5 [** **]: Mom called and updated x1. Will in to visit

tomorrow.

#6 CV: Soft murmur auscultated x1. Third dose of Indocin

given tonight at [**2118**]. BP 45/38 x43. HR 130's. Normal

pulses. Cont. to monitor.

#7 BILI: Under single phototx w/ eye shields in place.

Ordered for bili check on Sunday. Cont. to monitor.

"

"Neonatology

Doing well. Remains in RA. No spells. Comfortable apeparing. Finished course of indocin last night. WIll follow exam for recurrence of murmur. None nboted last night.

Wt 1785 up 60. TF at 120 cc/k/d. NPO on indocin course. Will slowly start feeds today.. Lytes in good range this am. Abdomen benign.

Bili in 10 range. Under photorx. To be repeated in am.

Will continue feeding advancement as tolerated, monitor for recurrence of PDA.

"

"Neonatology NP Note

PE

examined while on scale

AFOF

comfortable respirations in room air, lungs clear/=

RRR, no murmur appreciated, pink and well perfused

liver edge at RCM

abdomen soft, nontender and nondistended, active bowel sounds, inguinal edema

good tone.

updated [** **] at bedside.

"

"NPN 7a7p

Resp

Infant in RA with adeq sats. No desats, no bradys. LSC. No

WOB. Monitor and support resp status.

FEN

Infant resume feeds again today, 20 cc/k/d of BM or PE20.

Only 6cc and bottled well. DS stable. Abd soft, no loops, no

spits and active BS. PND10 and IL infusing via PIV, at 110

cc/k/d. Monitor weight and exam.

G/D

Infant in servo isolette with stable temps. MAEs. A/A with

cares. FS&F. Uses pacifier. Settles with boundries. AGA.

Support G/D.

Parenting

Both [** **] in for cares and bottling. Spoke with [**First Name9 (NamePattern2) 41**]

[**Doctor Last Name 29**]. Still in need of a family mtg. [**Doctor Last Name **] asking

appropiate question. Involved and loving. Support and

educate.

CV

Infant finished indomycin coarse last eve. No murmur heard

today. Pale pink/jaundice. Good pulses. Monitor .

Hyperbili

Infant under single PTX. Mild jaundice. Resuming feeds,

active and stooling. Bili repeat in am. Cont lights and

monitor labs.

"

"Discharge Note- nursing

[**Known lastname **] remains in room air, RR 30-60, lungs clear and equal, no retractions. No murmur audible, HR 140-160s, infant is pink and well perfused Bp today was 79/55 mean of 60. Discharge weight 2155g up 10grams, Taking ad lib demand Min of 130cc/k/d, taking more than minimums all po's via bottle and breastfeeding. occasional spits. Abdomen is benign by exam, voiding and stooling. Circ site is CDI. Temps are stable in open crib. Discharge teaching reviewed with [**Known lastname **]. CPR taken today prior to discharge. Car seat placement reviewed and demonstrated. VNA of [**Hospital3 **] [**Name (NI) 415**], referral faxed. [**Name (NI) **] excited to take infants home today. Expressed that they are comfortable in taking care of babies and are ready for them to come home. Dc'd at 1800.

"

"Neonatology Attending Note

Day 9

CGA 35 4

RA. RR30-50. >94% sats. Mild rtxns. Mild UA congestion. No A&Bs past 24 hrs. h/o PDA. s/p 1 course indocin. HR 140-160s. BP 77/49, 52. No murmur. Last ECHO w/ small 1.6 mm PDA.

Wt 1845, up 100. TF 140 cc/k/day. PN/IL at 45 and 95 enteral. Tol well. d/s 81. Nl voiding and stooling.

In off isolette.

A/P:

Growing preterm infant.

Cont enteral feeding advance and d/c IVFs as tol

Encourage po skills

Monitor cardioresp maturity

"

"NPN [**7-/2018**]

#3. O: Infant conts on TF 140cc/k/d. Advancing on feedings 20cc/k [**Hospital1 55**]. Presently on IVF PN d10 at 25cc/k/d. IL d/c'd. Via PIV w/o incident. Po feedings are 115cc/k of BM/PE20 (35cc). Taking all bottles or BF, 30-60cc q4hrs. Abd soft w/active BS, 1 sm spit, no loops, AG stable, voiding and stooled heme-. A: Tol current feeding plan. Taking more than min requirements. P: Adv to full feeds this eve.

#4. O: Temp stable in off isolette swaddled w/hat on. A&A w/cares. Wakes for some feeds. Sleeps well between. Brings hands to face. Loves pacifier. AF soft and flat. MAEW. A: AGA P: Cont to support dev needs.

#5. O: Mom and MGM in for 1200 cares. Mom BF and did cares independently. Held both infants together for the first time. Updates on infant's progress given at the bedside. Asking approp questions. A: Involved loving [**Hospital1 **]. P: Cont support keep updated and educate.

"

"Nursing Progress Note

#3. O: Infant remains on TF's of 140cc/k/d. PIV heplocked. Infant po feeding min amt well. Small spit x1. Abd soft and round with active bowel sounds. No loops. Voiding 3.5cc/k/hr. No stools. Wgt is up 20gms tonight to 1865gms. A: Full feeds. P: Continue to monitor FEN status.

#4. O: Infant remains in off isolette with stable temp. He is alert and active with cares. MAEW. A: AGA. P: Continue to assess and support developmental needs.

#5. O: Dad called x1 for update. Asking appropriate questions. A: Involved family. P: Continue to inform and support.

"

"Neonatology Attending Note

Day 10

CGA 35 5

RA. RR40-60s. > 96%. No A&Bs.

Wt 1865, up 20 gms. TF 140 cc/k/day PE/BM20. Tol well. Nl voiding and stooling (heme neg.).

In off isolette.

A/P:

Inc to 150 cc/k/day, 22 cals

continued CVR monitoring

"

"Fellow note; physical exam

Alert and active in isolette. Breathing comfortably in RA. Skin pale pink. AFOF. Lungs clear. RRR. No murmur. Normal femoral pulses. Abd soft, ND, +BS. Normal male, testes descended bilaterally. Extrem WWP. Good tone.

"

"NPN [**7-/2018**]

#3. O: Infant now on ad lib demand schedule BM/PE22 min

140cc/k (44cc). He is waking every 2.5-4hrs and BF well

(10-15min) twice today. he bottled 3 times taking 21-35cc.

Abd soft w/active BS, 2 sm spits, no loops, AG stable,

voiding and stooling heme-. A: Doing great w/po feeds. P:

Cont to support nutritional needs.

#4. O: Temp stable swaddled in off isolette. Wakes for

feeds. A&A w/cares. Sucks on pacifier. Brings hands to face.

MAEW. AF soft and flat. A: AGA P: Cont to support dev needs.

#5. O: Mom in at 1200 today. Stayed for 2 sets of cares.

Becoming more independent w/BF. Updates on infant's progress

given at the bedside. Asking approp questions. Dad may be in

tonight at [**2118**]. A: Involved vested [**Year (4 digits) **]. P: Cont support, educate and keep updated.

"

"NPN 7a-7p

#3: TF: 140cc/k/d. Currently on PND10 & IL infusing via patent peripheral IV at 65cc/k/d. Enteral feeds adv'ed at noon care to 75cc/k/d. Now tol'ing 22cc q4hrs. Bottling well, with good coordination. Uses yellow nipple. No spits noted. Abd soft, and round with +[**Last Name (un) 259**], no loops. AG stable. Voiding qs. No stool thus far. Did attempt to breastfeed x1 this afternoon. Latched briefly and took few ineffective sucks. A: Working up on feeds P:Cont to adv EF's by 20cc/k/[**Hospital1 55**] as tol'ed. Follow wt and exam. Monitor tol to feeds. Cont with PN as ordered.

#4: [**Known lastname **] has weaned to an off isolette. Conts with stable temps while swaddled and nested within boundaries. MAE. Fonts soft/flat. Brings hands to face. Will suck on fingers at times. Tol'ed being held. A: AGA P:Cont to support infant's dev needs.

#5: [**Known lastname **] in for noon care, both updated. Mom participated in care and breastfed infant. Dad then bottled infant. Reviewed positioning during feeding with both [**Known lastname **]. Dad responding to choking episode correctly. Also

reviewed bradycardia with [**Known lastname **] as infant did have mild brady after feeding. A: Involved, loving [**Known lastname **] learning to care for infant. P:Cont to support and educate.

#6: Hr stable. No murmur noted. No palmar pulses noted. Peripheral pulses nml. +brisk cap. refill. BP stable. Breathing comfortably in RA. A: stable P:Cont to monitor and provide support as needed.

"

"Neonatology note
16 d.o
in RA, 1 spells with feeding.
clear lungs
RR with no murmur
wt= [**2133**] gm +55, Neosure 24 at 160 cc/kg/d po
abdomen soft
AFOF
normal tone

A: ex 34 [**2-7**] wks GA, growing preemie, observe for episodes
P: continue current management, observe for immaturity of feeding.
"

"NPN [**7-/2018**]

#3. O: Infant on min 130cc/k Neosure 24cal adlib demand

schedule. Waking every 4hrs and taking 45-60cc. Had 1 episode so far today w/uncoordinated bottling HR went to 69 w/QSR. Abd soft w/active BS, 1 med spit, HOB elevated, no loops, voiding and stooled heme-. A: Conts to have immature feeding pattern. P: Cont to support nutritional needs.

#4. O: Temp stable, swaddled cobedding w/sibling in OC, Wakes for feeds. Sleeps well between cares. Sucks on pacifier, brings hands to face for comfort. AF soft and flat. MAEW. A: AGA P: Cont to support dev needs.

#5. O: mom called x2 for updates. will be in for 1630 cares. Updates on infant's progress given over the phone. Asking approp questions. A: Involved loving parent. P: Cont support, keep updated and educate.

"

"NPN 1900-0700

3. FEN

O: Current wgt= 1845g (+100)- wgt checked x3. TF 140cc/kg/day. Currently receiving 45cc/kg of PN D10 @ 3.1cc/hr and IL @ 0.4cc/hr via PIV. Infusing well. Enteral feeds @ 95cc/kg (min 29cc of BM20/PE20 q4h) PO. Bottling minimum volumes thus far this shift. Advancing feeds by 20cc/kg/d [**Hospital1 **] @ 1200/2400 as tolerated. Abd exam benign. A/G 24.5cm. Lg spit x1 during bottle. UO x24hrs= 3.6cc/kg/hr. Sm

trans stool x1. Will check D/S with next care. A: Tolerating
current regime. P: Cont to monitor for s/s feeding
intolerance.

4. G&D
O: [**Known lastname **] is alert/active with cares. Temps stable swaddled
in off isolette. [**Last Name (LF) 33**],[**First Name3 (LF) 120**]. Not waking for feeds this shift.
Roots and brings hands to face. A: AGA. P: Cont to provide
dev appropriate care.

5. [**First Name3 (LF) **]
O: Mom called x1 for update. Spoke w/this RN. Pleased
w/[**Known lastname 3437**] progress. Will be in this afternoon. A:
Attentive, loving family. P: Cont to support and educate
family.

See flowsheet for details.

"