Select Health of South Carolina | Healthy Connections

Delivery Notification Worksheet

BRIGHTSTART

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: 1.888.559.1010 Fax: 1.866.533.5493