UR MEDICINE

SH 1169 MR

OB/GYN MATERNAL TRANSFER FORM

140

☐ Inpatient
☐ Outpatient
☐ ED

Date: _____ Time of call: _____ Referring Hospital: _____

Patient's Name: _____ DOB: _____ Age: _____

Referring Physician: _____ Contact #: _____ Primary Ob/Gyn: _____

DONNELLEY

G: P: EDD: Gestational Age: ☐ Singleton ☐ Twins ☐ Other

[redacted]

Allergies: _____ Prior Cesarean: ☐ No ☐ Yes Type: ☐ LTCS ☐ Classical ☐ Unknown

Vital Signs: BP: ____/____ Pulse: _____ Temperature: _____ FHR Category: I II III

Presentation: ☐ VTX ☐ Breech ☐ Transverse Ultrasound: _____

Initial cervical exam: Changed to: GBS Result: / / Date: _____

[redacted]