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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:**
  - Onset Latent Labor: Date_____ Time_____
  - Onset Active Labor: Date_____ Time_____
  - Onset Second Stage: Date_____ Time_____
  - Most Recent Cervical Exam: Date_____ Time_____
  - Membranes: □ Intact □ SROM □ AROM
  - ROM: Date_____ Time_____ Color_____
    Methods to confirm ROM:_____
  - GBS Status: □ POS □ NEG □ UNK Treatment:_____
  - Intrapartum Fever (T ≥ 100.4°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

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