Highland Midwife Birth Services

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Emergency Transport Information

Name _____ **DOB** _____ **Age** _____ **Date** _____

Address _____ City _____
Phone-home _____ cell _____
Emergency contact name and number _____
Insurance company _____ Policy # _____

ABO/Rh		EDD		ALLERGIES
Antibody		Gestation		
RPR		G		
Rubella		P		
Hep B		A		MEDICATIONS
HIV		L		
GBS		U/S confirm	Y / N	

Prenatal/significant health history _____
_____
_____

MATERNAL Vitals prior to transport date _____ time _____
B/P _____ Pulse _____ Resp _____ Temp _____ ROM date / time _____
Dil _____ Eff _____ Station _____ Delivery date / time _____ EBL _____
Meds / treatments given _____
Reason for transport _____

NEWBORN Vitals prior to transport date _____ time _____
Apgar 1 min _____ 5 min _____ 10 min _____ Gender M F Name _____
Resuscitation needed? Y / N stimulation / O2 / chest compression / bag-mask
Pulse _____ Resp _____ Temp_____ rectal / axilla SpO_2 _____ Meconium present? Y / N
Reason for transport _____

	Time
EMS called	
Client left	
Hospital notified Name:	
MD notified Name:	

Client sig _____
Witness (if needed) _____
Midwife sig _____
Notes _____
_____