COMMUNITY BIRTH TRANSFER

STATE OF HAWAII

MOTHER'S NAME: _____

AGE/DOB: ____/_____ EGA/EDD: _____/_____

G/P: _____/_____ ALLERGIES: _____

REASON FOR TRANSPORT

MATERNAL: _____

☐ FETAL

☐ NEWBORN: _____

DATE & TIME 911 CALLED: _____/_____:_____ DATE & TIME EMS ARRIVED: _____/_____:_____

TIME OUT: INITIATED BY DESIGNATED TEAM MEMBER

EMS	HOSPITAL	
☐	☐	1. CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME & ROLE
☐	☐	2. PATIENT CONFIRMATION OF IDENTITY
☐	☐	3. ALLERGIES
☐	☐	4. VERBAL OR SIGNED PATIENT CONSENT FOR TRANSFER
☐	☐	5. COMMUNICATE AMONGST TEAM ANTICIPATED CRITICAL EVENTS OR UNEXPECTED STEPS
		NOTES:
☐	☐	6. KEY PATIENT CONCERNS FOR MANAGEMENT OF SELF AND FETUS OR NEWBORN
		CONCERNS:

DATE & TIME OF TRANSPORT: _____/_____:_____ NAME OF HOSPITAL: _____

REPORT GIVEN TO (NAME): _____ TIME REPORT GIVEN: _____:_____

MATERNAL HEIGHT: _____ WEIGHT: _____ LAST MEAL & VOID: _____/_____

LABOR ONSET: EARLY:_____/_____:_____ACTIVE:_____/_____:_____2ND STAGE:_____/_____:_____

MOTHER'S VITALS:

DATE	TIME	BP	HR	RR	O2	TEMP	FHT	VAGINAL EXAM	NOTES
		/			%			/ % /	
		/			%			/ % /	

CIRCLE OR FILL IN ALL THAT APPLY:

MEMBRANES: INTACT / RUPTURED	PLACENTA: IN UTERO / DELIVERED	EBL (ML):_____ MEDS: PIT / MISO / OTHER
DATE/ TIME: _____/_____:_____ SROM / AROM	DATE/ TIME: _____/_____:_____	DATE/ TIME: _____/_____:_____
APPEARANCE: CLEAR / MECONIUM / BLOODY	COMPLETE: YES / NO / UNKNOWN	FLOW: LIGHT / MOD / HEAVY

MATERNAL/ FETAL

NEWBORN

NEWBORN SEX/ NAME:_____/_____ DOB/TIME: _____/_____:_____

APGARS: 1:_____ 5:_____ 10:_____ RESUSCITATION: NO / YES: BULB / DELEE / PPV / CHEST COMPRESSIONS

VITAMIN K GIVEN: IM / ORAL / NONE EYE PROPHYLAXIS: NO / YES

NEWBORN'S VITALS:

DATE	TIME	HR	RR	O2	TEMP	WEIGHT	NOTES
				%			
				%			

PRENATAL HISTORY

PROVIDER: _____ PROVIDER'S PHONE: _____

MOTHER'S ADDRESS: _____ MOTHER'S PHONE: _____

PARTNER'S NAME: _____ PARTNER'S PHONE: _____

ABO/RH: _____ RHOGAM GIVEN: NO / YES DATE:_____ DAILY MEDS: _____

SIGNIFICANT MED/SURG HX: _____

MATERNAL LAB WORK:

DATE	LAB	RESULT		DATE	LAB	RESULT
	HGB/HCT	/ %			CT	NEG / POS
	PLATELETS				GC	NEG / POS
	HBsAG	NEG / POS			GCT	< 140 / ≥ 140
	HEP C	NEG / POS			GTT	NORM / ABNM
	HIV	NEG / POS			GBS	NEG / POS
	RPR	NEG / POS			GENETIC SCREEN	NA / NORM / ABNM
	RUBELLA	≥ 10 / < 10			ANATOMY US	NA / NORM / ABNM
	UA/CULTURE	NEG / POS			EDD METHOD	LMP / US / FUND HT

_____/_____:_____

MIDWIFE'S NAME/ SIGNATURE DATE/TIME

MIDWIFE'S: # OF BIRTHS THIS YEAR: _____ # OF TRANSFERS THIS YEAR: _____

WHITE: HOSPITAL YELLOW: EMS PINK: MIDWIFE