Assessment Guide for Newborn Examination

Name of midwife:_____ 15 - _____

Step/Task	Competent	Not Yet Competent
Examination Preparation and Facilitation of Relationship		
1. Prepare environment and necessary equipment		
2. Greet mother and newborn		
3. Discuss newborn examination procedure and process		
4. Listen and answer any questions		
5. Obtain informed consent for procedure to commence		
History		
1. Obtain personal information of the newborn (name, sex, dob, NHI)		
2. Pregnancy, birth and previous postnatal history for mother and/or baby		
3. Identification of historical factors that may impact wellbeing of newborn		
Newborn Behaviour		
1. Breastfeeding (frequency, duration, attachment, satisfaction)		
2. Urination and stool patterns (frequency, consistency, colour)		
3. Sleep and wake patterns		
4. Bonding and parental/infant relationship development		
5. Discusses age appropriate developmental milestones		
Physical Examination General Considerations and Assessments		
Examination of the Head		
1. General size, symmetry and proportion to body size		
2. Accurately performs head circumference		
3. Sutures and fontanelles, identification of molding		
4. Identification of bruising or other trauma (cephalohematoma, caput)		
Examination of the Eyes		
1. Notes general appearance and presence of abnormalities (erythema/discharge)		
2. Symmetry of shape and placement (identification of dysmorphic features)		
3. Accurately complete red eye reflex		
Examination of the Nose		
1. Note position and development of structure		
2. Patency and ease of respiration		
Examination of the Mouth		
1. Visualise palate		
2. Assess for tongue for size, position and frenulum for tongue-tie		
3. Note presence of any discharge, oral thrush or abnormal features		
4. Integrity of mucous membranes		
Examination of the Ears		
1. Appearance of external structure (integrity, placement, shape)		
2. Identification of any abnormalities (periauricular pits/tags, discharge)		

Midwifery Council
Te Tatau o te Whare Kahu

Step/Task	Competent	Not Yet Competent
Examination of the Neck		
1. Assess length and range of motion		
2. Identification of any abnormalities (masses, webbing, clefts)		
3. Palpate clavicle for crepitus		
Examination of the Thorax		
1. Shape of bony structure and symmetry of movement		
2. Position of nipples and presence of breast tissue		
Examination of the Respiratory System		
1. Observe respiratory effort and note any abnormalities (grunting, retractions)		
2. Auscultates respirations bilaterally – anterior/posterior		
3. Notes respiratory rate, sounds of breath entry, head bobbing, accessory muscles		
Examination of the Cardiovascular System		
1. Observe newborn's central and peripheral colour		
2. Palpates capillary refill to nail bed		
3. Palpates precordium		
4. Auscultates heart rate in four places on chest positions and on back		
5. Notes rate and rhythm of heart rate		
6. Identification of abnormalities – such as murmurs		
Examination of the Abdomen and Umbilicus		
1. Observes shape of abdomen (flat, scaphoid, distension)		
2. Auscultates for presence of bowel sounds		
3. Palpates liver and spleen noting size and placement		
4. Palpates four quadrants identifying presence of masses or organomegaly		
5. Observes umbilical cord and notes presence of 2 arteries and 1 vein (at birth)		
6. Assessment of umbilical cord healing – noting any signs of infection		
Assessment of Genitourinary System (Female)		
1. Observes external genitalia		
2. Notes presence of any abnormalities (hymenal tags or discharge etc.)		
3. Palpates femoral arteries		
4. Location and patency of anus		
Assessment of Genitourinary System (Male)		
1. Observes external genitalia (meatus location, penile size)		
2. Notes presence of any abnormalities (hydrocele, hernia, hypospadias etc.)		
3. Palpates scrotum to identify teste location		
4. Palpates femoral arteries		
5. Location and patency of anus		
Assessment of the Upper and Lower Extremities		
1. Observation and palpation of the skin, soft tissues and bony structures		
2. Observation for symmetry of structures and range of movement		
3. Identification of any abnormalities or dysmorphic features (number of digits, clinodactyly, palmer creases, talipes)		

Midwifery Council
Te Tatau o te Whare Kahu

Step/Task	Competent	Not Yet Competent
Assessment of Musculoskeletal System		
1. Assess general level of tone and spontaneous movement		
2. Observe and palpate the spine – noting positing and integrity		
3. Note any abnormalities of the spine (scoliosis, tuft of hair, sacral dimple)		
4. Assess hip joint stability (Ortolani and Barlow procedures)		
Assessment of the Neurologic System (can be completed throughout examination)		
1. Observe general level of alertness and tone (posture, symmetry, alignment)		
2. Assessment of newborn's behaviour (sleepy, feeding, vomiting)		
3. Assessment of newborn's cry (frequency, strength, sound)		
4. Assess 5 primitive reflexes (suck, grasp, root, moro, babinski)		
Assessment of the Skin (can be completed throughout examination)		
1. Observe central and peripheral colour and perfusion		
2. Observe for any break in skin integrity and presence of rashes, petechiae or birthmarks		
Assessment of Growth (can be completed throughout examination)		
1. Measurement of body size – weight, head circumference, length		
Completion of the Examination		
1. Dresses or supports mother to dress newborn at completion of the examination		
2. Washes hands		
3. Informs mother of all findings and asks/answers any additional questions		
4. Documents all findings of examination appropriately and accurately		

Name and Signature of Midwife Completing Exam:

Name_____

Signature:_____

Date_____

Midwifery Council Registration Number: _____

Name and Signature of Midwife Assessing Exam:

Name: _____

Signature:_____

Date: _____

Midwifery Council Registration Number: _____