NICU Report Sheet

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gestational age: _____ Gender: _____

Room number: _____ Bed number: _____

Admission date: _____ dd / mm / yyyy

MEDICAL HISTORY

Birth weight: _____ Apgar score: _____

Maternal history:

CURRENT MEDICAL STATUS

Vital signs: _____ Feeding method: _____

Medications:

Special care needs:

PROGRESS NOTES

Daily assessment:

Lab results:

Nursing observations:

PLAN OF CARE

Treatment plan:

Goals for the day:

Follow-up tests/procedures:

DOCTOR'S SIGNATURE

Name: _____

Signature:

Date: _____ dd / mm / yyyy