MATERNAL Transfer to Hospital Provider-to-Provider Report

UWNQC
Utah Women & Newborns Quality Collaborative

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

Patient Last Name: ______________________________

Patient First Name: ______________________________ DOB: ____/____/_____

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: ______________________________

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____

BACKGROUND: ________ y/o G__ P __ __ __ __ @ ______________ weeks

EDD: _________ by LMP: _____________ or U/S @ _____________ weeks

Fetal Number: _________ Presentation: ______________________________

Previous Cesarean? *Y/ N* #: ______ Scar Type: *LTCS/ Other:* ______________

Previous Vaginal Birth? *Y/ N* #: __________ Previous VBAC? *Y/ N* #: ________

U/S @ ________ weeks Findings: *NML/ Other*: ______________________

Placenta: *Anterior / Posterior / Previa / Low*: _______ cm from os.

Pertinent History: (Current Pregnancy / OB History / Medical/ Surgical)

____

____

____

Meds/Supplements/Allergies: ______________________________

____

____

CURRENT STATUS

Membrane Status: *Intact/ SROM/ AROM*

Date ROM: __/__/____ Time ROM: ___:_____

Fluid: *Clear/ Meconium/ Bloody*

Fetal Status: Last Exam: ______________

Baseline: ________ Variability: *Y / N*

Accels: *Y / N* Decels: *Y / N* __________

Monitoring: *Intermittent / Continuous*

Labor Status:

No Labor / Early / Active / 2nd Stage

Last Cervical Exam: ____________

Dil. _____ Eff. _____ Sta. _____ Pos. _____

Ctx Pattern: ____________________

Maternal VS Time: _____:_________

BP ______ P _____ R _____ T _____

LABS AND MEDICATIONS

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

H/H: ___/_____ PLTS: ________/ *UNK*

HIV: *Pos / Neg / UNK* RPR: *Pos / Neg / UNK*

HepB sAg: *Pos / Neg / UNK*

Rubella: *Imm./ Non-Immune / Equiv./ UNK*

GBS: *Pos / Neg / UNK* Date: ___/___/_____

ABX: *PCN / None / Other*: ____________

> 4 hours: *Y / N*

Intrapartum Meds: ____________________

____

____

Postpartum? Time of Birth: ___________:________ Placenta Delivered? *Y/ N* Time: ________:________

EBL: _________ Lacerations/ Complications: ______________________________

ASSESSMENT: ______________________________

____

RECOMMENDATION: ______________________________

____

Method of Transport: *Private Car / Ambulance* ETA: _____:________ Place of Arrival: *ED/ L&D/ Postpartum Unit*

Maternal Desires: ______________________________

Person(s) Accompanying Patient: ______________________________

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