AFFIX PATIENT LABEL
OR
PATIENT NAME: _____
DOB: _____

DELAWARE MATERNAL TRANSPORT FORM

TRANSPORT DETAILS

G ____ T ____ P____ A____ L____ EDD _____EGA_____wk _____d (or date delivered: _____) Pt. weight _____

Transferring physician/facility _____ Receiving Physician/facility _____
Indication(s) for transfer: Maternal _____ Fetal _____
Diagnosis: _____
Pertinent History (OB, Medical, Surgical) _____
Current Medications/Indication: _____
Allergies/Reactions: ☐ NKDA ☐ _____
Transportation: ☐ Ambulance ☐ Air Monitoring on transport: ☐ Auscultation ☐ Continuous EFM ☐ Tele

PATIENT DATA

Discharge Vitals: Time _____BP _____ P _____ R _____ O_2 Sat _____ T _____Pain Level _____
Vaginal exam: _____/_____/_____ Date/Time: _____
Vaginal Exam: _____/_____/_____ Date/Time: _____
Membranes: Intact Ruptured ☐ Bulging Date/Time: _____
Amniotic Fluid (if ruptured): ☐ clear ☐ bloody ☐ meconium ☐ odor ☐ Other _____
Bleeding: ☐ Yes (EBL: _____mL) ☐ No
Presentation: ☐ Cephalic ☐ Breech ☐ Transverse ☐ Unknown
Previa: ☐ Yes ☐ No
EFM: Baseline: _____ Variability: _____ Accels: _____ Decels: _____
Category ☐ I (Normal) ☐ II (Equivocal)
Contractions: ≥4/hr? ☐ Yes ☐ No
Pertinent Labs: Blood Type/Rh_____ Other: _____
Medications: ☐ Antenatal Steroids Given (Type_____ Date/time_____) Next dose due: _____
☐ Magnesium Sulfate: Loading dose _____gm time: _____, then drip at _____gm/hr
☐ Terbutaline (time_____) ☐ Antibiotics (Name, Date and time) _____
☐ Other _____
IV: Site: _____ Gauge: _____ Fluids Running: _____ Total volume infused at discharge: _____
Blood Products Given: (Units Given/type) _____PRBC _____FFP _____Cryoprecipitate _____ Platelets
Last food/fluid PO: Date/Time: _____

CHECKLISTS

DOCUMENTS: Sent: ☐ with patient ☐ faxed to receiving hospital (Transport to **CCHS Fax 302-733-4690**; Transport to **BHMC Fax 302-735-3246**)

☐ Prenatal Record ☐ Prenatal Labs ☐ Ultrasound reports ☐ Current labs ☐ H & P ☐ Triage records ☐ Discharge Summary
☐ Current Admission (relevant notes) ☐ Admission face sheet ☐ Patient consent to transfer ☐ Copy of this completed form

COMMUNICATIONS: ☐ Physician to physician communication done Time: _____
☐ Nurse-to-nurse communication done (**Transports to CCHS call report to charge nurse at 302-301-2480; Transports to BHMC, call report to charge nurse at 302-744-7245**)
Report given by: _____RN Date/Time: _____
Report given to: _____RN

SIGNATURES

Transferring Physician/CMN (Print) _____ /Signature _____ Date/Time:_____

Nurse Completing Form (Print) _____ /Signature_____ Date/Time:_____

AFFIX PATIENT LABEL
OR
PATIENT NAME: _____
DOB: _____

DELAWARE MATERNAL TRANSPORT FORM – EN ROUTE

Time	FHR	Contractions	BP	P	R	Narrative	Initials

Time ambulance dispatched: _____ Ambulance crew arrival on unit: _____
Departure Time: _____ Arrival at receiving facility: _____
Emergency Contact person for patient: _____ Relationship to patient _____
Emergency Contact phone number: _____

Transport Issues: (Check appropriate boxes and explain in comment section as needed)

☐ Finding a Transport Nurse ☐ Ambulance team delay ☐ Cleanliness of Ambulance
☐ Traffic ☐ Weather ☐ Ambulance Safety
☐ Professionalism of Ambulance Crew unprofessional 0 1 2 3 4 5 very professional
Comments: _____
☐ Professionalism of staff at receiving hospital unprofessional 0 1 2 3 4 5 very professional
Comments: _____

SIGNATURES

Transport Nurse (Print) _____/Initials_____/Signature _____Date/Time:_____

Receiving Nurse (Print) _____/Initials_____/Signature _____Date/Time: _____

Signatures, Other (Print) _____/Initials_____/Signature _____ Date/Time: _____

Signatures, Other (Print) _____/Initials_____/Signature _____ Date/Time: _____