

Label Area

**POST DELIVERY NEWBORN RESUSCITATION FORM**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Time: \_\_\_\_\_ Mode of Delivery: \_\_\_\_\_  
 Mother: \_\_\_\_\_ Birth Gestational Age: \_\_\_\_\_ Birth Weight: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Delayed Cord Clamping:  Yes  No Duration: \_\_\_\_\_ seconds

**Initial Resuscitation Steps: Minimum of 1 minute for first 5 minutes of resuscitation.**

Time	Assessment	Assessment	Assessment	Assessment	Assessment
<b>Heart Rate</b>	<input type="checkbox"/> < 60 <input type="checkbox"/> 60 - 100 <input type="checkbox"/> > 100	<input type="checkbox"/> < 60 <input type="checkbox"/> 60 - 100 <input type="checkbox"/> > 100	<input type="checkbox"/> < 60 <input type="checkbox"/> 60 - 100 <input type="checkbox"/> > 100	<input type="checkbox"/> < 60 <input type="checkbox"/> 60 - 100 <input type="checkbox"/> > 100	<input type="checkbox"/> < 60 <input type="checkbox"/> 60 - 100 <input type="checkbox"/> > 100
<b>Respiratory Effort</b>	<input type="checkbox"/> None <input type="checkbox"/> Weak/Irregular <input type="checkbox"/> Adequate	<input type="checkbox"/> None <input type="checkbox"/> Weak/Irregular <input type="checkbox"/> Adequate	<input type="checkbox"/> None <input type="checkbox"/> Weak/Irregular <input type="checkbox"/> Adequate	<input type="checkbox"/> None <input type="checkbox"/> Weak/Irregular <input type="checkbox"/> Adequate	<input type="checkbox"/> None <input type="checkbox"/> Weak/Irregular <input type="checkbox"/> Adequate
<b>P O<sub>x</sub> (SpO<sub>2</sub>)</b>	_____ %	_____ %	_____ %	_____ %	_____ %
<b>MR Sopa:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Respiratory Support</b>	<input type="checkbox"/> CPAP _____ cmH <sub>2</sub> O <input type="checkbox"/> PPV _____ / _____ x <input type="checkbox"/> SI _____ cmH <sub>2</sub> O x _____ sec <input type="checkbox"/> Other _____	<input type="checkbox"/> CPAP _____ cmH <sub>2</sub> O <input type="checkbox"/> PPV _____ / _____ x <input type="checkbox"/> SI _____ cmH <sub>2</sub> O x _____ sec <input type="checkbox"/> Other _____	<input type="checkbox"/> CPAP _____ cmH <sub>2</sub> O <input type="checkbox"/> PPV _____ / _____ x <input type="checkbox"/> SI _____ cmH <sub>2</sub> O x _____ sec <input type="checkbox"/> Other _____	<input type="checkbox"/> CPAP _____ cmH <sub>2</sub> O <input type="checkbox"/> PPV _____ / _____ x <input type="checkbox"/> SI _____ cmH <sub>2</sub> O x _____ sec <input type="checkbox"/> Other _____	<input type="checkbox"/> CPAP _____ cmH <sub>2</sub> O <input type="checkbox"/> PPV _____ / _____ x <input type="checkbox"/> SI _____ cmH <sub>2</sub> O x _____ sec <input type="checkbox"/> Other _____
<b>Interface</b>	<input type="checkbox"/> Mask <input type="checkbox"/> ETT	<input type="checkbox"/> Mask <input type="checkbox"/> ETT	<input type="checkbox"/> Mask <input type="checkbox"/> ETT	<input type="checkbox"/> Mask <input type="checkbox"/> ETT	<input type="checkbox"/> Mask <input type="checkbox"/> ETT
<b>FiO<sub>2</sub></b>	_____ %	_____ %	_____ %	_____ %	_____ %
<b>Compressions</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Comments</b>					

**Vital signs: After first 5 minutes of resuscitation**

Time	HR	Rcp	BP	Temp	P O <sub>x</sub>	FiO <sub>2</sub>	Mode	Settings

Time	HR	Resp	BP	Temp	P O <sub>x</sub>	FiO <sub>2</sub>	Mode	Settings

Additional Notes:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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**Airway Interventions**

	Size	Taped at	Time Successfully Placed	Number of Attempts	Successfully placed by
Endotracheal Tube					

Indication for intubation:  
 Resuscitation / Bradycardia  Oxygen Requirement  Other \_\_\_\_\_  
 Persistent Apnea/Irregular respirations  Surfactant

**Blood Gases/Labs**

Time/Site			
Vent Settings			
PH			
PCO <sub>2</sub>			
PO <sub>2</sub>			
Bicarb			
Base Excess			
H&H			
Glucose			

**Procedures**

	Time	Size	Site	Secured at	Placed by
Paracentesis					
Thoracentesis					
Chest Tube #1					
Chest Tube #2					
UAC					
UVC (double lumen)					
Peripheral art stick					
Peripheral IV					

Medications	Epinephrine	Normal Saline	PRBCs	Surfactant	Erythromycin	Phytonadione (Vitamin K)		
Dose/Rt								
Time								
Dose/Rt								
Time								
Dose/Rt								
Time								

**APGAR Score**

Sign	1 minute	5 minutes	10 minutes	15 minutes
<b>Heart Rate</b>				
>100	2			
<100	1			
Absent	0			
<b>Respiration</b>				
Strong Effort	2			
Weak/Irregular	1			
Absent	0			
<b>Muscle Tone</b>				
Active Motion	2			
Strong Flexion	1			
Limp	0			
<b>Reflex/Irritability</b>				
Cry/Active Withdraw	2			
Grimace	1			
No Response	0			
<b>Color</b>				
Pink	2			
Acrocyanosis	1			
Pale/Blue	0			
<b>Total</b>				

**Thermoregulation**

Neo Wrap  Plastic Wrap on Head  Portable Heat Mattress

**IV Fluids and Infusions**

Solution/Infusion	Rate	Site of Infusion	Time Started

**RESPONDERS**

Name	Signature	Time Arrived	Role

I was present and supervised the resuscitation. I reviewed the resuscitation record and agree except as noted:

\_\_\_\_\_

Medical Leader Signature

Print Name

Date

Time



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