



Pregnancy/Birth remarks/Apgar:	Risk factors/Family history:		Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance						GUIDE I		
			NAME: _____ Birth Day (d/m/yr): _____ M [] F [] Birth Length: _____ cm Head Circ: _____ cm Birth Wt.: _____ g Discharge Wt.: _____ g								
DATE OF VISIT	within 1 week			2 weeks (optional)			1 month (optional)				
GROWTH* Correct percentiles until 24-36 months if < 37 weeks gestation	Height	Weight	HC (avg 35 cm)	Height	Weight	Head Circ.	Height	Weight	Head Circ.		
PARENTAL CONCERNS											
NUTRITION*	<input type="checkbox"/> Breastfeeding (exclusive)* Vitamin D 400 IU/day* <input type="checkbox"/> Formula Feeding (iron-fortified) [150 mL(5 oz)/kg/day*] <input type="checkbox"/> Stool pattern and urine output			<input type="checkbox"/> Breastfeeding (exclusive)* Vitamin D 400 IU/day* <input type="checkbox"/> Formula Feeding (iron-fortified) [150 mL(5 oz) /kg/day*] <input type="checkbox"/> Stool pattern and urine output			<input type="checkbox"/> Breastfeeding (exclusive)* Vitamin D 400 IU/day* <input type="checkbox"/> Formula Feeding (iron-fortified) [450-750 mL(15-25 oz) /day*] <input type="checkbox"/> Stool pattern and urine output				
EDUCATION AND ADVICE <input checked="" type="checkbox"/> discussed and no concerns X if concerns	<u>Injury Prevention</u> <input type="checkbox"/> Car seat (infant)* <input type="checkbox"/> Sleep position/bed sharing/room sharing* <input type="checkbox"/> Crib safety* <input type="checkbox"/> Firearm safety/removal* <input type="checkbox"/> Carbon monoxide/Smoke detectors* <input type="checkbox"/> Hot water <49°C* <input type="checkbox"/> Choking/safe toys* <u>Behaviour and family issues</u> <input type="checkbox"/> Sleeping/crying** <input type="checkbox"/> Soothability/responsiveness <input type="checkbox"/> High risk infants/assess home visit need** <input type="checkbox"/> Parenting/bonding <input type="checkbox"/> Parental fatigue/postpartum depression** <input type="checkbox"/> Family conflict/stress <input type="checkbox"/> Siblings <u>Other Issues</u> <input type="checkbox"/> Second hand smoke* <input type="checkbox"/> No OTC cough/cold medn* <input type="checkbox"/> Inquiry on complementary/alternative medicine* <input type="checkbox"/> Counsel on pacifier use* <input type="checkbox"/> Temperature control and overdressing <input type="checkbox"/> Sun exposure/sunscreens/insect repellent* <input type="checkbox"/> Fever advice/thermometers*										
DEVELOPMENT** (Inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation <input checked="" type="checkbox"/> if attained X if not attained				<input type="checkbox"/> Sucks well on nipple <input type="checkbox"/> No parent/caregiver concerns			<input type="checkbox"/> Focuses gaze <input type="checkbox"/> Startles to loud noise <input type="checkbox"/> Calms when comforted <input type="checkbox"/> Sucks well on nipple <input type="checkbox"/> No parent/caregiver concerns				
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. <input checked="" type="checkbox"/> if normal X if abnormal	<input type="checkbox"/> Skin (jaundice, dry) <input type="checkbox"/> Fontanelles <input type="checkbox"/> Eyes (red reflex)* <input type="checkbox"/> Ears (TMs) Hearing inquiry/screening* <input type="checkbox"/> Heart/Lungs <input type="checkbox"/> Umbilicus <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Hips* <input type="checkbox"/> Muscle tone* <input type="checkbox"/> Testicles <input type="checkbox"/> Male urinary stream/foreskin care			<input type="checkbox"/> Skin (jaundice, dry) <input type="checkbox"/> Fontanelles <input type="checkbox"/> Eyes (red reflex)* <input type="checkbox"/> Ears (TMs) Hearing inquiry/screening* <input type="checkbox"/> Heart/Lungs <input type="checkbox"/> Umbilicus <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Hips* <input type="checkbox"/> Muscle tone* <input type="checkbox"/> Testicles <input type="checkbox"/> Male urinary stream/foreskin care			<input type="checkbox"/> Skin (jaundice) <input type="checkbox"/> Fontanelles <input type="checkbox"/> Eyes (red reflex)* <input type="checkbox"/> Corneal light reflex* <input type="checkbox"/> Hearing inquiry/screening* <input type="checkbox"/> Heart <input type="checkbox"/> Hips* <input type="checkbox"/> Muscle tone*				
PROBLEMS AND PLANS	<input type="checkbox"/> PKU, Thyroid <input type="checkbox"/> Hemoglobinopathy screen (if at risk)*										
IMMUNIZATION Provincial guidelines vary	Record on Guide V: Immunization Record If HBsAg-positive parent or sibling: <input type="checkbox"/> Hepatitis B vaccine			Record on Guide V: Immunization Record			Record on Guide V: Immunization Record If HBsAg-positive parent or sibling: <input type="checkbox"/> Hepatitis B vaccine				
	Signature			Signature			Signature				

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: **Good (bold type)**; *Fair (italic type)*; Consensus (plain type).

(*) see Infant/Child Health Maintenance Selected Guidelines on reverse of Guide I

(**) see Healthy Child Development Selected Guidelines on reverse of Guide IV

Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the Rourke Baby Record is meant to be used as a guide only.

Financial support has been provided by the Government of Ontario, with funds administered by the Ontario College of Family Physicians.