Patient Label Here

Postpartum Child Encounter

Was this baby admitted to this organization for Postpartum Care only (the birth did not occur at the admitting hospital)? □ ***Yes*** □ ***No***

**** If yes, complete all sections. If no, proceed to Section: 'Baby's Sex'.***

Admission Date: dd/mmm/yyyy Admission Time: hours

Birth Location: □ Hospital and Name of Hospital: _____ □ Home □ Nursing Station □ Other Ontario location
□ Birth Centre and Name of Birth Centre: _____ □ Outside of Ontario

Newborn Transfer From: □ Hospital and Name of Hospital: _____
□ Home Birth Midwifery (MW) Care and Name of MW Practice Group: _____ □ Nursing Station
□ Birth Centre and Name of Birth Centre: _____ □ Other unit same hospital □ Other

Newborn Date of Birth: dd/mmm/yyyy **Time of Birth:** hours **Birth Weight**: _____ grams □ Unknown *[GA at Birth – auto calculates*

Type of Birth: □ Spontaneous Vaginal Birth □ Assisted Vaginal Birth □ Spontaneous or Induced Caesarean Section □ No Labour Caesarean Section **Birth Order:** □ A □ B □ C □ D □ E □Unknown

Baby's Sex: √One □Male □Female □Ambiguous genitalia □Unknown

Arterial Cord blood test status: √One □ Not done □ Done □ Unsatisfactory Specimen □ Unknown
Arterial Cord Blood pH: _____ Arterial Cord Blood Base/Excess/deficit:_____
Venous Cord blood test status: √One □ Not done □ Done □ Unsatisfactory Specimen □ Unknown
Venous Cord Blood pH:_____ Venous Cord Blood Base/Excess/deficit:_____

Neonatal Health Conditions: □ None □ Hyperbilirubinemia □ Hypoglycemia □ NAS - Neonatal Abstinence Syndrome □ Other □ Unknown
Neonatal Birth Complications: □ None □ Caput succedaneum □ Cephalohematoma □ Clavicular fracture □ Fracture – other □ Facial nerve injury □ Brachial plexus injury □ Palsy - other □ Birth Injury - other □ Unknown
Congenital Anomalies: □ None □ Suspected: _____ □ Confirmed: _____

Bilirubin Measured within 72 hours of Births: □ Yes - Transcutaneous bilirubin (TCB) □ Yes - Total Serum Bilirubin (TSB)
□ No - Newborn Transferred Out/Discharged □ No - Declined □ No – Reason Unknown □ No – Reason - Other □ Unknown
Hyperbilirubinemia Requiring Treatment: □ Yes □ No □ Unknown
Hyperbilirubinemia Treatment: □ Phototherapy □ Treatment Declined
Highest Serum Bilirubin >340 umol/L □ Yes □ No □ Unknown **Highest Serum Bilirubin >425 umol/L** □ Yes □ No □ Unknown

Pain Relief Measures During First Blood Sampling by Heel Prick: □ Breastfeeding □ Skin to skin □ Sucrose □ Other
□ No pain relief measures □ No heel prick sampling □ Unknown if pain relief was provided

Newborn Hearing Screening Result: □ Pass □ Referral □Inconclusive/no result □ Referred to community □Not Done □Unknown

Newborn Feeding from Birth to Discharge: □ Breastmilk only □ Combination of breast milk and breast milk substitute □ – Breast Milk Substitute-Formula only □ Breast Milk Substitute -Other □ NA □ Other □ Unknown
Reason for Breast Milk Substitute: Infant Medical □ Hypoglycemia □ Inadequate Weight Gain □ Inborn Errors of Metabolism □ Significant weight loss in the presence of clinical indications □ Other clinical indications **Maternal Medical:** □ Active herpes on breast □ Additional health concerns □ Contraindicated maternal medication □ HIV infection □ Severe maternal illness □ Informed Parent Decision to use Any Breast Milk Substitute □ Insufficient Maternal Milk Supply **e** : □ Donor milk not available □ Not eligible for donor milk □ Birth mother not involved in care □ Unknown
Consent for Use of Breast Milk Substitute: √One □ Evidence that consent was obtained □ No evidence of consent □ Unknown

Neonatal Discharged or Transfer to: □ Home □ Transfer to NICU/SCN other hospital and Name of other hospital: _____
□ Transfer to NICU/SCN same hospital □ Transfer to Paediatric unit same hospital □ Transfer to other hospital and Name of other hospital: _____ □ Child and Family Services Apprehension □Other unit, same hospital
Reason for Newborn Transfer: □ Requires higher level of care □ Requires further investigation □ Observation 4 hours or less no interventions □ Other □ Unknown
Neonatal Transfer Date: dd/mmm/yyyy **Neonatal Transfer Time**: hours **Discharge Weight: _____** grams
If Discharged to Home or CAS: Discharge Date: dd/mmm/yyyy **Time**: hours
Neonatal Death: □ No □ Yes **Death Date:** dd/mmm/yyyy **Death Time:** hours

Additional Transfer: Newborn Transfer Back/Readmission Date: dd/mmm/yyyy **Newborn Transfer Back/Readmission Time:** hours
Newborn Discharged or Transferred To: □ Home □ Transfer to NICU/SCN other hospital
Name of hospital transfer to: _____□ Transfer to NICU/SCN same hospital □ Transfer to Pediatric unit
□ Child and Family Services Apprehension
Reason for Neonatal Transfer: □ Bed needed for sicker baby □ Condition improved □ Lack of physician coverage
□ Lack of RN coverage □ No bed available □ Requires further investigation □ Requires higher level of care
□ Keeping baby and mother together □ Care closer to home □ Other □ Unknown
Neonatal Transfer Date: dd/mmm/yyyy **Neonatal Transfer Time**: hours **Discharge Weight: _____** grams
If Discharged to Home or Child and Family Services: Discharge Date: dd/mmm/yyyy **Time**: hours
Neonatal Death: □No □Yes **Death Date**: dd/mmm/yyyy **Death Time**: hours

Version Date: April 2021