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

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| **Train Score:** RedYellowGreenBlue |
| **Maternal Hospital Level care needed; 1 2 3 (CIRCLE ONE)** |

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| --- | --- |
| 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: |  |

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|  |  |
| **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) |  |

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

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| **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 |  |

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| **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 #\_\_\_\_\_\_\_\_\_\_**