CHAPTER 15

Newborns and Other Neonates with Conditions Originating in the Perinatal Period

Basic Health Record

Discharge Summaries

Discharge Summary Notes

All notes

Author	Service	Author Type	Filed	Note Time
MD	(none)	Physician	06/10/2008 0831	06/10/2008 0830

NEWBORN DISCHARGE NOTE
Baby boy has been stable since last exam. Baby is voiding normally and stooling normally.
TcB: Patient TRANSCUTANEOUS BILIRUBIN in the past 96 hrs:

	Transcutaneous Bilimeter Screening Result	Neonatal Bilirubin Nomogram Zone
06/10/08 0128	5.5	Low Risk Zone

No results found for this basename: BILINEONATAL in the last 720 hours

No results found for this basename: BILIDIRECT in the last 720 hours

No components found with this basename: CORDRHTYPE

No components found with this basename: DAT
Born on 6/8/2008 at Time of Birth: 2155
Delivery Method: Vaginal;Vacuum Assisted
He was born at 40w 3d to a 31 y.o. G1P0000. Mom's prenatal labs include
PRENATAL LABS
GBS: Positive (adequately treated)
HbsAg: Negative
HIV: Negative
Blood Type: O
RH: Positive
Antibody Screen: Negative
Rubella Status: Immune
Hemoglobin: (not recorded)
VDRL/RPR: Non-reactive.
Newborn hearing test: Left Ear: Refer

Right Ear: Refer

There is no immunization history on file for this patient.
Patient DAILY WEIGHT in the past 96 hrs:

	Wt.	Daily Weight (grams)	Change from Previous (grams)	Change from Birth (grams)	% of Change from Birth
06/10/08 0128	4.264 kg (9 lb 6.4 oz)	4264 GRAMS	-241 GRAMS	-246 GRAMS	-5 %
06/09/08 0159	4.505 kg (9 lb 14.9 oz)	4505 GRAMS	-5 GRAMS	-5 GRAMS	0 %
06/08/08 2220	4.51 kg (9 lb 15.1 oz)	4510 GRAMS	-	-	-

EXAM: Birth Weight (lbs/oz): 4.51 kg (9 lb 15.1 oz)
Pulse 124 | Temp 98.1 °F (36.7 °C) | Resp 55 | Wt 4.264 kg (9 lb 6.4 oz)
GENERAL: male newborn
SKIN/HAIR/NAILS: Normal, bruise on occiput, no jaundice
HEAD: Normal
EYES: Normal, bilateral red reflex
EARS, NOSE, MOUTH, AND THROAT: Normal
NECK: Normal
RESPIRATORY: Normal
CARDIOVASCULAR: Normal, no murmurs
ABDOMEN/RECTUM: Normal
GENITOURINARY: Normal male
HIPS: Normal, no clicks or clunks
EXTREMITIES: Normal
NEUROLOGIC: Normal tone and reflexes

Assessment:
2 d.o. male infant doing well and ready for discharge

Plan: Discharge to home. Usual discharge instructions provided.
Breast/bottle feed every 2 to 3 hours around the clock.
Follow up in 2 days in the office.
Total time spent on discharge: 30 minutes

History and Physical

H&P Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/09/2008 0810	06/09/2008 0808

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS:

Baby boy was born at 40w 2d to , a 31 y.o., G1P0000 mother. Mom GBS +, but adequately treated. Baby born with vaccuum assist and has some facial and occiput bruising. LGA with BW of 9lb 15 oz.

OB HISTORY
Current Pregnancy: Denies
OB/GYN History: Denies. Visit history: Regular Care;First Visit by 13 Wks. Her prenatal labs include
PRENATAL LABS
GBS: Positive
HbsAg: Negative
HIV: Negative
Blood Type: O
RH: Positive
Antibody Screen: Negative
Rubella Status: Immune
Hemoglobin: (not recorded)
VDRL/RPR: Non-reactive. Estimated Date of Delivery: 6/7/08.

Onset of Labor Date: 6/8/08. Time: 0300.
INTRAPARTUM EVENTS
Significant L&D Medications: Antibiotic(s) received greater than 4 hours prior to delivery
Anesthesia/Analgesia: Lidocaine
Significant Events/Complications: See Note. Membranes: Date of Rupture: 6/8/08
. Time of Rupture: 1812
. Fluid Type: Normal odor;Thin meconium
.

DELIVERY METHOD
Delivery Method: Vaginal;Vacuum Assisted
Cesarean Birth Indications: N/A
Shoulder Dystocia: N/A
Forceps: N/A
ForcepsType: (not recorded)
. Presentation: Vertex
. ROM > 18 hours: No
. Maternal Temp > 100.4 F: No
.
VACUUM

History and Physical continued

Vacuum Type: M Style
Total time Vacuum in use: 40 seconds
# of pop-offs: 0
.
PLACENTA / CORD
Placenta: Spontaneous;Complete
Cord: Nuchal cord x 1;Cord blood sent to lab;Cord blood gases drawn
Cord Vessels: 3
. Birth date was 6/8/2008. Time of Birth: 2155
. Birth Weight (grams): 4510 GRAMS
.

Resuscitation: Spontaneous respirations
.
AIRWAY
Suction method: Bulb
Secretions: Clear
. Blow by Oxygen (lpm): (not recorded)
. Amount of time blow by used: (not recorded)
. Bag & Mask:(lpm): (not recorded)
. Amount of time Bag & Mask used: (not recorded)
.
Patient APGARS in the past 48 hrs:

	1 Minute Apgar Total	**5 Minute Apgar Total**	**10 Minute Apgar Total**
06/08/08 2200	8	9	-

PHYSICAL EXAMINATION:

Pulse 140 | Temp 98.5 °F (36.9 °C) | Resp 58 | Wt 4.505 kg (9 lb 14.9 oz)
Head Circumference (cm): 37 CM

Chest Circumference (inches): 14.76 INCHES

GENERAL: Term male newborn
EYES: Normal, RR bilaterally
HEAD, EARS, NOSE, MOUTH, AND THROAT: Normal except for ?low lying metopic suture, bruising on face and mild caput with bruising.
NECK: Normal
CHEST/BREAST: Normal
RESPIRATORY: Normal, CTA bilaterally
CARDIOVASCULAR: Normal, RRR, no murmur, 2+ fem pulses
ABDOMEN/RECTUM: Normal
GENITOURINARY: Male: Normal, testes down bilaterally
MUSCULOSKELETAL: Normal. Hips:Normal
LYMPHATIC: Normal
SKIN/HAIR/NAILS: Normal, bruising as noted above

History and Physical continued

NEUROLOGIC: Normal

ASSESSMENT:

male infant born at 40w 2d doing well.

PLAN:

Baby was admitted to the nursery.
Begin routine nursery orders and usual cares and precautions.
Defer hep b until 2mo visit.
Circ in am.
Likely discharge in am.

Initial Assessment Notes

Initial Assessment Notes

All notes

Author		Service	Author Type	Filed	Note Time
	NP	(none)	PHYS- Nurse Practitioner	06/08/2008 2210	06/08/2008 2207

Oncall Note:

Requested to attend delivery of this 40.1 week gestation male infant because of thin meconium stained fluid, vac assist. Delivery was via NSVD with infant in the vertex presentation. Infant cried immediatedly after delivery of the head while on mother's abdomen. Brought to the radiant warmer and stimulated, dried and bulb suctioned. Apgars 8 at one minute and 9 at five minutes. PE WNL, moderate caput present. Taken to NBN.

Author	Service	Author Type	Filed	Note Time
, RN	(none)	NURS-Registered Nurse	06/10/2008 0851	06/10/2008 0825

Newborn Circumcision

Data: Time Out completed by Dr. Circulator was Dr.

See Pain Assessment in Flowsheets Activity after Procedure

Action: Ointment applied to circumcision. Mother and Father will be instructed on care of circumcision with demonstration given by primary care nurse. Acetaminophen ordered. To observe for first voiding post procedure. Sucrose analgesia used during procedure. To repeat circumcision wound and pain assessment within 1 hour after procedure by primary care nurse.

Response: Baby appeared to tolerate procedure. No excessive bleeding at circumcision site immediately post procedure.

Author	Service	Author Type	Filed	Note Time
MD	(none)	Physician	06/10/2008 0829	06/10/2008 0829

CIRCUMCISION PROCEDURE NOTE

Circumcision performed by on 6/10/2008 at 8:29 AM.

PREOPERATIVE DIAGNOSIS: UNCIRCUMCISED

POSTOPERATIVE DIAGNOSIS: CIRCUMCISED

The patient was prepped and draped using sterile technique. Anesthetic used was 1% Lidocaine. Anesthetic technique was dorsal penile nerve block. Circumcision was performed using a Mogan Clamp.

TISSUE REMOVED: Foreskin

POST PROCEDURE STATUS: uncircumcised

COMPLICATIONS: None

All Progress Notes

Progress Notes

All notes

Author	Service	Author Type	Filed	Note Time
, RN	(none)	NURS-Registered Nurse	06/10/2008 1258	06/10/2008 1257

Newborn Discharge

Data:

Vital signs stable, assessments within normal limits.
Feeding well, tolerated and retained.
Cord drying, no signs of infection noted.
Circumcision healing, no swelling, no abnormal bleeding or signs of infection noted.
Baby voiding and stooling.
No evidence of significant jaundice, mother aware of signs/ symptoms to look for and report per discharge instructions.
Discharge outcomes on care plan met.
No apparent pain.

Action:
Review of care plan, teaching sheet and discharge instructions done with mother. Infant identification with I.D. bands done, mother verification with signature obtained. Metabolic and hearing screen completed.

Response:
Mother states understanding and comfort with infant cares and feeding. All questions about baby care addressed. Baby discharged with parents at 1255 and was secured in a car seat.

Laboratory Results

Results

BILIRUBIN,DIRECT (ID# 140208958)
Status: Canceled

Narrative
BILIRUBIN,DIRECT Canceled,
ordered on the wrong patient.

BILIRUBIN NEONATAL TOTAL ONLY (ID# 140208959)
Status: Canceled

Narrative
BILIRUBIN,NEONATAL Canceled,
ordered on the wrong patient.

Newborn Metabolic Screen (ID# 140149826)
Status: Completed

Component	Value	Units	Flag	Collected
BIRTH DATE	20080608	(none)	(none)	06/10/2008 7:10 AM
BIRTH TIME	2155	(none)	(none)	06/10/2008 7:10 AM
AMINO ACIDEMIAS (PKU)	Negative	(none)	(none)	06/10/2008 7:10 AM
BIOTINIDASE DEFICIENCY	Negative	(none)	(none)	06/10/2008 7:10 AM
ADRENAL HYPERPLASIA	Negative	(none)	(none)	06/10/2008 7:10 AM
CONGENITAL HYPOTHYROIDISM	Negative	(none)	(none)	06/10/2008 7:10 AM
FATTY ACID OXIDATION	Negative	(none)	(none)	06/10/2008 7:10 AM
GALACTOSEMIA	Negative	(none)	(none)	06/10/2008 7:10 AM
HEMOGLOBINOPATHY	Normal	(none)	(none)	06/10/2008 7:10 AM
ORGANIC ACIDEMIAS	Negative	(none)	(none)	06/10/2008 7:10 AM
CYSTIC FIBROSIS	Negative	(none)	(none)	06/10/2008 7:10 AM

Component	Units	Flag	Collected
TESTING PERFORMED BY	(none)	(none)	06/10/2008 7:10 AM

Value:

-

Narrative
The purpose of the Newborn Screening Program in is to
identify infants at risk and in need of more definitive testing.
As with any laboratory test, false positive or false negative
results are possible. Newborn screening test results are
insufficient information on which to base diagnosis or treatment.

GLUCOSE METER (ID# 140132161)
Status: Completed

Component	Value	Units	Flag	Collected
GLUCOSE METER	60	mg/dL	(none)	06/09/2008 1:55 AM

GLUCOSE METER (ID# 139968813)
Status: Completed

Component	Value	Units	Flag	Collected
GLUCOSE METER	55	mg/dL	**L**	06/08/2008 11:48 PM

GLUCOSE METER (ID# 139961582)
Status: Completed

Laboratory Results continued

Component	Value	Units	Flag	Collected
GLUCOSE METER	64	mg/dL	(none)	06/08/2008 10:38 PM

BLOOD GAS,CORD VENOUS (ID# 139958783)
Status: Completed

Component	Value	Units	Flag	Collected
PH,CORD VENOUS	7.22	(none)	**L**	06/08/2008 10:04 PM
PCO2,CORD VENOUS	50	mmHg	(none)	06/08/2008 10:04 PM
PO2,CORD VENOUS	27	mmHg	(none)	06/08/2008 10:04 PM
HCO3,CORD VENOUS	20	mmol/L	(none)	06/08/2008 10:04 PM
BASE EXCESS	-7.8	(none)	**L**	06/08/2008 10:04 PM
O2 SAT,VENOUS	35	%	(none)	06/08/2008 10:04 PM
INSPIRED O2	Not given	(none)	(none)	06/08/2008 10:04 PM

BLOOD GAS,CORD ARTERIAL (ID# 139958786)
Status: Completed

Component	Value	Units	Flag	Collected
PH,CORD ARTERIAL	7.15	(none)	(none)	06/08/2008 10:04 PM
PCO2,CORD ARTERIAL	68	mmHg	(none)	06/08/2008 10:04 PM
PO2,CORD ARTERIAL	16	mmHg	(none)	06/08/2008 10:04 PM
HCO3,CORD ARTERIAL	23	mmol/L	(none)	06/08/2008 10:04 PM
BASE EXCESS	-7.3	(none)	**L**	06/08/2008 10:04 PM
O2 SATURATION	13	%	(none)	06/08/2008 10:04 PM
INSPIRED O2	Not given	(none)	(none)	06/08/2008 10:04 PM