Alaska Birth Transfer Initiative: Neonatal Transfer Form

Patient's Full Name: _____ ☐Male ☐ Female Current Date: _____ Time: _____
Mother's Full Name: _____ Contact #: (_____) ____ - _____ EDD: _____
Referring Provider: _____ Contact #: (_____) ____ - _____ Gestation: _____
Referred to: _____ Contact #: (_____) ____ - _____
Chosen Pediatrician: _____ Contact #: (_____) ____ - _____
Does receiving hospital have prenatal records: ☐YES ☐ NO ☐UNKNOWN Medical records included: ☐ # of pages: _____

SITUATION and reason for transport:

_____

_____

Status at time of transport: ☐Stable ☐Unstable

LABOR HISTORY

Latent Onset (date/time): _____ / _____
Active Onset (date/time): _____ / _____
2nd State Onset (date/time): _____ / _____
AROM/SROM (date/time): _____ / _____
Birth date/time): _____ / _____
Placenta (date/time): _____ / _____
EBL: _____
Fluid: ☐CLEAR ☐MECONIUM ☐BLOODY
Complications: ☐NO ☐YES, Details: _____

MODE OF TRANSPORT: ☐Private vehicle ☐EMS ☐Other Time at hospital door: _____
EMS Staff: _____Called: _____ Time Hospital Provider Received: _____
Arrived: _____ Departed: _____ Time verbal report: _____

NEWBORN TRANSITION: ☐Resus ☐Suction ☐O2 ☐ PPV ☐Chest Compressions ☐ CPAP

NEWBORN EXAM Birth Weight: _____ APGAR 1 min:_____ 5 min: _____ 10 min: _____
Significant findings: _____

_____

Last VS time: _____ Heart rate: _____ Resp. rate: _____ Temp: _____ SpO2: _____
Feeding concerns: _____ Blood glucose: _____ Last feed time: _____
☐Eye tx ☐Vit K (☐ IM/ ☐Oral) ☐ CCHD screening ☐Metabolic screening ☐Hep B vaccine
Newborn visits: ☐ 24 hours ☐ 4 days Bilirubin level: _____ Other lab results:_____ (Date:_____)

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:_____)
Lab results: Rh _____ HSV _____ Rubella_____ HEP B _____ HIV_____
GBS _____Date:_____ Antibiotic therapy: _____
COVID-19 result: _____ (date: _____) Symptoms: ☐COUGH ☐FEVER ☐SOB ☐OTHER: _____

ASSESSMENT AND RECOMMENDATION: _____

_____

Completed by: _____ Signature: _____
Receiving Provider/Nurse: _____ Signature: _____

Adapted from the Home Birth Summit Model Transfer Forms for Best Practice Guidelines: Transfer from Planned Home Birth to Hospital. (January 25, 2015). Retrieved from http://www.homebirthsummit.org/transfer-guidelines-model-forms/