

## Facility Information

Facility name \_\_\_\_\_ Call back # \_\_\_\_\_  
 Facility contact person \_\_\_\_\_ Fax # \_\_\_\_\_

## Member Information

Member name \_\_\_\_\_ Medicaid ID # \_\_\_\_\_  
 Admission date \_\_\_\_\_ Delivery date \_\_\_\_\_ D/C date \_\_\_\_\_

## Delivery Information

Name of delivering physician \_\_\_\_\_

Type of delivery:  Vaginal  VBAC  C/S  Repeat C/S Gestational age: \_\_\_\_\_

EDC: \_\_\_\_\_  Single birth  Multiple birth:  Twins  Triplets  Other: \_\_\_\_\_

**Baby A name:** \_\_\_\_\_ Sex:  Male  Female Weight (grams): \_\_\_\_\_

Well nursery:  Yes  No If No:  NICU  SCN Baby A D/C date: \_\_\_\_\_

Transfer to facility: \_\_\_\_\_ Clinical sent:  Yes  No Baby A physician: \_\_\_\_\_

Baby A has been referred for Newborn Home Visit:  Yes If Yes which agency: \_\_\_\_\_  No

**Baby B name:** \_\_\_\_\_ Sex:  Male  Female Weight (grams): \_\_\_\_\_

Well nursery:  Yes  No If No:  NICU  SCN Baby B D/C date: \_\_\_\_\_

Transfer to facility: \_\_\_\_\_ Clinical sent:  Yes  No Baby B physician: \_\_\_\_\_

Baby B has been referred for Newborn Home Visit:  Yes If Yes which agency: \_\_\_\_\_  No

**Baby C name:** \_\_\_\_\_ Sex:  Male  Female Weight (grams): \_\_\_\_\_

Well nursery:  Yes  No If No:  NICU  SCN Baby C D/C date: \_\_\_\_\_

Transfer to facility: \_\_\_\_\_ Clinical sent:  Yes  No Baby C physician: \_\_\_\_\_

Baby C has been referred for Newborn Home Visit:  Yes If Yes which agency: \_\_\_\_\_  No

**This information may be called or faxed to the Maternal Child Department.**

**Phone: 888.559.1010**

**Fax: 866.533.5493**