MATERNAL REFERRAL FROM OUT OF HOSPITAL BIRTH TO HOSPITAL

PATIENT NAME:_____

DOB _____ **G** ___ **P** ___ **EDD** _____

TRANSPORT DETAILS

PRESENTING PROBLEM _____
Status at time of transport: Date/Time:_____
FHTs baseline _____ Ctx pattern _____
Vaginal exam _____ BP _____ Temp_____ Pulse_____ Void time_____
Last food/fluid PO (date/time) _____
IV Gauge _____Fluid type _____Total infused prior to transport _____
Method of transport: private car / ambulance

PRENATAL HISTORY

ALERTS: ☐ **Rh –** ☐ **HSV +** ☐ **GDM** ☐ **Rubella Non-immune** ☐ **HEP B +** ☐ **HIV +**

GBS + / - date _____ **Hct** _____ **date**_____ **BP Baseline** _____ **BLOOD TYPE** _____

SIGNIFICANT HISTORY: _____
_____
_____

☐ **ALLERGIES** ☐ **NKDA**
MED: _____ s/sx:_____
MED: _____ s/sx:_____
MED:_____s/sx:_____

ROUTINE MEDICATIONS
Med:_____ dose:_____
Med:_____ dose:_____
Med:_____ dose:_____

EDD based on ☐ LMP ☐ conception ☐ early ultrasound ☐ mid or late ultrasound

LABOR HISTORY

LATENT ONSET date _____time_____ **ACTIVE ONSET** date _____time_____
COMPLETE date _____time_____ **2 ND STAGE** date _____time _____
BIRTH date _____time_____ **PLACENTA** date _____time _____

AROM / SROM date_____ time_____ **FLUID** ☐ clear ☐ light mec ☐ moderate mec ☐ thick mec

LACERATIONS ☐ Yes ☐ No **DETAILS** _____ **TEBL** _____

MED_____date_____ time_____route_____MED_____date_____time_____route_____
MED_____date_____ time_____route_____MED_____date_____time_____route_____
MED_____date_____ time_____route_____MED_____date_____time_____route_____