

Best Practice Recommendations for Handoff Communication
During Transport from a
Home or Freestanding Birth Center to a Hospital Setting



BIRTH CARE PROVIDER to complete the sections that are applicable;
demographic and prenatal information may be filled out in advance.

Appendix E: Maternal/Neonatal Transport Form from Home or Freestanding Birth Center

Demographics

Client's Name _____ DOB _____ Age _____
GP _____ Gestational Age _____ Weeks by LMP U/S B-HCG First FHR

Individual(s) who will accompany the woman/baby:

Name _____ Relationship _____

Special considerations for the woman and her family: _____

Prenatal History (Additionally, please supply applicable prenatal records)

Current pregnancy course including any variations _____

Ultrasound findings _____

Labs/Pertinent findings _____

Prior pregnancy outcomes _____

Current meds/supplements _____

Allergies _____

Hx of medical problems _____

Reason for Transport Details

Antepartum:

- Preeclampsia:** First trimester BP _____ Current BP _____ Urine/pro _____
 - Presence of symptoms of severe preeclampsia
- Preterm Labor:** Frequency of contractions _____
 - Presence of bleeding or abnormal discharge
 - Cervical exam Date _____ Time _____
- Fetal Heart Rate status** (specify) _____
- Other:** _____

Labor:

- Fetal Heart Rate status** (specify) _____
- Pain Management** _____
- Duration of Active Labor** _____
- Duration of Second Stage** _____
- Prolonged ROM** (>18 hours) _____
- Labor History:**
 - o Onset Latent Labor: Date _____ Time _____
 - o Onset Active Labor: Date _____ Time _____
 - o Onset Second Stage: Date _____ Time _____
 - o Most Recent Cervical Exam: Date _____ Time _____
 - o Membranes: Intact SROM AROM
 - o ROM: Date _____ Time _____ Color _____
 - o Methods to confirm ROM: _____
 - o GBS Status: POS NEG UNK Treatment: _____
 - o Intrapartum Fever ($T \geq 100.4^{\circ}\text{F}$ or 38°C) YES NO

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- Interventions: _____

- Other: _____

Birth and Immediate Postpartum History:

- **Vaginal birth** □ **Vaginal birth after cesarean**
- **Episiotomy**
- **Lacerations** □ Perineal □ Vaginal □ Labial □ Other: _____
- **Complications of birth:**
 - Shoulder dystocia
 - Retained Placenta
 - Maternal Hemorrhage: Estimated blood loss _____ Medications _____
 - Placenta delivery time, method _____ Intact Placenta □ Y □ N
 - Suspected Infection: _____
 - Other: _____

Newborn:

- Abnormal tone
- Apnea
- Birth Defect
- Birth Injury
- Bradycardia
- Cyanosis
- Grunting, Flaring or Retractions
- Hypoglycemia, suspected
- Infection, suspected
- Jitteriness
- Seizure-like activity
- Tachypnea
- Tachycardia
- Temperature Instability
- Post Resuscitation Care
- Resuscitation measures
 - PPV _____
 - O2 _____
 - Chest Compressions _____
- Current Respiratory status _____

- Other conditions: _____

Established Relationships: Maternity Care Provider _____ Pediatric Care Provider _____

Preferred Hospital _____ Maternity Unit Contact Info: _____

Additional Information: _____

Person Completing Form: _____ **Date:** _____

Additional Documentation

It is anticipated that the transferring birth provider will bring additional appropriate records to the hospital copies, as applicable, such as:

- Prenatal records: Health history, prenatal visit flow sheet and notes, lab and ultrasound reports
- Labor records: flow sheets, progress notes
- Newborn records: flow sheets, newborn assessment, progress notes

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