Newborn Examination

Woman's Information

Woman's Initials
Mothers' initials
Venue
Where was the baby born, or where did the examination take place
DOB
Baby's date of birth XX/XX/XXXX
Gestation at birth
What was the gestation at birth e.g., 40+6
Age at assessment
State the hours or days old, for example 2 hours or 2 days. If a premature birth, also state the correct age here.

History:

Maternal history
Maternal pre-pregnancy history (Hx) (medical, surgical, anaesthetic etc.) Maternal blood group/ serology
Pregnancy history
• Previous Pregnancy Hx • Maternal antenatal Hx (GDM, hypertension, PE, cholestasis, APH etc.) • Maternal serology (Hb, Vit D, Rubella, Hep B & C, HIV – etc.) and test results (MSSU) • GBS status • Ultrasound morphology results
Family/social history
• Psychosocial Hx (mental health – EPDS & ANRQ) • Social factors (relationship issues, Families SA, housing, DV) • Family Hx (describe any genetic conditions or significant family Hx) • New paternity
Labour & birth history
• Gestation • Brief description (include SOL/IOL, 1st & 2nd stage length, type of birth [NVB/ instrumental, /caesarean section – Em or El] maternal analgesia, fetal distress, intrapartum complications, resuscitation, if unusual finding from newborn birth examination). • If GBS +ve (description of prophylactic A/B - medication and how many doses received) • Agars (1, 5 min and 10 [if required])
Immediate neonatal period (STS, Feeding)
• Skin to skin • Breastfeed • Observations (HR, RR, Temp and if applicable SpO2) • Hep B or Vitamin K given, if so date/time and location • if applicable Heel Prick Gas (HPG) or Blood Sugar Level (BSL) • Or resuscitation if undertaken. Describe the management
Maternal/neonatal lab findings

Maternal	Neonatal
• GBS +ve • Vitamin D – 28/40 level • If maternal negative blood group (Direct coombs & Kleihauer) • Any positive serology (e.g Hep A,B or C positive)	• Cord gases (venous/arterial) • Heel Prick Gas (HPG) • Blood Sugar Level (BSL) • Serum Bilirubin (SBR) • Blood group/cultures (if applicable)

Physical Assessment

General Appearance

Posture/general symmetry
• Note tone (present/absent) • Limbs – symmetrical/uneven/flexed/deflexed
Activity
Alert/ awake/ sleeping/ irritable
Responsiveness/Cry
Responsive/unresponsive/ irritable/ crying/ lethargic

Skin

Colour
• Pink/well perfused • Centrally pink/ acrocyanosis present • Jaundice (describe where; facial, chest, to nipple line etc.) Refer to Kramer rule. • Pale or cyanosed
Condition
Describe the appearance: Intact/ peeling /dry/ vernix/ lanugo/ note any trauma (describe) Note: Stork bites/ Mongolian blue spot/ Erythema toxicum/ Milia
Birth Marks
• Port wine stain • Strawberry naevus

Vital signs and cardiopulmonary assessment

Temperature
Note degree Celsius °C (normal range value: 36.5 to 37.40C refer to local policy) Was it taken PA, orally, rectally?
Respiration rate
Note respirations per min (rpm) (normal range value: 40-60 rpm refer to local policy)
Heart rate
Note beats per min (bpm) (normal range value: 110-160 bpm refer to local policy)
Respiratory effort
• Regular/ irregular periods • Apnoea <20 seconds • Synchronised diaphragm and abdominal movement • Breathes through nose- no nasal flaring • If respiratory distress, describe, for example: grunting, head bob, tracheal tug, nasal flaring.
Lung Assessment
Note sounds clear/crackle; listen for air entry note if left and right side is similar For more information use the link: Lung/chest sounds
Heart Assessment
Note regularity, heart sounds Clear heart sounds? For example- Muffled in between the S1 and S2. May indicate a murmur. (NOTE: midwives cannot diagnose a murmur so instead document objective findings (eg muffled sound between S1 and S2) Referral to the paediatrician to review (remember midwives need to involve the multidisciplinary team to diagnose heart murmurs) For more information use the link: Heart Assessment

Anthropometric Measurements

Weight
In grams (g)
Head Circumference
In centimetres (cm)
Length
In centimetres (cm)

Head

Head/facial symmetry
• Describe general shape, note unusual head size (macro/micro-cephaly). • Presence of moulding, caput succedaneum, cephalhaemotoma. • Note any cuts or abrasions (fetal scalp electrode [FSE], forceps etc.) or Chignon from a ventouse birth or lacerations from CS scalpel.
Sutures/ Fontanelles
• Anterior & posterior fontanelles (present/absent/appropriate size) (soft/ bulging/ firm/ sunken/ raised) • Sutures: assess size and appearance (note if widely/narrow spaced) (mobile/ fixed)
Eyes
• Note symmetry • Left and right eye absent/present • Eyes move and responsive • Note subconjunctival haemorrhage • Red reflex (absent/present) • If discharge present, state the colour.
Ears
• Two ears present, fully formed and note position (top of pinna in line with eyes/low set). • Auditory canal patent, responsive • Pinna flexible. • Note any skin tags • Passed/ failed hearing test
Nose
• Left and right nostril (nare) patent • Nasal flaring yes/no
Mouth
• Pink, moist, mouth opens symmetrically, closed at rest. • Soft & hard palate assessed and present • Cleft lip/cleft palette/tongue tie/ teeth/ thrush

Neck

Range of movement
Head moves freely from side to side and can flex towards the chest and extend backwards. Note any limited movement. Full range of motion
Symmetry/length
Short/ long/ appropriate length
Skin folds/masses
Note symmetrical creases/skin folds Note swelling or masses (present/absent)

Chest

Clavicles
Intact/ note any deviations from normal (e.g, high pitched cry on touching, lump evident) Check birth Hx. Does the newborn have symmetrical activity on both limbs? If not this can be linked to a broken clavicle or humerus.
Chest Symmetry
Observe for round shape, symmetry during respiration
Nipples/breasts
Nipples and areola formed, comment on symmetry. Note any accessory nipples or engorgement (hormonal swelling or discharge).

Upper extremities

Symmetry/ tone
Length, creases, flexion and muscle tone (absent/present) Note any abnormalities on the axillae and elbows
Range of movement
Full/ limited/ absent
Hands/fingers
Count digits, check for extra digits, note any abnormalities (syndactyly, polydactyly) Note palmar crease(s)

Abdomen

Shape
Round/ concave/ swollen – soft on palpation
Size
Appropriate/ In proportion
Bowel Sounds
Auscultated/ absent/ present
Muscle tone /masses
Soft, firm, rigid - Provide description if unusual
Umbilicus
Clean and dry/ moist/ clamped/ healed, note any abnormalities – if newly clamped, note vessels
Femoral pulses
Palpate individually first then palpated together and check that the beat is in unison, note any differences between the 2 pulses: absence of pulse/asynchronous rate.

Genitalia

	Male	**Female**
Genitalia	• Swollen • 2 X descended testes/note • urethra (tip of penis) • hypo/hyperspadias • Note any abnormalities	• Swollen discharge: present (describe blood stained/whitish/ mucous • Note any abnormalities • Labia Majora and Minora present

Elimination

	Urine	Bowels
Elimination	Describe number of wet nappies (in 24 hrs), (HPU/HNPU), comment on urates	Describe stool colour and number of dirty nappies (in 24hrs), (HPM/HNPM), (meconium/transitional/mustard)

Lower Extremities

Symmetry/ tone
• Symmetrical/ well flexed/ uneven/ deflexed/ creases, describe muscle tone • Note if the gluteal folds are symmetrical
Range of Movement
Full/ limited/ reduced/ absent
Feet/Toes
• Note digits, note if webbing between toes (syndactyl), talipes- club foot

Hips

Ensure assistance of experienced practitioner. *This skill is learnt in complex care of the neonate.*

Ortolani's test	Barlow's test
Note clicks or clunks / *Enlocated/ dislocated*	Note clicks or clunks / *Enlocated/ dislocated*

Spine and Anus

Spinal Integrity
Palpate length, note gap, dimple, swelling or hairy patches
Gluteal fold symmetry
Assessed: Absent/ present / symmetrical/asymmetrical / note if more folds are on a particular side May indicate hip dysplasia
Anal Patency
Visual – patent; correct position/passed meconium If signs of not being patent (24 hours and has not opened bowels) state management

Neurological

Rooting reflex	**Sucking reflex**	**Moro reflex**	**Asymmetric tonic neck reflex**
Absent/ present	Absent/ present	Absent/ present	Absent/ present
Swallowing reflex	**Stepping response**	**Babinski reflex**	**Grasp reflex**
Absent/ present Indicate strength - weak, strong, coordinated or uncoordinated	Absent/ present	Absent/ present	Absent/ present Note: symmetrical on each side

Midwifery management/education

TIP: if abnormalities were detected in the examination, please provide a thorough explanation of the consultation, referral and management processes that were undertaken.

In this section examples could include:

- Specific education provided to the parents, feeding method, care plan, interventions/treatments, medications

Signature and designation of the supervising midwife or doctor. Date of signature and date of the episode of care must match *(retrospectively signed records will not be counted).*