Your Hospital's Logo Here

NEWBORN DISCHARGE
Summary Instructions

PATIENT IDENTIFICATION

BIRTHDATE:	DISCHARGE DATE:
Weight:	Weight:
Head Circum:	Head Circum:
Length:	Length:

HISTORY: Mother

GRAVIDA:	PARA:	BLOOD TYPE:

Vag. C / S 1○ 2○ ☐ Preterm ☐ Posterm

Prenatal History Unremarkable:
☐ PRENATAL CARE ☐ BLEEDING
☐ PIH / PRE ECLAMPSIA ☐ Previa
☐ DIABETES ☐ Abrupto

Substance Use:
☐ PCP ☐ CIGARETTES
☐ ETOH ☐ NARCOTICS
☐ COCAINE ☐ OTHER _____

Infection:
☐ GC ☐ HEPATITIS
☐ GBS ☐ CHLAMYDIA
☐ HERPES ☐ OTHER _____

OTHER:

HISTORY: Baby

APGARS:	1 MIN:	5 MIN:	BLOOD TYPE / COOMBS:

☐ FEEDING ☐ BREAST ☐ BOTTLE .....

SPECIAL INSTRUCTIONS:

MEDICATIONS:

Date:	Signature / Title:	Teaching Completed - NURSE'S Signature / Title:	Date:

FOLLOW-UP Appointments:

	DOCTOR / CLINIC	APPT / DATE	PHONE NUMBER
1. Well Baby			
2. _____			

HEARING SCREEN COMPLETED: ☐ YES ☐ NO ☐ PASSED ☐ FAILED APPT DATE: _____

FOLLOW - UP LAB:	WHERE	WHEN	
1. Metabolic Screen			
2. Bilirubin			
3. _____			

I WILL CALL THE BABY'S DOCTOR OR CLINIC IF:

1. I see that my baby is weak, feeding poorly or has a rectal temperature above 100 degrees F.
2. I notice redness or a foul smell around the cord.
3. I see any eye discharge, redness or swelling.
4. I see swelling, bleeding or a foul smelling discharge from my son's circumcision.
5. I have any questions or problems.

I HAVE REVIEWED ALL THE INFORMATION ON THIS FORM, HAVE RECEIVED EXPLANATIONS I UNDERSTAND, AND HAVE NO FURTHER QUESTIONS.

_____ _____
Mother or Person Receiving Instructions Date

WHITE = HIM (Medical Records) CANARY = Patient Copy PINK = Physician Copy

PART OF THE MEDICAL RECORD