Newborn Care Journal

Baby's Name: ______________________ **Today's Date:** ______________________

FEEDING				*DIAPERING*		*SLEEPING*			*COMFORT*	
Time of baby's feeding (start to finish)	**Breastfeeding** (total # minutes)	**Bottle feeding** (total # mL)	**Did baby feed well?** (if no, describe)	**Check box for pee**	**Check box for poop**	**Time when baby fell asleep**	**Time when baby woke up**	**Did baby sleep for an hour or more?** (if no, describe)	**Did baby calm in 10 min?** (if no, describe)	**Extra Comments / Care Provided**
Example Below										
6:15 am - 6:45 am	*L – 20 min R – 10 min*	*mL*	*Yes*	✓	✓ *(black, sticky)*	*8:00 am*	*10:00 am*	*Yes*	*No, woke hungry, hard to calm until able to get latched on.*	*Mom and baby had skin-to-skin time. Will try to shorten length of time between feedings.*

Department of Health

Newborn Care Journal

Baby's Name: ______________________ **Today's Date:** ______________________

FEEDING				*DIAPERING*		*SLEEPING*			*COMFORT*	
Time of baby's feeding (start to finish)	**Breastfeeding** (total # minutes)	**Bottle feeding** (total # mL)	**Did baby feed well?** (if no, describe)	**Check box for pee**	**Check box for poop** (describe)	**Time when baby fell asleep**	**Time when baby woke up**	**Did baby sleep for an hour or more?** (if no, describe)	**Did baby calm in 10 min?** (if no, describe)	**Extra Comments / Care Provided**

This is adapted from: Boston Medical Center, Children's Hospital at Dartmouth-Hitchcock, Northern New England Perinatal Quality Improvement Network, Yale-New Haven Children's Hospital