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NEONATAL DISCHARGE SUMMARY

Jones, baby girl

aka Emily Jones

Mother: Lucille Smith

Birth weight: **1411 g (3 lbs, 2oz)**

Singleton Gestation

Neonatologist: **Hilary Neonatologist, M.D.**

Follow Up Physician: **Jane Follow Up, M.D.**

Delivering Obstetrician: **James Delivery, M.D.**

Delivery date: 12/20/2005 time: 08:45

Discharge: 1/10/2006 Time: 08:45 LOS: 21 days

ADMISSION DIAGNOSES: Prematurity (admit), RDS (admit)

DIAGNOSES: Singleton, inborn infant, Respiratory distress syndrome, Apnea and bradycardia (drug treated), Jaundice due to prematurity, Sepsis, ruled-out, Hypocalcemia (<7.0), Premature rupture of membranes, Preterm Newborn

PROCEDURES & TREATMENTS: Intravenous fluids, Parenteral nutrition, Umbilical artery line, Central venous line, Gavage feeding, Iron, Ventilation, Oxygen, Continuous positive airway pressure, Chest X-Ray, Intubation, Surfactant, Caffeine, Head ultrasound, Phototherapy, Ampicillin and Gentamicin (#1), Transport for continuing care, Delivery room resuscitation

MATERNAL HISTORY

Emily was born at 29 1/7 weeks (by dates) to a 26 year old woman who was G 1 and P 0 at the time of delivery.

Prenatal Labs: Blood Type: **O** Rh: **pos** Antibody: **Negative** Hepatitis B: **negative**

Rubella status: **immune** RPR: **nonreactive** Length ROM: **9 hr(s) and 25 min.**

GC: **negative** Chlamydia: **negative**

GBS Status: **positive** Labor Tmax: **37.2** Antibiotics: **prophylactic < 4 hr**

Glucose testing: **normal GLT**

Maternal diagnoses and procedures during the pregnancy, labor and delivery included:

Antepartum events: Maternal transport, Preterm labor with delivery, Tocolytic therapy, Steroids - complete course, Ultrasound (Prenatal) L&D events: Rupture of Membranes Prior to Labor (Preterm), Intrapartum Retained Placenta with Hemorrhage, Placental abnormality: abruptio placenta, Placental abnormality, Electronic Fetal Monitoring(labor), Amniotic Fluid Index (AFI)

Got prenatal care at Clinic X. Transferred care to Dr. PrenatalCare in Marin and seen by him once prior to presenting in preterm labor and some bleeding. Dr. PrenatalCare unable to get prenatal records after several attempts.

Transferred from Sample Hospital after being admitted there. Received 30 hrs of BMZ prior to delivery. Was on MagSO4 until about 8 hours prior to delivery. Received Clindamicin. GBS status pending. Some more bleeding this AM, suspect abruption

The mother was referred from Sample Hospital. Her prenatal care was provided by Harry PrenatalCare, M.D.

DELIVERY vaginal cephalic, spontaneous assisted

Apgars 1 min: **09** 5 min: **09** 10 min: **NA**

Resuscitation: 02, mask vent

Henry Resuscitator, M.D. was called to the delivery room because of prematurity. Delivery analgesia used: epidural. The respiratory effort at birth was spontaneous. Delivery outcome: live birth admitted to ICN.

Cord Blood Gases: ART pH=7.232 pCO2=57 pO2=10 BE=-5 VEN pH=7.28 pCO2=53 pO2=12 BE=-3

called for prematurity. Cried spontaneously. Needed blow by O2 for color and then a few BM breaths for poor resp. effort. HR good through out. Abruption confirmed after delivery

ADMISSION HISTORY

brought over on Mask O2. First gas with pH of 7.27, CO2 60. CPAP just started. CBC, BC sent. UAC placed and adjusted. Amp and Gent started. Hct 49.

ADMIT EXAM

Weight (g): 1411 (3 lbs, 2 oz) Length (cm): 39.5 Head circ (cm): 27.5 GA Exam: 29 1/7 wks AGA

GENERAL: immature infant, exam consistent with dates, on CPAP

SKIN: no icterus or rashes

HEAD: open, flat anterior fontanelle

EYES: normal shape and size, equal red reflexes

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EARS: immature cartilage, normally set, no anomalies
NOSE & MOUTH: nares appear patent, intact palate
NECK & CLAVICLES: no masses, clavicles intact
LUNGS & CHEST: fair air motion bilaterally
CARDIAC: normal rate and rhythm, no murmurs, pulses equal in all 4 extremities
ABDOMEN & CORD: no hepatomegaly, 3 vessel cord
GENITALIA: immature external genitalia
BACK & SPINE: straight spine
LIMBS & HIPS: symmetric, moves all 4 limbs, 10 fingers and toes
NEUROLOGIC: appropriate strength and tone for gestational age

CUMULATIVE SUMMARY

Emily was cared for in the ICN for 26 days. The hospital course will be summarized by a problem list.

FLUID AND NUTRITION

Her nadir in weight was 1237 grams(2 lbs, 12oz) on 12/24/2005. She gained an average of 13 grams a day to a current weight of 1739 grams. A caloric intake of 80 kcal/kg was reached on day 7. A total of 10 days of parenteral nutrition were used. Deep lines included: umbilical artery catheter (4 days) and central venous line (11 days).

DIAGNOSES:

Hypocalcemia (<7.0) (12/21/2005 - 12/22/2005) responded to IV bolus

TREATMENTS:

Intravenous fluids (12/20/2005 - 1/2/2006)
Parenteral nutrition (12/22/2005 - 12/31/2005)
Umbilical artery line (12/20/2005 - 12/23/2005)
Central venous line (12/23/2005 - 1/2/2006)
Gavage feeding (12/25/2005 - 1/15/2006)
Iron (1/6/2006 - 1/6/2006) Discharge on Iron supplements

RESPIRATORY

She was treated with 7 days of oxygen, 1 day of ventilation (0 on high frequency) and with CPAP for 2 days. The highest oxygen percentage used was 30%.

DIAGNOSES:

Respiratory distress syndrome (12/20/2005 - 1/2/2006)
Apnea and bradycardia (drug treated) (12/22/2005 - 1/5/2006) No Apnea and bradycardia for over 7 days. Will continue caffeine.

TREATMENTS:

Ventilation (12/20/2005 - 12/20/2005)
Oxygen (12/20/2005 - 12/26/2005)
Continuous positive airway pressure (12/21/2005 - 12/22/2005)
Chest X-Ray (12/20/2005 - 12/20/2005)
Intubation (12/20/2005 - 12/20/2005)
Survanta (12/20/2005 - 12/20/2005), 2 doses
Caffeine (12/20/2005 - 1/7/2006)

HEMATOLOGY

The most recent hematocrit was 9% on 1/2/2006. The blood type is A+. The DAT is Negative. The highest bilirubin level was 8.5 mg/dl on 1/2/2006. The last bilirubin level was 2 mg/dl on 1/3/2006. She received phototherapy for 4 days.

DIAGNOSES:

Jaundice due to prematurity (12/22/2005 - 1/14/2006)

TREATMENTS:

Phototherapy (12/22/2005 - 12/25/2005)



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INFECTIOUS DISEASE

Emily received 4 days of antibiotics.

DIAGNOSES:

Sepsis, ruled-out (12/20/2005 - 12/23/2005)

TREATMENTS:

Ampicillin and Gentamicin (#1) (12/20/2005 - 12/23/2005)

CARDIAC

No issues

NEURO & SCREENING

The most recent neurological tracking showed: Head ultrasound: 12/26: normal, Eye exam: sched for week of 1/27, Hearing test: transfer out.

TREATMENTS:

Head ultrasound (12/26/2005 - 12/26/2005) normal

GENITOURINARY

No issues

MUSCULOSKELETAL

No issues

GENETIC / ENDOCRINE

No issues

ADDITIONAL ISSUES

Premature rupture of membranes (12/22/2005 - 12/22/2005)

Preterm Newborn (12/22/2005 - 12/22/2005)

Delivery room resuscitation (12/20/2005 - 12/20/2005)

Blood type: A+. DAT: Negative

Social issues: discussed care with the family and Dr. Follow Up.

INTERIM Hx: being transferred to Sample Hospital to be closer to home. Was on vent and CPAP first 24 hours after birth then to room air. Doing well on room air. Off Caffeine since 1/7. Last A/B while asleep 1/2. On 24 cal HMF fortified MBM 34 q 3, nipples 3-4 x/day. On 3 mg/kg/d supplemental Fe. HUS at age 6 days normal. Needs eye exam week of 1/27 for ROP screen. Hearing screen needs to be done prior to dc. No immunizations or transfusions while in NICU

EXAM

Weight (g): 1739 (3 lbs, 13 oz) Length (cm): 43 Head circ (cm): 29

GENERAL: alert and active, pink and well perfused

SKIN: no rashes

HEAD: open, flat anterior fontanelle

EYES: no anomalies, equal red reflexes

EARS: normally set, no anomalies

NOSE & MOUTH: nares patent, palate intact

NECK & CLAVICLES: no neck masses, intact clavicles

LUNGS & CHEST: no distress, clear and equal breath sounds

CARDIAC: normal rate and rhythm, no murmurs, good femoral pulses

ABDOMEN & CORD: soft, non-tender, no masses or organomegaly

GENITALIA: somewhat immature female external genitalia

BACK & SPINE: straight spine

LIMBS & HIPS: moves all 4 limbs, stable hips

NEUROLOGIC: normal suck, symmetric Moro, good strength and tone

Special considerations: Will need Synagis prior to DC

State newborn screen: normal

PLANS



Green Acres Children's Hospital

123 Main St, Green Acres, CA

Jones, baby girl

12345678

12/20/2005

Attending, Sam

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12/20/05

03444444

Neonatologist, Hilary

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NEONATAL DISCHARGE SUMMARY

Infant was transferred to Sample Hospital on 1/10/2006 (Transport for continuing care).

Additional appointments: Developmental clinic Infant referred for developmental follow-up testing.

The infant was being fed fortified MBM (24 cal) 34 q 3 Nipple/Gavage.

Follow-up tests: initial eye exam week of 1/27, hearing screen prior to dc

Discharge medications: iron 0.2 ml daily (~3 mg/kg/d). Will need synagis prior to DC

Special Instructions to family: Instructions to parents are typed in this field on the Discharge Note

Mary ExaminedBy, M.D./Hilary Neonatologist, M.D.
Fog City Neonatology Medical Group

CC's to: Jane Follow Up, M.D. 123 Green St Green Acres, CA