

NEWBORN REFERRAL FROM OUT OF HOSPITAL BIRTH TO HOSPITAL

PATIENT NAME: _____

DOB: _____ TIME: _____

SEX: M / F WEIGHT: _____

MOTHER'S NAME: _____

TRANSPORT DETAILS

PRESENTING PROBLEM _____

Status at time of transport: _____ Date/Time _____

HR _____ RR _____ Temp _____ Oxygen _____ Glucose, time _____

Feeding Method _____ Last Feeding Time _____ Output _____

NEWBORN INFORMATION

NAME _____ DOB _____ Time _____ Sex _____ Weight _____

APGAR 1" _____ 5" _____ 10" _____ Duration of ROM to delivery: _____

Meconium: in labor? Yes No at delivery? Yes No

RESUSCITATION: Bulb / Delee / PPV for _____ minutes / Other _____

Vitamin K: IM Oral None Eye treatment _____

Cord Blood: Yes No Hepatitis B vaccine Yes No

Intrapartal Antibiotics No Yes Type / Dosage/Time _____

MATERNAL HISTORY

Name _____ DOB: _____ G ___ P ___ EDD _____

ALERTS: Rh - GBS+ HSV + GDM Hep B + HIV + Blood Type _____

SIGNIFICANT HISTORY: _____

MEDICATIONS

Rx: _____ dosage _____ route _____ date _____ time _____

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