



NCA Referral Form for Follow-Up

Referring NCA Physician _____

Date: _____

Delivery Hospital: **BNO FHH GSH MAN MFH 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**

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