Mothercraft
Baby record sheet

Referral by: ____________________________________________

Reason for admission: ________________________________________________________________

Gestation: ___________________ Birthweight: ____________________ Midwife: _______________________

Neonatal period

First few days after birth, were there any problems: [ ] Yes [ ] No
Describe: ___________________________________________________________________________________________

Feeding

Breast only
How often during the day: _______________________________________________________________
How often overnight: ________________________________________________________________
Length of feed (e.g. 10 minutes each side): ______________________________________________
Do you feed from both sides: [ ] Yes [ ] No
Alternate side started on? [ ] Yes [ ] No
Are you on a dairy free diet? [ ] Yes [ ] No

Breast and bottle
How often breast fed during the day: ___________________________________________________
How often bottle fed during the day: ___________________________________________________
Formula type: __________________________ Amount given: ____________________________
How often breast fed during night: _______________________________________________________
How often bottle fed during night: _______________________________________________________

Bottle only
Formula type (current): __________________________ Amount given: _______________________
Past formula's tried: _______________________________________________________________________
How often during the day: _______________________________________________________________
How often at night: _______________________________________________________________________

Solids [ ] Yes [ ] No
Age introduced: ___________________ How often given: ___________ Amount given: ___________
What foods do you offer: ________________________________________________________________
Do you mix with formula, breast milk, or water: ___________________________________________

Snack food
Do you offer snack between meals: [ ] Yes [ ] No
What is offered: __________________________________________________ How often: ___________

Cup
Does your baby drink from a cup: [ ] Yes [ ] No
What do you offer in the cup: __________________________ How often: __________________________

To be filed in Clinical Record in Baby Record section.
Spilling and vomiting

Does your baby spill:  
☐ Yes  ☐ No
☐ small amounts  or  ☐ large amounts

When does your baby spill:  
_________________________________________________________________________

Is it forceful?  
☐ Yes  ☐ No

Bowel motions

Frequency of babies bowel motions in every 24 hours:  
_________________________________________________________________________

What colour and consistency are they?  
_________________________________________________________________________

Any concerns about babies bowel motions?  
☐ Yes  ☐ No
Describe:  
_________________________________________________________________________

Does your baby have a rash on their bottom?  
☐ Yes  ☐ No
Describe:  
_________________________________________________________________________

Urine

How many wet nappies does baby have in 24 hours?  
☐ Less than 4  ☐ 4 to 8  ☐ 8+

Sleeping patterns

Where does your baby sleep?  
☐ Bassinet  ☐ Cot  ☐ Bed  ☐ Pepi pod/wahakura

Do they have a separate room?  
☐ Yes  ☐ No – who does baby share with?  
_________________________________________________________________________

Do you feed your baby to sleep?  
☐ Yes  ☐ No

Can you describe daytime sleep patterns:  
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

And night time patterns:  
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Which of the following do you use to settle baby:  
☐ Dummy  ☐ Wrapping  ☐ Patting  ☐ Rocking/music  ☐ White noise

Do you have any special bed time routines (e.g singing/feeding to sleep)?  
_________________________________________________________________________

Do you at any time take your baby into your bed?  
☐ Yes  ☐ No
Describe when:  
_________________________________________________________________________

Do you know about the “safe sleep / SUDI prevention” messages?  
☐ Yes  ☐ No

Crying

Do you feel your baby cries too much?  
☐ Yes  ☐ No

Do you recognise your babies different cries?  
☐ Yes  ☐ No

How do you pacify your baby:  
_________________________________________________________________________

Do you know about the “power to protect”/”shaken baby” messages?  
☐ Yes  ☐ No
Medications

List any medications (including homeopathic/over the counter) that baby is on: _________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
Who and when were these prescribed? ______________________________________________________________
Still using these medications?   □ Yes   □ No
Describe why if not: _________________________________________________________________________________

Immunisations

☐ 6 weeks  ☐ 3 months  ☐ 5 months  ☐ BCG  ☐ NIR status checked
Immunisation reactions - comment: ________________________________________________________________

Allergies or food intolerances

Does your baby have any allergies/food intolerances? __________________
Do any family members/extended family have any allergies/intolerances? __________________

Illnesses

List any previous illnesses baby has had in the last 3 months: _________________________________________
________________________________________________________________________________________________
List any previous hospital admissions and or procedures e.g. tongue/lip tie release: ______________________
________________________________________________________________________________________________
Has your baby seen a specialist or is due to be seen by one: _________________________________________
________________________________________________________________________________________________
Have you or your baby been in recent contact with anyone with an illness? ___________________________
________________________________________________________________________________________________
Any recent overseas travel? ____________________

Consumer rights

Posters and pamphlets which explain the Code of Health and Disability Services Consumers’ Rights are available in
the hallway pamphlet display bench - please feel free to take pamphlets to read.

Students

Waikato Hospital is a training hospital for nurses and doctors. We may ask if you are willing to talk with a student
about your experience here.

Signed: ___________________________________________ Date: ___/___/___
(parent/parents signature)  (nursing staff signature)  (nursing staff printed name)