

This form is to be completed by attending physician.

**A. Physical Examination**

Condition at Birth

Baby ULI/PHN

Gestational Age (weeks)	By exam	Birth	Head Circum. cm	Weight gm	Size for Gestational age <input type="checkbox"/> ≤ 5 %ile <input type="checkbox"/> _____ %ile <input type="checkbox"/> ≥ 97 %ile
Arterial <input type="checkbox"/> Cord pH <input type="checkbox"/> Base Excess		Venous <input type="checkbox"/> Cord pH <input type="checkbox"/> Base Excess		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous	

	Normal	Abnormal (describe)
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>
2. Skin	<input type="checkbox"/>	<input type="checkbox"/> Bruising <input type="checkbox"/> Mec. Stain <input type="checkbox"/> Jaundice <input type="checkbox"/> Petechiae <input type="checkbox"/> Peeling <input type="checkbox"/> Other
3. Head	<input type="checkbox"/>	<input type="checkbox"/>
4. E.E.N.T.	<input type="checkbox"/>	<input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft lip/Palate <input type="checkbox"/> Micrognathia <input type="checkbox"/> Other
5. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
6. C.V.S.	<input type="checkbox"/>	<input type="checkbox"/>
7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
8. Umbilical Cord	<input type="checkbox"/>	<input type="checkbox"/> 2 Vessels
9. Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/> Spine <input type="checkbox"/> Foot <input type="checkbox"/> Hip
10. Genital-Rectal	<input type="checkbox"/>	<input type="checkbox"/> Hypospadias <input type="checkbox"/> Imperforate Anus <input type="checkbox"/> Undescended Testes
11. C.N.S.	<input type="checkbox"/>	<input type="checkbox"/> Hypotonia <input type="checkbox"/> Reflexes <input type="checkbox"/> Poor Suck/Swallow <input type="checkbox"/> Head control
12. Other		
13. Congenital Abnormality		

**Problem List: (Delivery/Newborn)**

**Progress Notes: (State date and time of entry)**

Date	Time	Signature
		X

**B. Discharge Exam**

Normal     Abnormal (specify below)    Discharge Weight \_\_\_\_\_ gm

**D. Follow Up**

**Problems:**

**C. Discharge Diagnosis**

**Plans:**

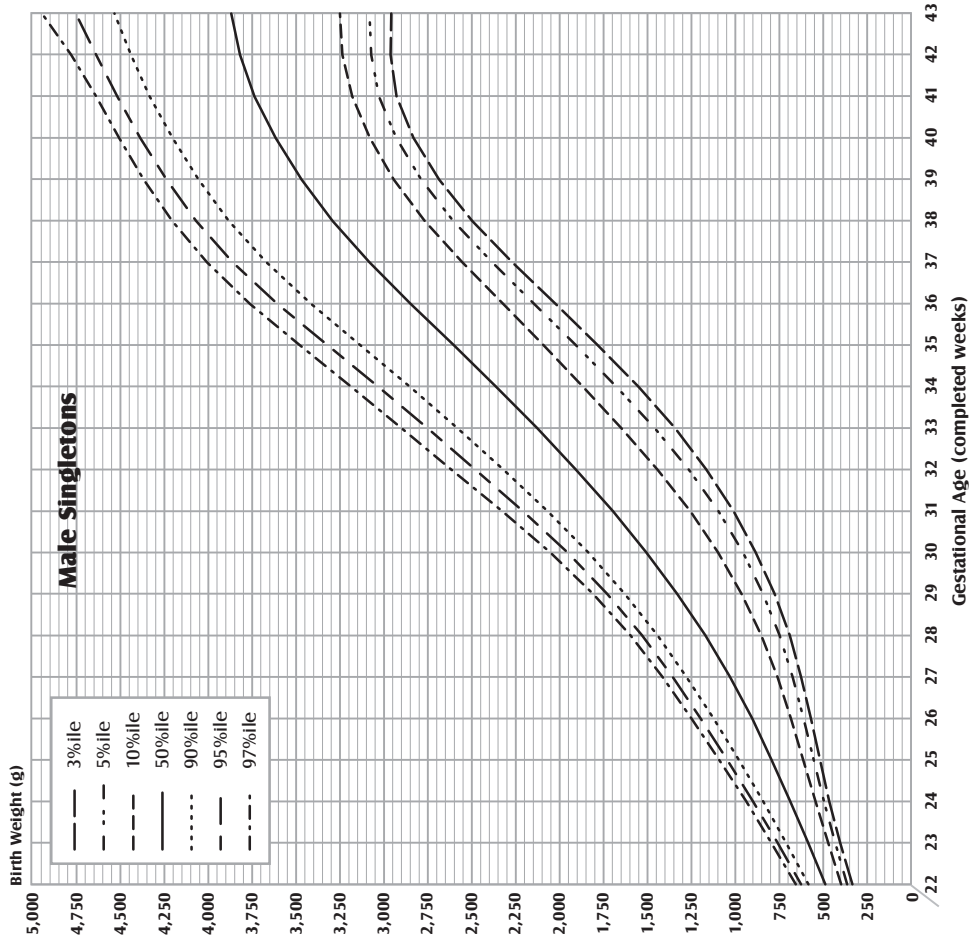
Copy to Primary Physician/Midwife    Name of Primary Care Physician/Midwife  
 Yes     No

Signature

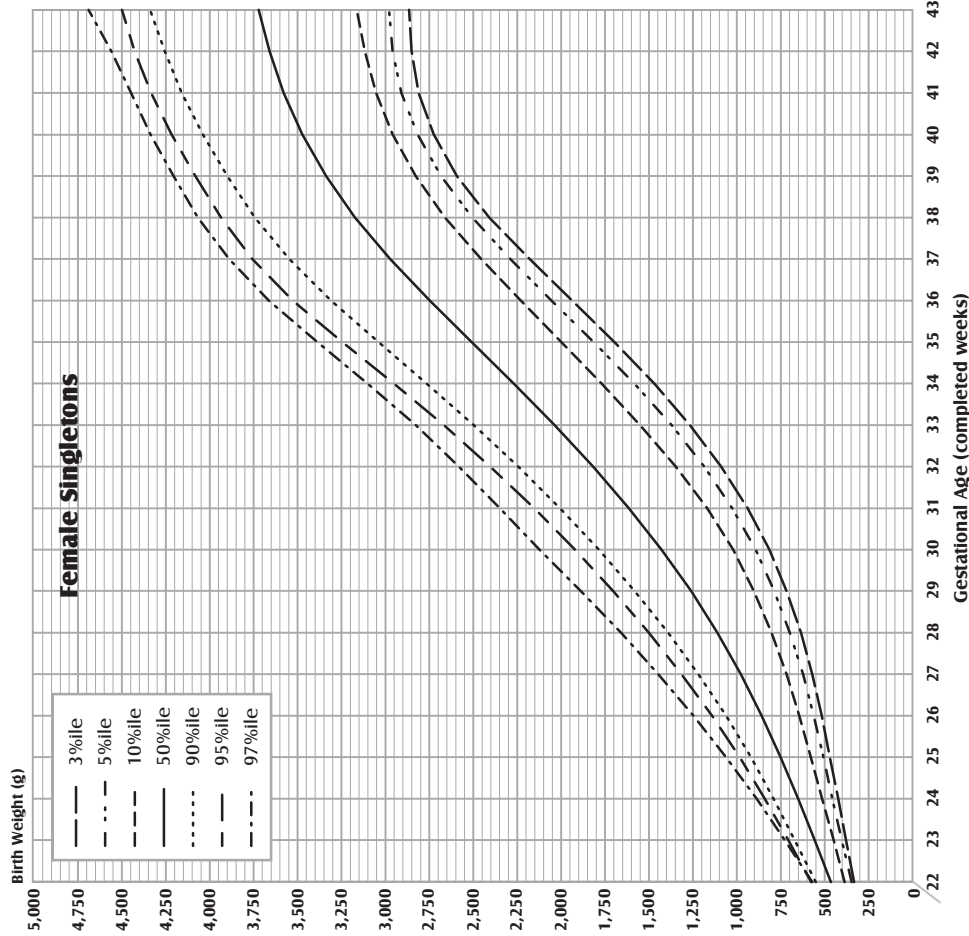
X

# BIRTHWEIGHT PERCENTILES SINGLETON LIVE BIRTHS

**Figure 1**  
Birthweight percentiles for male singleton live births



**Figure 1**  
Birthweight percentiles for female singleton live births



Source of information:  
Michael S. Kramer et al.  
A New and Improved Population-based  
Canadian Reference for Birth Weight for Gestational Age. Pediatrics.  
Electronic version, August 2001.  
<http://www.pediatrics.org/cgi/content/full/108/2/e35>