

**PRINTER: Cut sheet on dotted line exactly (at 75)**

**Assessment of baby well-being** To be completed by health professional

Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time	<input type="text"/>	Labels checked	<input type="text"/>	Where seen	<input type="text"/>	Feeding method	<input type="text"/>		
Are there any concerns about the following:		<b>No</b>	<b>Yes</b>	<b>Comments</b>		Day	<input type="text"/>	Key to risk reviewed (page 2) <input type="checkbox"/>			
A.	Feeding	<input type="checkbox"/>	<input type="checkbox"/>								
B.	Weight Gain, static, loss	<input type="text"/>	<input type="text"/> g							<input type="checkbox"/>	<input type="checkbox"/>
C.	Activity, tone Movement, reflexes	<input type="checkbox"/>	<input type="checkbox"/>								
D.	Colour Pale	<input type="checkbox"/>	<input type="checkbox"/>								
E.	Eyes Stickiness, redness, discharge	<input type="checkbox"/>	<input type="checkbox"/>								
F.	Mouth Thrush	<input type="checkbox"/>	<input type="checkbox"/>								
G.	Cord Bleeding, redness, swelling, irritation, odour, on/off	<input type="checkbox"/>	<input type="checkbox"/>								
H.	Skin Spots, rashes, dryness, nappy area	<input type="checkbox"/>	<input type="checkbox"/>								
I.	Jaundice Fading, resolved, referral	<input type="checkbox"/>	<input type="checkbox"/>								
J.	Urinary output Urates, nappy rash	<input type="checkbox"/>	<input type="checkbox"/>								
K.	Stools Meconium, green, mucous, constipation, diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>								
L.	Sleeping Position, bed sharing, smoking	<input type="checkbox"/>	<input type="checkbox"/>								
<b>Management plan (page 3)</b>										Reviewed	<input type="checkbox"/>

**Additional support** (eg Sure Start, social services, child protection, community physiotherapist, infant feeding coordinator)

Signature\*

Name
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A. Feeding		<input type="checkbox"/>	<input type="checkbox"/>						
B. Weight	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>						
Gain, static, loss									
C. Activity, tone		<input type="checkbox"/>	<input type="checkbox"/>						
Movement, reflexes									
D. Colour		<input type="checkbox"/>	<input type="checkbox"/>						
Pale									
E. Eyes		<input type="checkbox"/>	<input type="checkbox"/>						
Stickiness, redness, discharge									
F. Mouth		<input type="checkbox"/>	<input type="checkbox"/>						
Thrush									
G. Cord		<input type="checkbox"/>	<input type="checkbox"/>						
Bleeding, redness, swelling, irritation, odour, on/off									
H. Skin		<input type="checkbox"/>	<input type="checkbox"/>						
Spots, rashes, dryness, nappy area									
I. Jaundice		<input type="checkbox"/>	<input type="checkbox"/>						
Fading, resolved, referral									
J. Urinary output		<input type="checkbox"/>	<input type="checkbox"/>						
Urates, nappy rash									
K. Stools		<input type="checkbox"/>	<input type="checkbox"/>						
Meconium, green, mucous, constipation, diarrhoea									
L. Sleeping		<input type="checkbox"/>	<input type="checkbox"/>						
Position, bed sharing, smoking									
<b>Management plan (page 3)</b>				Reviewed	<input type="checkbox"/>	Revised	<input type="checkbox"/>	Signature* <input type="text"/>	

**Additional support** (eg Sure Start, social services, child protection, community physiotherapist, infant feeding coordinator)

Signature\*

\* Signatures must be listed on page 24 for identification

Name
Unit No