NEONATAL Transfer to Hospital Provider-to-Provider Report

UWNQC
Utah Women & Newborns Quality Collaborative

Date: ___/___/_____ Time: _____:_____

Neonate: ☐ *Male* / ☐ *Female* Name: _____

DOB: ____/____/_____ TOB: _____:_____

Mother's Name: _____ DOB: ____/____/_____

Father's Name: _____

Transfer to: _____

Contact Name: _____ Contact Number: (_____) _____-_____

Transfer from: *Birthing Center/ Home Birth*

Provider: _____

Contact Number: (_____) _____-_____

Facility Name: _____

Contact Number: (_____) _____-_____

Fax: (_____) _____-_____

***Hospital*: Please send communication and discharge summary to the above "Transfer from" provider.**

SITUATION: _____

_____

_____

_____

_____

BACKGROUND: _____ y/o G__ P __ __ __ __ @ _____ weeks

EDD: _____ by LMP _____ or U/S @ _____ weeks

Membranes: ROM Prior to Labor? ☐ *Y* / ☐ *N* Time: _____:_____

Total ROM Time: _____ hrs _____ min

Meconium: ☐ *Y* / ☐ *N* ☐ *Lt*/ ☐ *Mod* / ☐ *Thick*

Resuscitation: *Deep Suction / Blow-by O2 / PPV/ Cardiac Compressions for ___ min /Other:* _____

Labor History: _____

_____

_____

Current Pregnancy History: _____

_____

_____

LAST NEONATAL VS

Time: _____:_____

HR: _____ RR: _____ T: _____

SpO2: _____Resp. Status: _____

APGARs:

1 min: _____ 5 min: ____ 10 min: _____

Feeding: ☐ *Y* / ☐ *N* Urine: ☐ *Y* / ☐ *N* BM: ☐ *Y* / ☐ *N*

NEONATAL MEDICATIONS

Eye Prophylaxis: ☐ *Y* / ☐ *N*

Vit K: ☐ *IM* / ☐ *Oral* / ☐ *None*

RISK FACTORS FOR INFECTION

☐ *Prolonged Labor* / ☐ *PROM* / ☐ *Maternal Fever* /☐ *Fetal Tachycardia*

GBS: ☐ *Pos*/ ☐ *Neg* / ☐ *UNK Date*:___/___/____

ABX: ☐ *PCN*/ ☐ *None*/ ☐ *Other*: _____

> 4 hours: ☐ *Y* / ☐ *N*

MATERNAL LABS AND MEDICATIONS

ABO/Rh: ☐ *A* ☐ *B* ☐ *AB* ☐ *O* ☐ *UNK* ☐ *Pos* / ☐ *Neg*/ ☐ *UNK*

HIV: ☐ *Pos*/ ☐ *Neg*/ ☐ *UNK* HepB sAg: ☐ *Pos*/ ☐ *Neg*/ ☐ *UNK*

Other Intrapartum Meds: _____

_____

_____

Pertinent Maternal History (Medical/ Surgical/ OB): _____

_____

ASSESSMENT: _____

_____

RECOMMENDATION: _____

_____

Method of Transport: ☐ *Private Car* / ☐ *Ambulance* ETA: _____:_____ Place of Arrival: ☐ *ER*/ ☐ *NICU*/ ☐ *Transition Nursery*/ ☐ *Peds Floor*

Parental Desires: _____

Person(s) Accompanying Neonate: _____

To submit feedback on this form or to comment on the transfer process, please visit UWNQC.org or call 801.273-2856.
Go to UWNQC.org for updated versions of the Maternal Transfer to Hospital Provider-to-Provider Report Form. Revised 7/2/2015