# 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: (_____)_____-_____

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

Transfer from: *Birthing Center/ Home Birth*

Provider: _____

Contact Number: (_____)_____-_____

Facility Name: _____

Birth Center Code: _____

Contact Number: (_____)_____-_____

Fax: (_____)_____-_____

**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: _____

_____

_____

**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: _____

_____

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: _____

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.org or call 801-273-2856. V12/2018

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