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.

_____ _____

Attending Signature Date

For non-originating Hospital Transfers:
MCO Approved ❑
MCO Denied ❑