NEWBORN REPORTING SHEET

To report a newborn to Health Choice **fax in the completed form to (480) 760-4867 within twelve (12) hours of the delivery**

Facility: _____
Facility Provider ID # _____
Facility Contact Person:_____
Facility Phone Number: _____
Facility Fax Number: _____

MOTHER'S INFORMATION

Mother's Name: _____ DOB: _____

Mother's HCIC ID Number: _E_ __ __ __ __ __ __ __ __

Type of Delivery: VAG ☐ VBAC ☐ C/SECT ☐
Reason for C/Sect: _____

Tubal Ligation at Delivery? Yes ☐ No ☐

Delivering Physician: _____

Prenatal Medical Complications: _____

NEWBORN INFORMATION

Newborn's Name: _____ Male☐ Female☐ DOB: _____
Medical Record Number _____
Birth Weight: _____ grams Gestational Age: _____ weeks APGARS: _____

Twin A: Male or Female Twin B: Male or Female (Each newborn requires a separate form.)

Well ☐ Sick ☐ **If Sick, Diagnosis: _____**

NICU Admit? **Yes ☐ No ☐**
Hospital Transferred to: _____ Date: _____

Newborn Attending Physician: _____