First Weeks

WELL CHILD VISIT

Revised March 2012

Name	BIRTH DATE	AGE	ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE
		❑M ❑F		

ID NUMBER	CURRENT MEDICATIONS	DRUG ALLERGIES
	See other side for current medication list	

WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	DATE/TIME

See growth chart.

BF = Bright Futures Priority Item

History

HOSPITAL / BRIGHT FUTURES

❑ Term or _____weeks
Birth weight _____
Discharge weight _____
Newborn hearing screening ❑ Normal
❑ Pending results ❑ Not performed
❑ Abnormal_____
Newborn blood spot screen ❑ Normal
❑ Pending results ❑ Not performed
❑ Abnormal_____

Blood type: Maternal _____
Infant _____Direct Coombs _____
Bilirubin screening ❑ None
Transcutaneous bilirubin _____
Serum bilirubin _____
Hep B (maternal): ❑ Pos ❑ Neg ❑ Unk
Hep B vaccine _____/_____/_____
Comments _____

❑ Home birth ❑ Previsit Questionnaire reviewed

BF Concerns /questions raised by _____❑None ❑Addressed (see other side)

BF Follow-up on previous concerns ❑None ❑Addressed (see other side)

BF ❑ Medication Record reviewed and updated

Social/Family History

Family situation ❑ Single Parent

BF Parent adjustment to new child _____

BF Maternal Depression ❑ Yes ❑ No _____

PHQ 9	❑ Pass	❑ Refer
PHQ 2	❑ Pass	❑ Refer
Edinburgh	❑ Pass	❑ Refer

BF Reaction of siblings to new child _____

BF Work plans _____

BF Child care plans _____

Heat source _____

BF ❑ Tobacco Exposure

Review of Systems

BRIGHT FUTURES

☑ = NL

Date of last visit _____
Changes since last visit _____

Nutrition: ❑ Breast milk Minutes per feeding _____
Hours between feeding _____Feedings per 24 hours _____
Problems with breastfeeding _____
❑ Formula Ounces per feeding _____
Source of water _____Vitamins/Fluoride _____
Elimination: ❑ NL _____
Sleep: ❑ NL _____
Behavior: ❑ NL _____

Development (if not reviewed in Previsit Questionnaire)

❑ SOCIAL-EMOTIONAL
*Eats well
❑ COMMUNICATIVE
*Turns and calms to your voice
❑ PHYSICAL DEVELOPMENT
*Can suck, swallow, and breathe easily
❑ COGNITIVE
*Follows your face

(see other side for plan, immunizations and follow-up)

Physical Examination

☑ = Reviewed w/Findings **OR** ☑ NL = Reviewed/Normal

	❑ GENERAL APPEARANCE	❑NL
BF	❑ **SKIN (rashes, jaundice)**	❑NL
BF	❑ **HEAD / FONTANELLE**	❑NL
BF	❑ **EYES (red reflex/strabismus/appears to see)**	❑NL
	❑ EARS/APPEARS TO HEAR	❑NL
	❑ NOSE	❑NL
	❑ MOUTH AND THROAT	❑NL
	❑ NECK	❑NL
	❑ LUNGS	❑NL
BF	❑ **HEART**	❑NL
BF	❑ **FEMORAL PULSES**	❑NL
BF	❑ **ABDOMEN (umbilical cord, vessels)**	❑NL
	❑ HERNIA	❑NL
	❑ GENITALIA	❑NL
	❑ Male/Testes down	❑NL
	❑ Female	❑NL
	❑ CIRCUMCISION	❑NL
BF	❑ **NEUROLOGIC (tone, symmetry, state regulation)**	❑NL
	❑ EXTREMITIES	❑NL
BF	❑ **MUSCULOSKELETAL (torticollis)**	❑NL
BF	❑ **HIPS**	❑NL
	❑ NO DYSMORPHISMS	❑NL
	❑ HYGIENE	❑NL
	❑ BACK	❑NL

BF Comments _____

Assessment

BF ❑ Well Child

Anticipatory Guidance

☑ = Discussed and/or handout given

❑ Identified at least one child and parent strength
❑ Raising Readers book given

BRIGHT FUTURES

❑ NEWBORN TRANSITION
- Back to sleep
- Daily routines
- Calming techniques

❑ NEWBORN CARE
- Emergency preparedness plan
- Frequent hand washing
- Avoid direct sun exposure
- Expect 6-8 wet diapers/day

❑ NUTRITIONAL ADEQUACY
- Breastfeeding (vitamin D supplement)
- Iron-fortified formula (if not breastfed)
- No solid foods
- No honey; no Karo syrup

❑ PARENTAL WELL-BEING
- Baby blues
- Accept help
- Sleeps when baby sleeps
- Unwanted advice

❑ SAFETY
- Car safety seat (infant rear facing)
- Smoke-free environment
- No shaking
- Burns
- Water heater
- Smoke detectors
- Crib safety
- Sun safety

First Weeks WELL CHILD VISIT

NAME	Male Female	Medical Record Number	DOB Actual age (weeks): O 1 O 2 O 3 O 4

Current Medications _____

_____

_____

Plan

BF Patient is up to date, based on CDC/ACIP immunization schedule. ❑Yes ❑No
If no, immunizations given today. ❑Yes ❑No
ImmPact2 record reflects current immunization status: ❑Yes ❑No

_____

_____

❑ Immunization plan/comments _____

_____

_____

❑ Ask about WIC

BF Laboratory/Screening results _____

_____

_____

_____

_____

_____

Hearing screen _____

❑Previously done Date completed _____

MaineCare Member Support Requested

❑ Transportation to appointments
❑ Find dentist
❑ Find other provider
❑ Make doctor's appointment
❑ **Public Health Nurse referral**
❑ Family aware

_____

_____

_____

_____

_____

BF Referral to _____

_____

BF Follow-up/Next Visit _____

_____

Narrative Notes:

_____

_____

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_____

EXAMINER'S SIGNATURE	DATE

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner