

British Columbia Community Liaison Record NEWBORN

1

Surname _____		Given Name(s) _____	
PHN # _____		Hospital/Place of Birth _____	
Permanent Address (if different from mother) _____ Phone: () _____ Cell phone: () _____		Temporary Address (if different from mother) _____ Phone: () _____ Cell phone: () _____	
Parent/Guardian _____		Relationship _____	
Family Physician &/or Midwife (if different from mother) _____		Admitting Physician &/or Midwife (if different from mother) _____	
Hospital consultant/Referral _____			

2 BIRTH SUMMARY

Birthdate _____ yy/mm/dd	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Undifferentiated	Type of birth: <input type="checkbox"/> SVD <input type="checkbox"/> Forceps _____ <input type="checkbox"/> Vacuum <input type="checkbox"/> C/S	Gestational age _____
Birthweight _____ gms Discharge wt (if >24 h) _____ gms	Appgar score 1 min 5 min 10 min	ABO group _____ Rh _____ (if applicable)	HC _____ L _____
Other information (e.g. delivery complications, congenital anomaly) _____			

3 NEWBORN HEALTH & WELL-BEING

Screening Tests & Procedures, Communicable Disease & Exposure

In utero exposure Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes Substance(s) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____	Group B Strep exposure <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, prophylaxis _____ If no prophylaxis, reason/plan: _____ _____	Hep B prophylaxis indicated <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> HBIG given <input type="checkbox"/> Hep B vaccine given Date _____
Serum bilirubin level <input type="checkbox"/> N/A Initial _____ µmol/L at _____ hrs of life D/C _____ µmol/L at _____ hrs of life Treatment/follow-up _____	Blood spot card done <input type="checkbox"/> Yes <input type="checkbox"/> No If no: <input type="checkbox"/> Deferred <input type="checkbox"/> Refused	Initial hearing screen <input type="checkbox"/> Yes <input type="checkbox"/> No Needs follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No (by BC Early Hearing Program)
Newborn exposure to second-hand smoke <input type="checkbox"/> No <input type="checkbox"/> Yes		

Infection/risk for infection No Yes Specify: _____

4 INFANT FEEDING (at discharge)

Exclusive breastmilk Partial breastmilk Breastmilk substitute (specify) _____
 Variances (specify) _____ Feeding plan at d/c _____

5 ADDITIONAL INFORMATION

Seen by other resources: Social Worker MCFD SW Other (specify) _____ Follow-up needed (specify) _____

Community resources, follow-up & how to access: PHN PHCP On reserve (name) _____ Other (specify) _____

Comments _____

6 HOSPITAL DISCHARGE

Home with mother Other (specify) _____
Date _____ Time _____

Seen by liaison nurse (if applic) _____ Date: _____

Health Unit _____ Faxed _____ Signature Discharge RN/Liaison RN/Midwife (for home birth) _____

NURSING PRIORITY SCREENING

A. CHILDREN WITH A CONGENITAL OR ACQUIRED HEALTH CHALLENGE

1. Congenital anomaly
 - a) Major (probability of permanent disability) e.g.: Down Syndrome, Cerebral Palsy, FASD 9
 - b) Moderate (correction may be possible) e.g.: Cleft palate 6
2. a) Major disability acquired during the first 5 years of life (probability of permanent disability) e.g.: Cerebral Palsy, severe brain damage. 9
- b) Moderate disability acquired during the first 5 years of life (correction may be possible) e.g.: loss of limb 6

B. DEVELOPMENT RISK FACTORS

3. Low birth weight
 - a) 0 – 1499 gm 9
 - b) 1500 – 1999 gm 8
 - c) 2000 – 2499 gm 6
4. Bilirubin level: Treatment/follow-up required as noted by the primary care provider/staff in the acute care setting 8
5. Complications of pregnancy
 - a) Infections that can be transmitted in utero and may damage the fetus (e.g.: rubella, HIV) 9
 - b) Drugs – e.g.: alcohol or drug use diagnosed in mother 9
6. Complications of labour and birth
 - a) Labour – interventions such as vacuum and forceps, vacuum/forceps and C/S 4
 - b) Infant trauma or illness (e.g.: convulsions, respiratory distress syndrome) 6
 - c) Apgar at 5 minutes only if less than 7. Deduct apgar score at 5 minutes from 10 points ---
7. Family history of a disability not detectable at birth that could affect development e.g.: deafness, mental disability. 4
8. Developmental concerns not already covered in any above category
 - a) Acquired risk of developmental delay due to illness or trauma in first 5 years 6
 - b) Delayed developmental assessment in first 5 years 9

C. FAMILY INTERACTION RISK FACTORS

9. Age of mother
 - a) 15 and under 9
 - b) 16 or 17 8
 - c) 18 or 19 5
10. Social Situation
 - a) One parent family with other support available. 2
 - b) One parent family – no support available 7
 - c) Two parent family – no social support and/or severe isolation related to culture, language or geography 4
11. Financial difficulties 3
12. No prenatal care before sixth month 4
13. Mental illness or disability in mother and/or father
Double score if both parents positive in (a) or (c)
 - a) Schizophrenia or bipolar affective disorder. 7
 - b) Postpartum depression or psychosis 9
 - c) Mental disability of parent 6
14. Prolonged postpartum maternal separation (5 days or more)
 - a) With frequent infant contacts (visits or phone as feasible) 2
 - b) Little or no contact. 6
15. Assessed lack of bonding (e.g. minimal eye contact or touching) 6
16. >3 hospitalizations in one year in absence of known chronic illness or condition 7
17. Other – e.g.: marital distress, family violence, low education level, failure to thrive, parenting difficulties, maternal smoking during pregnancy, maternal low/excessive weight gain (score 0-9)
Specify ---

PRIORITY SCORE: 9 and over = *high priority* 6–8 = *moderate priority* 3–5 = *low priority* 0–2 = *minimal priority*

TOTAL PRIORITY SCORE

British Columbia Community Liaison Record POSTPARTUM

1

Surname		Given Name(s)	
Hospital/Place of Birth			
PHN#		Birthdate (yy/mm/dd)	
<input type="checkbox"/> Interpretation Req'd: Language			
Permanent Address		Temporary Address	
Phone: ()		Cell phone: ()	
Next of Kin		Relationship	
Family Physician &/or Midwife		Admitting Physician &/or Midwife	
Hospital Consultant/Referral			

2 BIRTH SUMMARY

G _____ T _____ P _____ A _____ L _____ (at discharge) Infant birth date: Date (yy/mm/dd) Time _____

Ages of other children _____ Sex of infant M F Undifferentiated

Type of birth: <input type="checkbox"/> SVD <input type="checkbox"/> VBAC Asst vaginal: <input type="checkbox"/> Vacuum Forceps: <input type="checkbox"/> Outlet <input type="checkbox"/> Low <input type="checkbox"/> Mid <input type="checkbox"/> Rotation C/S: <input type="checkbox"/> Elective <input type="checkbox"/> Emergent Reason: _____	Perineum: <input type="checkbox"/> Intact <input type="checkbox"/> Laceration _____ ° <input type="checkbox"/> Episiotomy <input type="checkbox"/> Repaired	Blood group _____ Rh _____ EBL: <input type="checkbox"/> <500 mL <input type="checkbox"/> 500–1000 mL <input type="checkbox"/> >1000 mL Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Yes _____	Intrapartum analgesia/anesthetic: <input type="checkbox"/> No <input type="checkbox"/> Yes Specify _____ Antibiotics: <input type="checkbox"/> No <input type="checkbox"/> Yes Specify _____
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Breasts:
 Previous breastfeeding experience Comments _____
 Variances/feeding concerns No Yes Plan (specify) _____

Other information—e.g. birth complications, referrals

3 MATERNAL HEALTH & WELL-BEING

Emotional health & well-being: <input type="checkbox"/> Hx Depression <input type="checkbox"/> Depression current pregnancy <input type="checkbox"/> Medication(s) <input type="checkbox"/> IPV Comments _____	Lifestyle: Tobacco use: <input type="checkbox"/> Non smoker <input type="checkbox"/> Quit before preg <input type="checkbox"/> Quit during preg <input type="checkbox"/> Current smoker Alcohol use: <input type="checkbox"/> Non drinker <input type="checkbox"/> Quit before preg <input type="checkbox"/> Other _____ Substance use: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Other _____
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Tests & Procedures, Communicable Diseases & Exposure

Rubella status: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	Rh immune globulin	Hep B
MMR Given: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____	<input type="checkbox"/> Given: Date _____	<input type="checkbox"/> Neg <input type="checkbox"/> Positive

Exposure to/or other communicable disease: No Yes (specify, e.g. Hep. C) _____

4 ADDITIONAL INFORMATION

Seen by hospital resources: Lactation Consultant Social Worker Other (specify) _____ Follow-up needed (specify) _____

Support at home (specify) _____

Other information: _____

Community resources, follow-up & how to access: PHN PHCP On reserve (name) _____ Other (specify) _____

Given PURPLE Crying materials Yes No Has *Baby's Best Chance* Yes No Prenatal education accessed Yes No

5 HOSPITAL DISCHARGE

<input type="checkbox"/> To home <input type="checkbox"/> Other (specify) _____	Mother D/C with baby <input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____ Time _____	Comment _____
<input type="checkbox"/> Seen by liaison nurse (if applic) Date: _____	
Health Unit _____ <input type="checkbox"/> Faxed _____	Signature Discharge RN/Liaison RN/Midwife (for home birth) _____

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