

Manitoba Public Health Nurse Newborn Assessment

Surname: _____

Given Name(s): _____

DOB: _____

PHIN/Nunavut #: _____

MFRN: _____

Mother's surname (if different from newborn)

Date of birth: _____ / _____ / _____ G.A. _____ Birth wt. _____
MONTH DD YYYY

Discharge

_____ Weight

_____ Weight loss %

_____ Date

Date (Month/DD/YYYY)

Time of Interaction

Age in days

Contact type

Assessment and Education

1. Growth & Nutrition

Exclusively breastfed at discharge from hospital Yes No

Breastfeeding

Human Milk Substitute

Weight (grams)

Weight loss percentage %

Vitamin D (As per breastfeeding/human milk substitute pathways)

2. Physiological

Head, nares, eyes, ears, mouth

Chest, abdomen/umbilicus

Skeletal/extremities

Skin/jaundice

Neuromuscular

Genitalia

Elimination – Urine/stool

Vital signs (T/HR/R) prn

3. General Health

Behaviour

Crying

Immunization

Communicable diseases

Health follow-up

4. Lifestyle, Safety, Injury Prevention

Safety and injury prevention

Exposure to tobacco

Hazards (hot water, pets, environment, carbon monoxide/
smoke detectors, etc)

Safe Sleep/SIDS

Personal Safety (shaking, falls, pacifiers, choking, etc)

Newborn screening (metabolic, hearing)

Initials

Other (specify)

Note: This form must be used in conjunction with Newborn Care Pathway.

