NCA Referral Form for Follow-Up

Referring **NCA** Physician _____ Date: _____

Delivery Hospital: **BNO FHH GSH MAN MFF TCH TUH**

Mother First/Last Name: _____ Baby Last name @ D/C: _____

Gravida: ____ Para: ____ DOB/***Time***: _____ GA weeks/days: _____

Mother's Blood Type: _____ Baby's Blood Type: _____ Coombs: ____ Risk Factors: _____

Birth Wt: _____ grams; D/C Wt: _____ grams

Breastfeeding Bottle Both Feeding well: **YES NO**

Family Phone Number: _____ Alt. Number: _____ Primary Language: **English Spanish Other:** _____

Primary Care Physician @ discharge _____ PCP notified: **YES NO**

REASON FOR REFERRAL

Outpatient Bili Level By: LAB HHN Date to be drawn: _____

Home Phototherapy: YES NO

Relevant lab values (TCB or TSB), *include hours old*; **plus** phototherapy history (time of start/discontinued & light types):

_____

Follow-up Labs/Clinic Appointments:

_____

*******PLEASE FAX: 1) REFERRAL FORM AND 2) FACE/DEMOGRAPHIC SHEET TO**

FAX NUMBER 803-2633 **

Questions: 9am-5pm call Clinical Coordinators: **@ 803-2681** or Page: @ **736-0571**