Assessment of baby well-being Day No. | Where seen | Labels checked | Method of feeding

Are there any concerns about the following:	No	Yes
Feeding	☐	☐
Weight Gain, static, loss ____ g	☐	☐
Activity, tone Movement, reflexes, behaviour, responsiveness	☐	☐
Colour Pale	☐	☐
Eyes Stickiness, discharge, redness, sclera colour	☐	☐
Mouth Colour, palate, tongue-tie, thrush	☐	☐
Cord On/off, bleeding, redness, swelling, smelly	☐	☐
Skin Spots, rashes, dryness, bruising fading/improving	☐	☐
Jaundice Not improving, fading, resolved	☐	☐
Urinary output - colour, urates no. of wet nappies per day	☐	☐
Stools - colour, consistency no. of dirty nappies per day	☐	☐
Sleeping Safe sleeping discussed, position, bed sharing, smoking	☐	☐

Additional support required: ☐

Specific to individual, including referrals to social care, sure start, infant feeding specialist

Key to risk reviewed ☐ Yes

Management plan reviewed/revised ☐ Yes

Signature*	
Date/Time	