Ministry of Health Adan Hospital	**NEONATAL ASSESSMENT SHIFT–TO-SHIFT NURSING HANDOVER TOOL & TRANSFER FORM**	BABY OF_____ DOB_____TIME_____ SEX _____NATIONALITY_____ CID NO:_____ DIAGNOSIS
S	MODE OF DELIVERY:	
B	*AGE OF GESTATION*_____*APGAR*_____*WEIGHT*_____*LENGTH*_____*HC*_____ *CORRECTED AGE & WEIGHT* _____	
	*MATERNAL HISTORY*_____ Conducted by Doctor: Conducted by Midwife:	
	Known Allergies	Isolation Type/ Site

A	Recent Vital Signs	TEMPERATURE	HR	BP	RR	SPO2

NEURO/ SENSORY	Muscle Tone _____Reflexes _____Pain Score _____Others_____
RESPIRATORY	Respiration Status _____Accessory Muscles _____Secretions_____ Airway _____ETT/Size _____ETT Depth _____ Date & Time of Intubation_____ Ventilation: Ventilator_____ Ambubagging_____None_____ BGA _____Others:_____
CARDIOVASCULAR	Color _____Skin Condition_____Specify_____
GASTRO INTESTINAL/ NUTRITION	NUTRITION: NPO _____Breast milk _____Milk Formula _____Tube Feed _____ Cup Feed_____ Frequency_____Amount_____Sucking/SwallowingReflex_____Lips/Pallete_____ Abdominal Distention: Yes ___No_____ Abdominal Girth _____Anal Patency_____ Meconium_____
GENITOURINARY	VOIDING: YES_____NO____ GENITALS: MALE_____ FEMALE_____Abnormalities_____
INTEGUMENTARY	Intact_____Abnormalities_____Head/Neck:_____Facial Features_____Extremities_____UmbilicalStump_____ Others_____
Endocrine:	B.Sugar Value_____ Frequency_____ Intervention _____
Musculoskeletal	BIRTH INJURY:_____Hip____leg_____Foot____Specify abnormalities _____ Bone Fracture: Site/Location _____Others_____

RECOMMENDATIONS	PROCEDURES	DATE	REFERRALS
	NEONATAL SCREENING		
	PHOTOTHERAPY		
	IUGR WORK UP		
	Risk Assessment	**Yes/ NA**	**Score**
	Fall Risk		
	Restraint Use		
	Decubitus Ulcer		

MEDICATIONS					Post Procedure Orders/ TPN/ Blood Transfusion
MEDICATION NAME	**DOSAGE**	**FREQUENCY**	**DATE STARTED**	**DATE DISCONTINUED**	
VITAMIN K					
HEPATITIS B VACCINE					

LABORATORY/ XRAY	REPORT	LINES	DATE OF INSERTION	DUE DATE
BLOOD GROUPING		CANNULA		
CBC		IVF		
SERUM BILIRUBIN		UVC		
OTHERS				

BEDSIDE SAFETY CHECK	YES/NO/ NA	Neonatologist Instructions/ Contingency Plan/ Code Status/ Discharge Plan/ Unusual Event :
Patient ID band		
Dressings, drains, IV site and Infusion pumps		
Baby's Foot Print		
Mother' Finger Print		
Review observation reports		
Equipment function		
Tracing lines and tubes & lines routed in different directions		
Labeling high risk catheters		
Review medication & IO chart		

Name of Endorsing Nurse: _____Name of Receiving Nurse:_____

Date:_____ Time:_____