SOUTHWESTERN ONTARIO PERINATAL PARTNERSHIP

Name of Hospital: _____

NEONATAL RESUSCITATION RECORD

Date (YYYY/MM/DD): _____

(KEY: ✓ APPROPRIATE BOX)

Time of Birth:

First Heart Rate: **(AGE IN MINUTES)**

Age of 1st Gasp: **(AGE IN MINUTES)**

Age of Sustained Respirations: **(AGE IN MINUTES)**

AIRWAY

Meconium: ☐ Absent ☐ Watery ☐ Thick

Suction at perineum: ☐ Yes ☐ No

Suction after birth: ☐ Yes ☐ No

Tracheal suction: ☐ Yes ☐ No

Meconium below cords: ☐ Yes ☐ No

Stomach emptied: ☐ Yes ☐ No

BREATHING

Oxygen: ☐ Yes ☐ No

Age Started: Age Stopped:

Bag & Mask Ventilation: ☐ Yes ☐ No

Age Started: Age Stopped:

Oral Gastric Tube Inserted: ☐ Yes ☐ No

Endotracheal Intubation: ☐ Yes ☐ No

Age: ☐ Oral ☐ Nasal

Size ETT:

CIRCULATION

Cardiac Compressions: ☐ Yes ☐ No

Age Started: Age Stopped:

Volume Expander: ☐ Yes ☐ No

MEDICATION ADMINISTRATION

TIME	DRUG	DOSE	ROUTE	GIVEN BY/ CHECKED BY

APGAR SCORE	1 MIN	5 MIN	10 MIN
Heart Rate			
Respiration Rate			
Muscle Tone			
Reflex Responses			
Skin Colour			
TOTAL			

PROCEDURES

AGE	PROCEDURE
	Name band applied: ☐ Wrist ☐ Ankle ☐ Hat applied
	UVC inserted: ☐ Yes ☐ No
	Size: By whom:
	Length (as in taped at): cm
	Peripheral IV inserted: ☐ Yes ☐ No
	Size: Site:
	IV solution: Rate:
	X-rays:
	Blood Work:
	☐ Blood Gases ☐ Blood Culture
	☐ CBC ☐ Dextrostix
	☐ Blood Sugar ☐ Other:

VITALS ON TRANSFER FROM BIRTHING AREA

Temp: Pulse: Resp:

O_2 Sat: FiO_2: BP:

Congenital Anomalies:

OUTCOME

Admitted to NICU, Special Care, with mother:

Transfer to:

Expired: Time:

Discussion with Parents: ☐ Yes ☐ No

Patient's Name: _____

TIME	ADDITIONAL OBSERVATIONS AND COMMENTS

RESUSCITATION TEAM

RN Signature(s): _____ Printed Name(s): _____

_____ _____

RRCP Signature: _____ Printed Name: _____

MD/RM/CNS/NP Signature: _____ Printed Name: _____

Date (YYYY/MM/DD): _____