HBS COLLABORATION TASK FORCE- NEWBORN TRANSFER FORM

Patient's Full Name: _____ ☐ Male ☐ Female Date/ Time: _____ / _____ : _____

Mother's Full Name: _____ Phone # (____) ____ _____ EDD: _____

Referring Provider: _____ Phone # (____) ____ _____ Gestation: _____

Referred to: _____

Does receiving hospital have maternal/ prenatal records? ☐ YES ☐ NO ☐ UNKNOWN

Medical records included: ☐ # Pages: _____

SITUATION and Reason for Transport

_____

_____

Status at Time of Transport: ☐ Stable ☐ Unstable

Mode of Transport: ☐ Private Vehicle ☐ EMS

EMS Staff:_____

Called:_____ Arrived_____ Departed:_____

Time arrival at hospital: _____ : _____

Time Hospital Provider Received _____ : ____

Time verbal report: _____ : _____

Labor History:

Latent Onset: (date/time): _____ / _____:_____

Active Onset: (date/time): _____ / _____:_____

2nd Stage Onset: (date/time): _____ / _____:_____

AROM/ SROM: (date/time): _____ / _____:_____

Birth: (date/time): _____ / _____:_____

Placenta: (date/time): _____ / _____:_____

EBL: _____

Fluid: ☐ CLEAR ☐ MECONIUM ☐ BLOODY

Complications: NO YES, Details_____

NEWBORN TRANSITION: ☐ RESUS ☐ SUCTION ☐ O2 ☐ PPV ☐ CHEST COMPRESSIONS

NEWBORN EXAM: Birth Weight: _____ APGAR: 1MIN: _____ 5 MIN: _____ 10 MIN: _____

Significant Findings: _____

_____

Last VS: Time: _____ Heart Rate: _____ Resp. Rate: _____ Temp: _____ SpO2: _____

Feeding Concerns: _____ Blood Glucose: _____ Last Feed (time): ____ : ____

☐ Eye Tx ☐ Vitamin K (☐ IM / ☐ Oral) ☐ CCHD Screening ☐ Metabolic Screening

MATERNAL BACKGROUND

Current Pregnancy Complications: _____

_____

Significant Medical History: _____

_____

Prior Pregnancy Outcomes: _____

☐ NKDA, Allergies: _____ Height / Weight: _____ / _____

Current Medications /Supplements: _____

Blood Type: _____ BP Baseline: _____ / _____ GDM Testing: ☐ YES ☐ NO Hct: _____ (date: _____)

ALERTS: ☐ Rh- ☐ HSV+ ☐ Rubella Non-Immune ☐ HEP B+ ☐ HIV+

☐ GBS Unknown ☐ GBS+ ☐ GBS- (date: _____)

ASSESSMENT: _____

_____

RECOMMENDATION: _____

_____