



GIFT OF LIFE MATERNITY CARE PROGRAM

NOTIFICATION OF DELIVERY

PATIENT (MOTHER) INFORMATION

_____ Name _____ Patient DOB _____ Race: B, W, O
 _____ Medicaid # _____ County _____ Delivering Physician _____
 _____ Hospital Admit Date _____ Delivery Date _____ Time _____ Discharge Date _____ Time _____
 _____ Gestational Age at Delivery _____ Post delivery: Gravida _____ Para _____
 _____ Type of delivery (V=Vag, CS=C/Section, VB=VBAC, RC=Repeat C/Section, HB=Homebirth)
 _____ Type of Anesthesia (G=General, R=Regional, L=Local, NA=Narcotics, N=None, O=Other)
 _____ If Other, List: _____
 _____ Pregnancy Outcome (LB=Live Birth, FD=Fetal Demise, ND=Neonatal Demise)

Medical Risk Factors (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Advanced Maternal Age |
| <input type="checkbox"/> Pre-eclampsia/eclampsia | <input type="checkbox"/> Mentally Challenged | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Insulin Dependent Diabetes | <input type="checkbox"/> Placental Complication/Abruption | <input type="checkbox"/> PROM/PPROM |
| <input type="checkbox"/> Gestational Diabetes Mellitus | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Group B Step | <input type="checkbox"/> Pre-Term Labor | <input type="checkbox"/> Previous Mult. Sponta. Abortion |
| <input type="checkbox"/> Late Entry | <input type="checkbox"/> Multiple Pregnancy | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> RH Negative | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Vaginosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Use |
- Other-List: _____

Patient meets criteria listed below for Postpartum Home Visit, within 10-20 days of discharge: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> 1. Under 16 years of age at conception | <input type="checkbox"/> 5. IUFD greater than 22 weeks |
| <input type="checkbox"/> 2. Drugs &/or alcohol abuse | <input type="checkbox"/> 6. Other _____ |
| <input type="checkbox"/> 3. Mental Illness | _____ |
| <input type="checkbox"/> 4. Infant 2500 grams or less | _____ |

INFANT INFORMATION

Did infant go to well baby nursery? Yes No

Name: _____ Sex: Male Female

APGAR: 1 Min _____ 5 Min _____ Birthweight _____ Discharge Weight _____

Neonatal Complications: _____

If delivered early (21-34 weeks), were antenatal steroids given? Yes No

Complaints/Problems: _____