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Modified Finnegan Scoring Key for Late Preterm and Term Infants

1. Begin scoring the infant approximately every 4 hours. Do not wake the infant just for scoring; if the infant is still sleeping at the 4 hour mark, wait until the infant awakens to score.
2. In general, infants should be scored while calm and awake. If infant awakens and is calm and awake, proceed with scoring. If infant is fussy, consider feeding and re-evaluating afterwards.
3. Once the infant has a score of 8 or higher, change the scoring interval from approximately every 4 hours to approximately every 2 hours. However, once again, do not wake the infant at the 2 hour mark if still sleeping. Once the infant's score drops below 8, return the scoring interval to approximately every 4 hours.
4. Give points for all signs or symptoms observed during the scoring interval even though they may not be present at the time of recording. For example, if the infant was diaphoretic at 1300 and is scored at 1400, when he/she is no longer diaphoretic, the infant still receives the "sweating" score of 1.
5. Mark 0 for any item where symptom is not present.
6. Use the comments section on the scoring sheet to note any contributing or environmental factors.
7. A total abstinence score of 8 or higher for three consecutive scorings, or 12 or higher for two consecutive scorings, indicates a need to consider pharmacologic intervention.

Part I: Review the Infant Diary

Measure / Criteria	Scoring	Notes
Sleeps / Content < 3 Hours After Feeding Sleeps / Content < 2 Hours After Feeding Sleeps / Content < 1 Hour After Feeding	**Score 1** **Score 2** **Score 3**	*This score should be based on the longest sleep cycle during the scoring interval.*
Yawning (4 or more times over scoring interval)	**Score 1** if the infant yawns 4 or more times during the entire scoring interval.	
Sneezing (4 or more times over scoring interval)	**Score 1** if the infant sneezes 4 or more times during the entire scoring interval.	*Sneezing may occur as individual episodes or may occur serially.*
Poor Feeding	**Score 2** if the infant sucks infrequently during feeding time, takes small amounts of milk, or demonstrates an uncoordinated feeding pattern.	
Regurgitation (2 or more times over scoring interval) Projectile Vomiting	**Score 2** if regurgitation occurs two or more times during the entire scoring interval (not with burping). **Score 3** if one or more forceful vomiting episodes occur during the entire scoring interval.	*Regurgitation is an effortless return of gastric contents from the infant's mouth.*
Loose Stools Watery Stools	**Score 2** if the infant has a stool that is more liquid than a normal stool. **Score 3** if the infant has any type of watery stool (may see a watery ring on the diaper).	

Part II: Vital Signs (Best when Infant is Quiet)

Measure / Criteria	Scoring	Notes
Respiratory Rate > 60 per Minute Respiratory Rate > 60 per Minute with Retractions	**Score 1** if the infant's RR is greater than 60 breaths per minute **without** retractions. **Score 2** if the infant's RR is greater than 60 breaths per minute **with** retractions.	*Respirations should be taken over a full minute and in a quiet state.*
Fever 99° to 101° F Axillary Fever > 101° F Axillary	**Score 1** if the axillary temperature is between 99 and 101 degrees F. **Score 2** if the axillary temperature is greater than 101 degrees F.	*Always take the infant's temperature in the same way (e.g. rectal vs. axillary).*

Part III: Assessment

Measure / Criteria	Scoring	Notes
Sweating	**Score 1** if wetness is felt on the infant's head, upper lip, or back of the neck.	*Do not give points for perspiration if it occurs due to swaddling.*
Mottling	**Score 1** if mottling is present over the infant's trunk, chest, arms or legs.	*Mottling typically resembles a marbled appearance of pink and white areas.*
Nasal Stuffiness	**Score 1** if the infant exhibits noisy upper airway congestion due to the presence of mucus.	
Nasal Flaring	**Score 2** if nasal flaring is present at any time during the entire scoring interval.	
Hyperactive Moro Reflex	**Score 2** if the infant exhibits pronounced tremors of the hands or feet after reflex is elicited.	*Calm the infant before assessing Moro reflex. A Moro reflex needs to be elicited.*
Hyperactive Moro Reflex w/Clonic Movements	**Score 3** if the infant exhibits pronounced tremors AND clonic movements after reflex is elicited.	*Clonic movements are rhythmic jerking movements of an extremity; they are slower and larger than tremors.*
Mild Tremors when Disturbed	**Score 1** if the infant exhibits observable tremors of the **hand or foot** when the infant is being handled.	*Tremors are quick, fine, repetitive involuntary movements. Tremors and jitters are generally the same.*
Moderate / Severe Tremors when Disturbed	**Score 2** if the infant exhibits observable tremors of the **entire arm(s)** or **leg(s)** when the infant is being handled.	
Mild Tremors when Undisturbed	**Score 3** if the infant exhibits observable tremors of the **hand or foot** when the infant is **not** being handled, and ideally is **calm and quiet**.	
Moderate / Severe Tremors when Undisturbed	**Score 4** if the infant exhibits observable tremors of the **entire arm(s)** or **leg(s)** when the infant is **not** being handled, and ideally is **calm and quiet**.	
Increased Muscle Tone	**Score 2** if the infant has stiff arms or legs (extremities are difficult to flex or extend).	*Methods to assess tone may include: pull to sit, ventral suspension ("flying superman"), or flexion/extension of arms or legs.* *Ideal time to examine tone is when infant is quiet and alert, or awake and moving. Tone should not be assessed when infant is asleep or crying.*
Myoclonic Jerks at Rest	**Score 3** if you observe involuntary spasm or twitching of a muscle.	*A myoclonic jerk is a type of clonic movement: a jerking movement of an extremity that is slower and longer than tremors. These may or may not be repetitive. Myoclonic jerks can be stopped by lightly holding the extremity.*
Seizure or Convulsion	**Score 5** if generalized seizure or convulsion is present.	*Seizures/convulsions are involuntary muscle contractions of limbs and body.*
Skin Excoriation	**Score 1** if excoriation is present due to excessive rubbing. Scoring for excoriation should continue until rub marks are no longer present.	*Do not score for excoriation in the immediate perianal area, or for buttock excoriation due to loose/watery stools.*
Excessive Sucking	**Score 1** if the infant displays continuous vigorous sucking with or without a pacifier.	
Excessive Crying (2 to 5 Minutes) Continuous Cry (more than 5 Minutes)	**Score 2** if the infant is able to be consoled with caregiver intervention in two to five minutes. **Score 3** if the infant is **not** able to be consoled with caregiver intervention within five minutes.	*If the infant remains calm, or is able to self-console or be consoled with caregiver intervention in less than two minutes, then **score 0**.*