Southwestern Ontario
Maternal, Newborn, Child and Youth Network

NAME OF HOSPITAL: _____

NEONATAL RESUSCITATION RECORD

Date (YYYY/MM/DD): _____ Time: _____

Gestational Age: _____ Estimated Wt: _____ grams

(KEY: ✓ APPROPRIATE BOX)

To be completed whenever free flow oxygen is required or when positive pressure ventilation with either room air or supplemental oxygen is initiated.

Time of Birth: First Heart Rate: **(AGE IN MINUTES)**

AIRWAY **Meconium:** ☐ Absent ☐ Present Suction after birth: ☐ Yes ☐ No Suction below cords: ☐ Yes ☐ No Meconium below cords: ☐ Yes ☐ No

APGAR SCORE	0	1	2	1 MIN	5 MIN	10 MIN	15 MIN	20 MIN
Skin Colour	Blue or Pale	Acrocyanotic	Completely Pink					
Heart Rate	Absent	< 100	> 100					
Reflex Irritability	No Response	Grimace	Cry/ Active Withdrawal					
Muscle Tone	Limp	Some Flexion	Active Motion					
Respiration	Absent	Weak Cry Hypoventilation	Good Crying					
			TOTAL SCORE:					

RESUSCITATION	**AGE IN MINUTES: (✓) APPROPRIATE COLUMN ➡**	**1**	2	3	4	**5**	6	7	8	9	**10**	11	12	13	14	**15**	16	17	18	19	**20**
CLINICAL OBSERVATIONS:	First Gasp																				
	Spontaneous Respirations																				
	First Grimace																				
Oxygen Max O_2: Room Air used x _____ sec																					
PPV/CPAP Via: ☐ Bag Mask ☐ Neo Puff PIP _____ / PEEP _____																					
ETT (Size:) ☐ Rt Nare ☐ Lft Nare ☐ Oral Depth:																					
NG/OG Tube: ☐ Left ☐ Right																					
Chest Compressions:																					
Epinephrine (1:10,000)	Dose: **IV 0.1 mL/kg** =																				
	ETT 1 mL/kg =																				
Volume Expanders: Dose: 10 mL/kg =	Indicate: NS = Normal Saline BL = Blood																				
Response to Resuscitation:	Increase in Heart Rate																				
	Improvement in Colour																				

Condition at Completion of Code: ☐ Good ☐ Fair ☐ Guarded ☐ Expired Time:

PROCEDURES		**VITALS ON TRANSFER FROM BIRTHING AREA**		
AGE	**PROCEDURE**	Temp:	Pulse:	Resp:
	Name band applied: ☐ Wrist ☐ Ankle	O_2 Sat:	FiO_2:	BP:
	UVC inserted: ☐ Yes ☐ No	Glucose:		
	By whom:	**COMMENTS:**		
	Size: Taped at: cm			
	Peripheral IV inserted: ☐ Yes ☐ No Size:			
	Site:			
	IV solution: Rate:			

OUTCOME

Admitted to: ☐ NICU ☐ Special Care ☐ With Mother

Transfer to:

Discussion with Parents: ☐ Yes ☐ No

By:

Patient's Name: _____

MEDICATION ADMINISTRATION				
TIME	**DRUG**	**DOSE**	**ROUTE**	**GIVEN BY/ CHECKED BY**

TIME	ADDITIONAL OBSERVATIONS AND COMMENTS

RESUSCITATION TEAM

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

_____ _____ _____

RRT Signature: _____ Printed Name: _____ Initials: _____

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

Date (YYYY/MM/DD): _____