**Disaster Transfer Summary Postpartum with Well Baby (DRAFT5-3-15) ROOM # \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| **Train Score:**  Red  Yellow  Green  Blue |
| **Maternal Hospital Level care needed; 1 2 3 (CIRCLE ONE)** |

|  |  |
| --- | --- |
| Patient name: (Last, First) |  |
| MRN: (MRN) |  |
| DOB: |  |
| Primary OB provider: (PMD) |  |
| Other important outside care provider(s): |  |
| Date of Admission to LPCH: |  |
| Family Members/contact info: |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| **Newborn** |  |  |  |
| Patient name: (last, first) |  | Primary Peds provider (PMD) |  |
| MRN: |  | Contact #: |  |
| DOB: |  | Date of Transfer (if different than maternal) |  |
| Time of birth |  | Time of Transfer (if different than maternal) |  |

|  |  |
| --- | --- |
| **DELIVERY** | |
| NSVD | |
| CD in labor | |
| Elective CD not in labor |  |
| Type of anesthetic: (circle one) General Regional | |
| Narcotics during surgery (circle one): IV Regional | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MATERNAL: AGE G P** | | | | |
| (CIRCLE ALL THAT APPLY) | | | | |
|  | | | | |
| ***Allergies*** | | | | |
| No medical illnesses | | | | |
| Medical illness | | | | |
| Chorioamnionitis | | | | |
| PPH | | | Most recent hct | |
| Preeclampsia/Gestational HTN | | | | |
| Magnesium Y N | | | | dose gram/hr |
| DM GDM/IR | | | | |
| **Insulin dose:** | | **AM Type amount** | | |
| **PM Type amount** | | |
| Other | |  | | |
| 4th degree laceration | | | | |
| Thromboprophylaxis | | | | med dose |
| Other |  | | | |

|  |  |
| --- | --- |
| **Maternal MEDICATIONS** | |
| Antibiotics: gent/clind/amp/vanc | |
| Antibiotics |  |
| Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Given |  |
| Pain medication: percocet/norco/oxycodone/ibuprofen/acetaminophen | |
| Last Dose Given |  |
| Antihypertensive meds: |  |
| labetalol/procardia/hydralzine/Other |  |
| Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Given |  |

Car seat challenge passed Y N N/A

|  |  |  |
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| **NEONATE  (well baby ONLY, FOR ALL OTHERS SEE PEDS TRAIN)** | | |
|  | | |
| ***No medical problems*** | | |
| GA | | |
| Birth weight |  | |
| Last weight |  | |
| Blood type |  | |
| Last bilirubin |  | |
| CRP (if applicable) |  | |
| Vit k | Y N | |
| Erythromycin | Y N | |
| Hep B Y N |  | |
| Type of feed: | Breastfeeding | Formula |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MD Signature: |  | | | | |
|  |  | | | | |
| Date |  | | Time |  | |
| Transferred to: |  | | | | |
| Location of Baby | | With mom | | | Other |

**Newborn Screening Completed Y N #\_\_\_\_\_\_\_\_\_\_**