Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

PARIS
PRIMARY ACCESS
Regional Information System

# POSTNATAL/NEWBORN V2

| | | | |
|---|---|---|---|
| **Name:** | | **PARIS ID:** | |
| **DOB:** | **Age:** | **PHN:** | |
| **Gender:** | | **Phone:** | |
| **Home Address:** | | **GP/NP:** | **GP/NP Phone:** |

**Assessment Start Date:** **Assessment End Date:**
**Reason For Assessment:** **Carried Out By:**

## Birth Event

### Birth Summary

Date of Birth Time of Birth
Birth Location
Type of Birth
Gestation Age Birth Sequence
ABO Blood Group A
RH Factor

Apgar 1 min Apgar 5 min Apgar 10 min
Congenital Anomaly ☐ YES ☐ NO ☐ UNKNOWN
If YES, Specify
Delivery Complications ☐ YES ☐ NO ☐ UNKNOWN
If YES, Specify
Birth Summary Comments

### Newborn Health and Well-being

In-Utero Exposure:

Tobacco ☐ YES ☐ NO ☐ UNKNOWN
Alcohol ☐ YES ☐ NO ☐ UNKNOWN
Substance Use ☐ YES ☐ NO ☐ UNKNOWN
If YES, Specify

Newborn Exposure to Second Hand Smoke
☐ YES ☐ NO ☐ UNKNOWN

Serum Bilirubin Level ☐ N/A
Initial µmol/L at Hrs of life
D/C µmol/L at Hrs of life
Treatment/Follow-Up

Newborn Screen Done? ☐ YES ☐ NO ☐ UNKNOWN
If NO ☐ Deferred ☐ Refused
Early Hearing Screening ☐ YES ☐ NO ☐ UNKNOWN
Need Follow-Up? ☐ YES ☐ NO

Group B Strep Exposure ☐ YES ☐ NO ☐ UNKNOWN
If YES, Prophylaxis? ☐ YES ☐ NO ☐ UNKNOWN
If Prophylaxis not Given, Reason/Plan

Hep B Prophylaxis Indicated ☐ YES ☐ NO ☐ UNKNOWN
If YES, HBIG Given? ☐ YES ☐ NO ☐ UNKNOWN
HBIG Given Date
If YES, Hep B Vaccine Given? ☐ YES ☐ NO ☐ UNKNOWN
Hep B Given Date
Infection/Risk for Infection ☐ YES ☐ NO ☐ UNKNOWN
If YES, Specify

### Infant Feeding (at Discharge)

Infant Feeding at Discharge

| Name: | PARIS ID: |
|---|---|

## Birth Event (continued)

Additional Feeding Information

**Additional Information**

Seen By Other Resources: Social Worker ☐
MCFD SW ☐
Other ☐

If Other, Specify

Follow-Up Needed? ☐ YES ☐ NO If YES, Specify

Community Resources, Follow-up and How to Access: PHN ☐
PHCP ☐
On Reserve ☐ Reserve Name
Other ☐ If Other, Specify

Comments

**Hospital Discharge**

Date of Discharge Time of Discharge Infant Discharged with Mother ☐ YES ☐ NO

Other Information

Completed By: Completed On

Section Complete ☐

| **Name:** | **PARIS ID:** |
|---|---|

## Postnatal/Newborn Assessment Entry

Assessed By:
Date Assessed:
Time:
Contact Type:

| **Assessment** | **Client Outcomes NC (Normal or No Concern), C (Concern), X Not Assessed** | | | | | |
|---|---|---|---|---|---|---|
| **Physiological Health** | Head | | | | | |
| | Nares | | | | | |
| | Eyes / Vision | | | | | |
| | Ears / Hearing | | | | | |
| | Mouth | | | | | |
| | Chest | | | | | |
| | Abdomen/Umbilicus | | | | | |
| | Skeletal/Extremities | | | | | |
| | Skin | | | | | |
| | Neuromuscular | | | | | |
| | Genitalia | | | | | |
| | Elimination - Urine | | | | | |
| | Elimination - Stool | | | | | |
| | Vital Signs | | | | | |
| **Behavioural** | Behaviour | | | | | |
| | Crying | | | | | |
| | Shake Baby Syndrome Period of PURPLE Crying Resources | | | | | |
| **Infant Feeding** | Method of Feeding (Exclusive, Total, Partial, or No Breastmilk) | | | | | |
| | Weight | | | | | |
| | Breastfeeding | | | | | |
| | Vitamin D | | | | | |
| | Breastmilk Substitute (Formula) Feeding | | | | | |
| **Health Follow-Up** | Health Follow-up | | | | | |
| | Immunization and Communicable Diseases | | | | | |
| **Safety and Injury Prevention** | **Safe Sleep** Safe Sleep Environment | | | | | |
| | Sleep Surfaces | | | | | |
| | Sleep Position | | | | | |
| | **Lifestyle** Exposure to Substance Abuse | | | | | |
| | Smoke Free Environment | | | | | |
| | Environmental Safety Risks | | | | | |
| **OTHER** | If Other, Specify | | | | | |

| **Name:** | **PARIS ID:** |
|---|---|

## Postnatal/Newborn Assessment Entry (continued)

**Notes**

**Next Planned Contact**

Planned Date **or in** Week(s) **or in** Month(s)

Contact Type Reason

Planned Staff ☐ Completed Previous Planned Date?

Sign Off ☐

**Name:** **PARIS ID:**

## Other Contacts and Contact Attempts

Recorded By:
Method of Contact:
Name of Contact (Tip: Name if Known, Profression e.g. Social Worker, or Agency Contacted e.g. MCFD)
Date of Contact
Notes

**Next Planned Contact**

Planned Date **or in** Week(s) **or in** Month(s)

Contact Type Reason

Planned Staff ☐ Completed Previous Planned Date?

Tick to Sign Off ☐

## Weight And Growth Chart

| Date Measured | Age | ---- Weight ---- kg %ile | --- Height --- cm %ile | ----- BMI ----- %ile | ------ Head ------ Circumference cm %ile | ---% Birth --- Wgt Lost | -- Wgt for -- Length %ile | --- Waist --- Hip cm ratio |
|---|---|---|---|---|---|---|---|---|

| **Name:** | **PARIS ID:** |
|---|---|

## Nursing Priority Screening

**Recorded By:** **Date Recorded**

**A. CHILDREN WITH A CONGENITAL OR ACQUIRED HEALTH CHALLENGE**

1. ☐ Congenital Anomaly
   - ☐ A) Major (Probability of Permanent Disability) ☐ B) Moderate (Correction May Be Possible)
2. ☐ Major or Moderate Disability Acquired During the First 5 Years of Life
   - ☐ A) Major (Probability of Permanent Disability) ☐ B) Moderate (Correction May Be Possible)

**B. DEVELOPMENT RISK FACTORS**

3. ☐ Low Birth Weight
   - ☐ A) 0 - 1499 gm ☐ B) 1500 - 1999 gm ☐ C) 2000 - 2499 gm
4. ☐ Bilirubin Level: Treatment/Follow-Up Required as Noted By the Primary Care Provider/Staff in the Acute Care Setting
5. ☐ Complication of Pregnancy
   - ☐ A) Infections That Can Be Transmitted in Utero and May Damage the Fetus ☐ B) Drugs
6. ☐ Complications of Labour and Birth
   - ☐ A) Labour ☐ B) Infant Trauma or Illness
   - ☐ C) Apgar At 5 Minutes Only If Less Than 7. Deduct Apgar Scores at 5 Minutes from 10 Points
7. ☐ Family History of a Disability Not Detectable at Birth That Could Affect Development
8. ☐ Development Concerns not Already Covered in any Above Category
   - ☐ A) Acquired Risk of Developmental Delay Due to Illness or Trauma in First 5 Years
   - ☐ B) Delayed Developmental Assessment in First 5 Years

**C. FAMILY INTERACTION RISK FACTORS**

9. ☐ Age of Mother
   - ☐ A) 15 and under ☐ B) 16 or 17 ☐ C) 18 or 19
10. ☐ Social Situation
    - ☐ A) One Parent Family - Other Support Available
    - ☐ B) One Parent Family - No Support Available
    - ☐ C) Two Parent Family - No Social Support and/or Severe Isolation Related to Culture, Language or Geography
11. ☐ Financial Difficulties
12. ☐ No Prenatal Care before Sixth Month
13. ☐ Mental Illness or Disability in Mother
    - ☐ A) Schizophrenia or Bipolar Affective Disorder
    - ☐ B) Postpartum Depression or Psychosis
    - ☐ C) Mental Disability of Parent
14. ☐ Mental Illness or Disability in Second Parent
    - ☐ A) Schizophrenia or Bipolar Affective Disorder
    - ☐ B) Mental Disability of Parent
15. ☐ Prolonged Postpartum Maternal Separation (5 Days or More)
    - ☐ A) With Frequent Infant Contacts (Visits or Phone as Feasible)
    - ☐ B) Little or No Contact
16. ☐ Assessed Lack of Bonding

**Name:** **PARIS ID:**

## Nursing Priority Screening (continued)

17. ☐ >3 Hospitalizations in One Year in Absence of Known Chronic Illness or Condition

18. ☐ Other, Specify:

**Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.**

**------------------------------------------------------------ End of Report ------------------------------------------------------------**