

British Columbia Newborn Record Part 2

9.	DATE DONE D M Y	<input type="checkbox"/> DEFERRED <input type="checkbox"/> PKU, TSH, GALACTOSEMIA TIME: _____ <input type="checkbox"/> POSITIVE MATERNAL HBsAg STATUS <input type="checkbox"/> HBIG GIVEN <input type="checkbox"/> HEPATITIS B VACCINE GIVEN <input type="checkbox"/> POSITIVE MATERNAL HIV STATUS <input type="checkbox"/> OTHER	HOSPITAL NAME _____ DATE _____ SURNAME _____ GIVEN NAME _____ ADDRESS _____ PHONE NUMBER _____ PHYSICIAN / MIDWIFE NAME _____
10.	D M Y	PROBLEM LIST	DATE RESOLVED D M Y
11.	D M Y	PROGRESS NOTES	
12.	D M Y	CIRCUMCISION <input type="checkbox"/> DONE METHOD: _____ ANALGESIA USED: _____ SIGNATURE: _____ MD	
13.	DISCHARGE EXAMINATION		
	DATE D M Y	WEIGHT g	HEAD CIRCUMFERENCE cm
		NORMAL ABNORMAL <input type="checkbox"/> <input type="checkbox"/>	COMMENT
	1. GENERAL	<input type="checkbox"/> <input type="checkbox"/>	
	2. SKIN	<input type="checkbox"/> <input type="checkbox"/>	
	3. HEAD	<input type="checkbox"/> <input type="checkbox"/>	
	4. EENT	<input type="checkbox"/> <input type="checkbox"/>	
	5. RESPIRATORY	<input type="checkbox"/> <input type="checkbox"/>	
	6. CVS	<input type="checkbox"/> <input type="checkbox"/>	
	7. ABDOMEN	<input type="checkbox"/> <input type="checkbox"/>	
	8. UMBILICAL CORD	<input type="checkbox"/> <input type="checkbox"/>	
	9. GENITORECTAL	<input type="checkbox"/> <input type="checkbox"/>	
	10. MUSCULOSKELETAL	<input type="checkbox"/> <input type="checkbox"/>	
	11. NEUROLOGICAL	<input type="checkbox"/> <input type="checkbox"/>	
	12. OTHER	<input type="checkbox"/> <input type="checkbox"/>	
		SIGNATURE _____ MD/RM	
		14. STATUS AT DISCHARGE	
		PROBLEMS REQUIRING FOLLOWUP:	
		FEEDING: <input type="checkbox"/> BREAST <input type="checkbox"/> VIT. D <input type="checkbox"/> FORMULA	
		15. DISCHARGED	16. FOLLOW UP BY (when?)
		<input type="checkbox"/> HOME <input type="checkbox"/> ADOPTION <input type="checkbox"/> FOSTER HOME <input type="checkbox"/> OTHER HOSPITAL (specify):	<input type="checkbox"/> FAMILY PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/> PEDIATRICIAN <input type="checkbox"/> OTHER CONSULTANT <input type="checkbox"/> COMMUNITY HEALTH NURSE <input type="checkbox"/> MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT
		<input type="checkbox"/> NEONATAL DEATH <input type="checkbox"/> AUTOPSY PERFORMED	