**NEONATAL TRANSFER FORM**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Sex: M\_\_\_\_ F\_\_\_\_

Mother’s Name: & SC Medicaid #: \_\_\_

Mother’s Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of request: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Weight Today: \_\_\_\_\_\_\_\_\_\_\_\_

Gestational Age (Birth): \_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age (today): \_\_\_\_\_\_\_\_\_\_\_\_

Anticipated Length of Continued Hospitalization:

❑ >=5 days ❑ <5 days (Explanation Req’d) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Hospital/Hospital where labor initiated:

Transfer to (receiving facility): \_\_\_\_\_\_\_\_\_\_ \_\_\_\_ by:

❑Ground transport

❑Neonatal Facility Transport

❑Other (Explain)

Reason for transfer:

❑ Near Census ❑ Transfer to original hospital ❑ Transfer to non-original

hospital

❑ Census at time of request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Current Medical Status (Or attach internal form):  Nutrition: ❑ PO, ❑ Gastric gavage, or ❑ (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Respiratory: Current Oxygen Supplementation/Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Temperature Support: ❑ Incubator  ❑ Radiant Warmer  ❑ Open Crib |

❑ The facility is equipped to care for the acuity of the infant. All needed components of care have been completed or can be performed at the receiving facility.

**Provide attending signature/date or attach signed attending progress note from today’s date.**

For non-originating Hospital Transfers:

Attending Signature Date MCO Approved ❑

MCO Denied ❑