

Maternal Transfer Form

DATE: _____ TIME: _____

Provided By



Basic info

PATIENT FULL NAME: _____ AGE: _____ DOB: _____

G: _____ P: _____ WEEKS GESTATION: _____ EDD: _____ DATING ULTRASOUND LMP/CONCEPTION

REFERRING PROVIDER: _____ PHONE: _____

HOSPITAL REFERRED: _____ CALL RECEIVED BY: _____ TIME: _____

Have medical records been sent?

YES NO UNKNOWN

Records sent by

EMAIL FAX HAND DELIVERED ATTACHED

Situation

Status at Time of Transport

REASON FOR TRANSPORT: _____ STABLE UNSTABLE

FHTs: _____ CONTRACTIONS: _____ DILATION/STATION: _____

BP: _____ TEMP: _____ PULSE: _____ LAST VOID TIME: _____ LAST FOOD/FLUID TIME: _____

IV GAUGE: _____ TOTAL AND TYPE INFUSED PRIOR TO TRANSPORT: _____

MEDICATIONS GIVEN: _____

Mode of transport

PRIVATE VEHICLE EMS EMS CALLED: _____ ARRIVED: _____ DEPARTED: _____

EMS STAFF: _____

PEOPLE ACCOMPANYING PATIENT: _____

TIME OF ARRIVAL AT HOSPITAL: _____ TIME RECEIVED: _____ TIME VERBAL REPORT: _____

Labor History

LATENT ONSET

DATE: _____ TIME: _____

2ND STAGE

DATE: _____ TIME: _____

BIRTH

DATE: _____ TIME: _____

FLUID

CLEAR

ACTIVE ONSET

DATE: _____ TIME: _____

AROM/SROM

DATE: _____ TIME: _____

PLACENTA

DATE: _____ TIME: _____

MECONIUM BLOODY GBS + ANTIBIOTICS GIVEN (TIME): _____ PLACENTA EXAM: _____

LACERATIONS: (If yes)

NO YES DESCRIBE: _____ REPAIRED? BLOOD LOSS: _____ EBL QBL

Background

CURRENT PREGNANCY COMPLICATIONS: _____

ULTRASOUND FINDINGS: _____

SIGNIFICANT MEDICAL HISTORY: _____

PRIOR PREGNANCY OUTCOMES & ROUTE OF DELIVERY: _____

NKDA ALLERGIES: _____

CURRENT MEDICATIONS: _____

HEIGHT: _____ WEIGHT: _____ BLOOD TYPE: _____ BP BASELINE: _____ PRE-PREG BMI: _____

GBS - GBS + GBS TEST DATE: _____ HCT/HGB: _____ TEST DATE: _____ GDM TEST: _____RH- HSV+ RPR+ GC/CT+ RUBELLA NON-IMMUNE HEP B + HIV+ HEP C+

PERTINENT LAB NOTES: _____

ASSESSMENT:

RECOMMENDATIONS:

Newborn Transfer Form

DATE: _____ TIME: _____

Provided By 

Basic info

PATIENT FULL NAME: _____ MALE FEMALE
EDD: _____ GESTATIONAL AGE: _____
MOTHER'S FULL NAME: _____ PHONE: _____
REFERRING PROVIDER: _____ PHONE: _____
HOSPITAL REFERRED: _____ CALL RECEIVED BY: _____ TIME: _____

Have medical records been sent?

YES NO UNKNOWN

Records sent by

EMAIL FAX HAND DELIVERED ATTACHED

Situation

REASON FOR TRANSPORT: _____

Status at Time of Transport

STABLE UNSTABLE

Mode of transport

PRIVATE VEHICLE EMS EMS CALLED: _____ ARRIVED: _____ DEPARTED: _____

EMS STAFF: _____

PEOPLE ACCOMPANYING PATIENT: _____

TIME OF ARRIVAL AT HOSPITAL: _____ TIME RECEIVED: _____ TIME VERBAL REPORT: _____

Labor History

LATENT ONSET

DATE: _____ TIME: _____

2ND STAGE

DATE: _____ TIME: _____

BIRTH

DATE: _____ TIME: _____

FLUID

CLEAR

ACTIVE ONSET

DATE: _____ TIME: _____

AROM/SROM

DATE: _____ TIME: _____

PLACENTA

DATE: _____ TIME: _____

MECONIUM BLOODY GBS + ANTIBIOTICS GIVEN (TIME): _____ PLACENTA EXAM: _____

COMPLICATIONS

(If yes)

NO YES DESCRIBE: _____

NEWBORN RESUSCITATION

 NONE TACTILE STIMULATION SUCTION PPV OXYGEN CPAP CHEST COMPRESSIONS

Newborn Exam

BIRTH WEIGHT: _____ APGAR 1 MIN: _____ 5 MIN: _____ 10 MIN: _____

SIGNIFICANT FINDINGS: _____

EYE OINTMENT

(IM) VITAMIN K (ORAL) VITAMIN K CCHD SCREENING

Last Vital Signs

TIME: _____ HEART RATE: _____ RESP. RATE: _____ TEMP: _____ SPO2: _____ BLOOD GLUCOSE: _____

FEEDING CONCERNS: _____ LAST FEED (TIME): _____ LAST FEED (TYPE): _____

Maternal Health Background

MATERNAL AGE: _____ G: _____ P: _____

CURRENT PREGNANCY COMPLICATIONS: _____

ULTRASOUND FINDINGS: _____

SIGNIFICANT MEDICAL HISTORY: _____

PRIOR PREGNANCY OUTCOMES & ROUTE OF DELIVERY: _____

NKDA ALLERGIES: _____ CURRENT MEDICATIONS: _____

HEIGHT: _____ WEIGHT: _____ BLOOD TYPE: _____ BP BASELINE: _____ PRE-PREG BMI: _____

GBS - GBS + GBS TEST DATE: _____ HCT/HGB: _____ TEST DATE: _____ GDM TEST: _____RH- HSV+ RPR+ GC/CT+ RUBELLA NON-IMMUNE HEP B + HIV+ HEP C+

PERTINENT LAB NOTES: _____

ASSESSMENT: _____**RECOMMENDATIONS:** _____