MATERNAL TRANSFER FORM

Patient's Full Name: _____Weeks Gestation: _____Date/Time: _____/____:_____

Age: _____ G: ____ P: ____ EDD: _____ Based on: ☐ LMP/Conception ☐ Dating Ultrasound

Referring Provider _____ Contact #: (____)_____

Name of person receiving call: _____ Time Called: _____

Does receiving hospital have medical records: ☐ YES ☐ NO ☐ UNKNOWN

Medical Records Included: ☐ # of pages _____

SITUATION and Reason for Transport

_____

Status at Time of Transport: ☐ Stable ☐ Unstable

Emergency Contact: _____ Contact #: (_____)_____

FHTs:	Ctx Pattern:		**Mode of Transport** □ Private Vehicle □ EMS □ Other EMS Staff: _____ Called: _____ Arrived: _____ Departed: _____
Dilation/Station:	BP: /		
Last food/fluid PO (date/time):	Temp:	Pulse:	Time at hospital door: ____:_____ Time at L&D room: ____:_____ Time Hospital Provider Received ____:____ Time verbal report: ____:_____
Last Void Time: _____:_____	Ultrasound Findings:		
IV Gauge:			
Total infused prior to transport:			

Labor History:
Latent Onset: (date/time): ____/ ____:____
Active Onset: (date/time): ____/ ____:____
2nd Stage Onset: (date/time): ____/ ____:___
AROM/SROM: (date/time): ____/ ____:____

Birth: (date/time): _____ / _____:_____
Placenta: (date/time): _____/ _____:_____
EBL: _____
Fluid: ☐ CLEAR ☐ MECONIUM ☐ BLOODY
Lacerations: ☐ NO ☐ YES, Details_____

BACKGROUND
Current Pregnancy Complications:
_____
Significant Medical History:
_____
Prior Pregnancy Outcomes: _____
□ NKDA, Allergies: _____ Height/Weight: _____ / _____
Current Medications/Supplements: _____
Blood Type: _____ BP Baseline: _____ / _____ GDM Testing: □ YES □ NO Hct: _____ (date:_____)
ALERTS: ☐ **Rh-** ☐ **HSV+** ☐ **Rubella Non-Immune** ☐ **HEP B+** ☐ **HIV+**
☐ **GBS Unknown** ☐ **GBS+** ☐ **GBS-** **(date:_____)**
ASSESSMENT: _____

RECOMMENDATION_____