PATIENT LABEL

HURON-PERTH NEWBORN CARE CLINIC COMMUNITY REFERRAL FORM

PLEASE FAX FORM **AND** ALL SERUM BILIRUBIN RESULTS TO THE HPNCC AT 519-271-6264-CLINIC WILL CONTACT PATIENT WITH APPOINTMENT

REASON FOR REFERRAL:

◯ FEEDING SUPPORT WITHIN 10 DAYS OF BIRTH

◯ BILIRUBIN SCREENING

REFERRING PHYSICIAN: _____

FAX NUMBER: _____

INFANT INFO:

DATE/TIME OF BIRTH: _____ BIRTH WEIGHT: _____

GESTATIONAL AGE AT BIRTH: _____ MOST RECENT WEIGHT/DATE: _____

BLOODTYPE & DAT: _____ MOST RECENT TSB/DATE OF DRAW: _____

RISK FACTORS FOR BILIRUBIN TOXICITY (CHECK ALL THAT APPLY):

◯ ABO OR RH INCOMPATABILLITY

◯ POSITIVE FAMILY HISTORY OF G6PD DEFICIENCY

◯ NEED FOR RESUSCITATION AT BIRTH

◯ EVIDENCE OF METABOLIC OR RESPRIATORY ACIDOSIS (CORD GAS PH <7.1)

◯ SEPSIS, TEMPERATURE INSTABILITY, SIGNIFICANT LETHARGY

MOTHER'S INFO:

MOTHER'S NAME: _____ PHONE: _____

MOTHER'S BLOOD GROUP: _____

NOTES:

_____

_____

_____

_____

_____

PLEASE HAVE PATIENT EMAIL CANCELLATIONS TO: hpnewborncareclinic@gmail.com

PATIENT LABEL

PLEASE HAVE PATIENT EMAIL CANCELLATIONS TO: hpnewborncareclinic@gmail.com