



SH 1169 MR
OB/GYN MATERNAL
TRANSFER FORM



140

- Outpatient
ED

RR DONNELLEY

Date: Time of call: Referring Hospital:
Patient's Name: DOB: Age:
Referring Physician: Contact #: Primary Ob/Gyn:

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

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:

Requested Results: Prenatal Labs Outpatient Prenatal Records Sent Collected, Sent with patient

Medications (include dose/date/time)

BMZ 12 mg date/time: DMZ 6 mg date/time: Nifedipine:
Mag Sulfate: Bolus: 4 gr 6 gr time: Run: 2 gr time:
Antibiotics (specify):

Reason for Transfer:

- Abruption/vaginal bleeding Other (spec):
Diabetic- DKA Type: 1 2 Current therapy:
Infant anomalies/findings (specify):
IUGR:
Maternal Cardiac Disease (specify):
Postpartum Transfer (include DOH Form) Bonding Maternal complications:
PPROM- Time/Date of Rupture: Clear Meconium Bloody
Preeclampsia Severe features: Eclampsia: Time/Date of seizure:
Preterm Labor Cerclage Remove: Yes No Date/Time Removed: Initial cervical exam: Changed to:
Previa Active bleeding? Y / N Evidence of Accreta? Y / N
Sepsis/infection Source: EGDT initiated? Y / N ICU needed? Y / N
Trauma (time of accident, mechanism):

Significant Medical History:

Recommended Interventions Prior to Transfer:

NICU aware of transfer (when applicable) Receiving Unit 3-1200 3-1400 Birthing Center

Provider Signature: Nurse Signature:

Instruction to referring provider: Fax records to: 585-756-7786;
The transferring RN must call report prior to transfer: 585-275-4262 (3-1200) 585-275-5222 (3-1400) 585-275-2294 (Birthing Center) prior to patient transfer.
For ICU/Surgical transfers: Utilize transfer center to assure accepting ICU provider 275-6022
If provider wants CONSULTATION (either instead of, or before transfer) page to MFM attending on call

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