

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

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

Date / / Time Labels checked Where seen Feeding method

Are there any concerns about the following: No Yes **Comments** Day Key to risk reviewed (page 2)

A. Feeding	<input type="checkbox"/> <input type="checkbox"/>	
B. Weight Gain, static, loss <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"/>	

Management plan (page 3) Reviewed Revised Signature*

Affix additional free text sheets here, and number them 12.1, 12.2 etc

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

Signature*

Name

Unit No

