Patient Addressograph

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Proforma for history and assessment of a neonate following in-hospital fall or drop.

Date and Time of event		Gestation (wk)	
Age at time of event (hours)		Birthweight (gms)	
Date and Time Neonatal team informed		Head circumference at birth(cm)	
Maternal history BMI Underlying medical conditions Known substance Misuse Known sedative medications at time of event Any known social Concerns?		**Birth** Parity Type of delivery Medications during labour Maternal Hb post delivery Did PPH occur?	
Circumstances of fall: Who was caring for baby at time of fall? What happened? Who found baby after fall? What was estimated height from where baby fell to floor? What was height of bed from floor? Type of surface baby was found on? Had parents received information about preventing falls on admission to ward? What and when was the last risk assessment of mother undertaken? What and when were the last observations of mother undertaken?			

Initial assessment of Newborn (document injuries on body map in postnatal notes)

Basics Airway Breathing Circulation	
Neurology Head circumference Level of consciousness Tone Primitive reflexes Anterior fontanelle Extracranial trauma Pupillary size, symmetry and reaction	
Feeding Adequacy Vomiting	
Any other injuries	

Management plan: