

MATERNAL TRANSFER TO HOSPITAL Provider-to-Provider Report

Place patient Medical Record Sticker here

Date: ___ / ___ / ___ Time: ___ : ___

Patient Last Name: _____

Patient First Name: _____ DOB: ___ / ___ / ___

Transfer to: _____

Contact Name: _____

Contact Number: (____) _____ - _____

Transfer from: *Birth Center/ Home Birth*

Provider: _____

Contact Number: (____) _____ - _____

Facility Name: _____

Birth Center Code: _____

Contact Number: (____) _____ - _____

Fax: (____) _____ - _____

Hospital: Please send communication and discharge summary to the above "Transfer from" provider.

CURRENT STATUS

Membrane Status: *Intact/ SROM/ AROM* _____

Date ROM: ___ / ___ / ___ Time ROM: ___ : ___

Fluid: *Clear/ Meconium/ Bloody*

Fetal Status: Last Exam: _____

Baseline: _____ Variability: *Y/N*

Accels: *Y/N* Decels: *Y/N* _____

Monitoring: *Intermittent / Continuous*

Labor Status:

No Labor / Early / Active / 2nd Stage

Last Cervical Exam: _____

Dil. _____ Eff. _____ Sta. _____ Pos. _____

Ctx Pattern: _____

Maternal VS Time: _____ : _____

BP _____ P _____ R _____ T _____

LABS AND MEDICATIONS

ABO/Rh: *A B AB O UNK Pos / Neg / UNK*

H/H: ___ / ___ PLTS: _____ / *UNK*

HIV: *Pos / Neg / UNK* RPR: *Pos / Neg / UNK*

HepB sAg: *Pos / Neg / UNK*

Rubella: *Imm. / Non-Immune / Equiv. / UNK*

GBS: *Pos / Neg / UNK* Date: ___ / ___ / ___

ABX: *PCN / None / Other:* _____

> 4 hours: *Y/N*

Intrapartum Meds: _____

SITUATION: _____

BACKGROUND: _____ y/o G__ P__ @ _____ weeks

EDD: _____ by LMP: _____ or U/S @ _____ weeks

Fetal Number: _____ Presentation: _____

Previous Cesarean? *Y/N* #: _____ Scar Type: *LTCS/ Other:* _____

Previous Vaginal Birth? *Y/N* #: _____ Previous VBAC? *Y/N* #: _____

U/S @ _____ weeks Findings: *NML/ Other:* _____

Placenta: *Anterior / Posterior / Previa / Low:* _____ cm from os.

Pertinent History: (Current Pregnancy / OB History / Medical/ Surgical)

Meds/Supplements/Allergies: _____

Postpartum? Time of Birth: _____ : _____ Placenta Delivered? *Y/N* Time: _____ : _____

EBL: _____ Lacerations/ Complications: _____

ASSESSMENT: _____

RECOMMENDATION: _____

Method of Transport: *Private Car / Ambulance* ETA: _____ : _____ Place of Arrival: *ED/ L&D/ Postpartum Unit*

Maternal Desires: _____

Person(s) Accompanying Patient: _____

Hospital: please scan or otherwise include this form in the patient medical record



Midwives: Please email this form to: birthregistration@utah.gov

To submit feedback on this form or to comment on the transfer process,

please visit mihp.utah.gov/UWNQC or call 801-273-2856. v12/2018

