Regional Perinatal Intensive Care Centers Program
Obstetrical Component
Discharge/Referral
(Circle one)

To: _____Date:_____
(Center/Physician/County Health Unit)
Address:_____
_____

Referring Source:_____Telephone Number:_____
Address: _____

Patient Information

Name:_____Telephone Number: _____
Address:_____
Admission Date: _____Discharge Date: _____Identifying Number: _____

Social Security Number:_____ Date of Birth(DOB): _____ Age:_____

Estimated Date of Confinement:_____ Gravida/Parity/Abortions:_____
Blood Type:_____HIV: _____/_____RPR:_____/_____Hgb/Hct:_____
Pap smear:_____Chlamydia/Gonnorhea_____
Rubella Titer:_____Vaccination:_____ Rhogam:_____
Medication:_____

Diagnosis:_____
History:_____

Problems: _____
Plan: _____

Newborn Outcome: DOB: _____Weight: _____Gestational Age: _____
Eligible Medically Yes___ Financial: Yes___
No___ No___
Signature of referral staff/physician: _____

Date Received: _____ Patient's next appointment_____
Date/Location
Return information from Referral Source_____
Signature

Place original to RPICC Liaison and provide copy to Referral Source