First Examination of the Newborn : Form

(Examine 1 hour after birth but in any case within 6 hours from the birth. If you are not present on the day of delivery then fill the form on the day of your first visit and write the date of your visit)

Part I :

1) Date of birth : _____

2) Preterm cut-off date : _____ Is baby preterm? : Yes / No

3) Date of first examination : _____

Time : Early Morning Morning Afternoon Evening Night Hrs. _____

4) Does mother have any of the following problems ?

a. Excessive bleeding Yes / No

b. Unconscious / fits Yes / No

Action : If Yes refer immediately to hospital Action taken : Yes / No

(In case of Still Birth do not perform further examination but complete the examination of the mother as per home visit form on day 2, 3, 7, 15, 28)

5) What was given as the first feed to the baby after birth ? _____

6) At what time was the baby first breast fed ? Hrs _____ Min _____

How did the baby take feed? (Mark ✓)

1) Forcefully
2) Weakly
3) Could not breast feed but has to be fed with spoon
4) Could neither breast feed nor takes milk given by spoon

7) Does the mother have breast feeding problem ? Yes / No

Write the problem _____

If breast feeding problem is present help mother to overcome it

Part II :

First examination of the baby

1) Temperature of the baby (Measure in axila and record) : _____

2) Eyes : Normal
Swelling or
Oozing pus

3) Is umbilical cord bleeding : Yes / No

Action : If yes, get it tied by TBA or tie again with clean thread.
Action taken : Yes / No

For supervisor #

Correct / incorrect

Correct / incorrect

First examination done

Days : ___ Hours : ____

after birth

Yes / No / NA

Correct / incorrect

Correct / incorrect

Correct / incorrect

Correct / incorrect

Yes / No / NA

Yes / No / NA

Correct / incorrect

Correct / incorrect

Correct / incorrect

Yes / No / NA

Mark yes if necessary and possible action has been taken without any mistake

Name of the ASHA : _____ **Date :** _____

Name of the trainer : _____ **Total score :** _____

Block : _____

For supervisor

4) Weight : Kg ____ Grams _____ Colour on scale : Red / Yellow / Green

Weight matches with the colour? Yes / No

5) Record (✓ or X)

1. All limbs limp	
2. Feeding less/stopped	
3. Cry weak/stopped	

Correct / Incorrect

Routine Newborn Care	**Whether the task was performed**	Action taken?
1) Dry the baby	**Yes / No**	Yes / No / NA
2) Keep warm, don't bathe, wrap in the cloth, keep close to mother	**Yes / No**	Yes / No / NA
3) Initiate exclusive breast feeding	**Yes / No**	Yes / No / NA

6) Vitamin K injection

Home delivery : Give injection (after you have been trained) Yes / No — Yes / No

Hospital /PHC delivery : Baby received vitamin K injection in hospital Yes / No — Yes / No

If 'no', then give vitamin K injection (after you have been trained) Yes / No — Yes / No

7) Anything unusual in baby ?: Curved limbs / Cleft lip / Other _____ Yes / No

_____

For supervisor

Form checked by : Name _____ Date : _____

Corrections _____

_____

Unusual or different observation _____

_____

Whether there is any complication at the injection site Yes / No

If Yes , what action was taken ? _____

Whether the form has been completed ? Yes / No

Signature : _____