# **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.**

**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: __________________

____________________________________

____________________________________

**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: ______________________________________

____________________________________________________________

____________________________________________________________

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