Newborn Baby Visit

Name of Child_____ DOB: _____

Name of Parent(s) _____

Current Phone: _____

Place of Visit: □ Home □ Other _____

EHS Staff in attendance: _____

Medical Provider: _____

Name of Pediatrician: _____

Has the baby had his/her first doctor visit?

□ No □ Yes Date: _____

Have you scheduled your 6-week postpartum visit?

□ No □ Yes Date: _____

INFORMATION DISCUSSED

___ Any medical condition
___ Special Needs (medical, nutrition, developmental)
___ Jaundice
___ Urine output and bowel movement
___ Skin care
___ Cord care
___ Feeding your baby (breast or bottle)
___ Burping your baby
___ Bathing your baby
___ Talking to your baby
___ Diapering your baby
___ Where does baby sleep?
___ Choosing a pediatrician
___ Circumcision
___ Baby's first visit to the doctor (what to expect)
___ Postpartum doctor visit
___ Infant car seat (correct position)
___ Passive smoking
___ Support system
___ Family planning options
___ Father's feelings/questions
___ Child care options
___ All about my baby
___ Basic baby needs

Comments/follow-up:

_____

_____

_____

_____ _____

Staff Signature Date of Visit

_____

Staff Title