Mother's Name ______________________________
Address ______________________________
Phone ______________ Date of Birth __________ Age ______
Support Person ______________________________
Circle One: FOB Doula Family/Friend Other: ______________

Indication for Neonatal Transport: **Date** ____________ **Time** __________

Baby's Name ________________ **Date of Birth** __________ **Time** __________

Neonatal Summary

Gender: ?Male ?Female

Weight: ________________

Nuchal Cord: ? No
? Yes X: _______

Latest vitals (Date/Time): _________

Temp ________________

Heart Rate ______________

Respiratory Rate ____________

First breastfeeding:
Time ______________
Duration ____________

Meds/Treatments used:
____
____
____
____
____
____

Suction: ?None ?Bulb ?DeLee

Resuscitation: ?None ?Free O2 ?Tactile stim ?Bag & Mask ?Intubation

Time/duration ____________________

CPR: Time/duration ____________________

Observations:
____
____
____
____
____
____
____
____
____
____
____

APGAR	1min	5min
Heart Rate		
Absent	0	0
Below 100	1	1
Above 100	2	2
Respiratory Effort		
Absent	0	0
Weak Cry	1	1
Strong Cry	2	2
Reflex		
No Response	0	0
Grimace	1	1
Cough/Sneeze	2	2
Muscle Tone		
Limp	0	0
Slight Flexion	1	1
Well Flexed	2	2
Color		
Blue	0	0
Body Pink/Ext. Blue	1	1
All Pink	2	2
Total Apgar Scores		

Narrative: ______________________________
____
____
____
____
____
____

Pediatric

Pediatric health care provider: ______________________ Phone: ______________
Comments: ______________________________
______________ Date/Time notified: ______________________