HUMBER RIVER HOSPITAL

Maternal & Child Program

NEONATAL FOLLOW-UP CLINIC REFERRAL FORM

Please FAX this referral form to 416-242-1095

Birth Hospital: _____ Hospital Transferred from: _____

Patient Name: _____

Birth Surname: _____

Reason for Referral: _____

EDC: DD_____ MM_____ YY_____ **DOB**: DD_____ MM_____ YY_____

Gestational Age at Birth: _____ wks. _____ days Birth weight: _____ g

Gestational Age at Discharge: _____ wks. _____ days Discharge weight: _____ g Hc _____

Date of Discharge: DD_____ MM_____ YY_____

☐ Parents had full explanation of Neonatal Follow-up (NFU)

Mother's Name _____

Address: _____

Phone # (H)_____ Phone # (B)_____

Father's Name _____

Phone # (H)_____ Phone # (B)_____

Primary Physician: _____

Phone # _____ Fax # _____

Cardiology Results: _____

Neurology Results:_____

ROP (R) Zone _____ Grade _____ (L) Zone _____ Grade _____

☐ ULTRASOUND ☐ CT ☐ MRI ☐ BLOOD WORK

HEARING/SCREENING TESTS: ☐ Passed **or** ☐ Referred

FEEDING ISSUES: ☐ YES ☐ NO ☐ Other

ALLERGIES: ☐ YES ☐ NO

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Patient meets the criteria for Neonatal Follow-up at Humber River Hospital and consents to sharing the following information with other members of the Humber River Hospital Team.

- ☐ Prematurity less than 33 weeks
- ☐ Perinatal acidosis, apgar less than 5 @ 5 mins. & cord pH less than 7
- ☐ Abnormal cranial US and/or Intra Ventricular Hemmorhage (IVH) grade I, II, III
- ☐ Newborn needing ventilation Intermittent Positive Pressure Ventilation (IPPV) greater than 24 hour, CPAP greater than 24 hour.
- ☐ Newborn with major congenital abnormality or other syndromes
- ☐ Persistent hypoglycemia less than 2.2 mmol/L over 6 hours.
- ☐ Mother with alcohol and/or other substance abuse or newborn who shows drug withdrawal symptoms with confirming test.
- ☐ History of seizures or meningitis
- ☐ High risk social environment
- ☐ Physician referral (explanation)
- ☐ Birth weight 1000 – 2000 g.
- ☐ Hyperbilirubinemia greater than 425 mmol/L requiring exchange transfusion
- ☐ SGA less than 3rd percentile
- ☐ Other _____

Tertiary Centre referral will follow the central criteria in the Greater Toronto Area (i.e. Retrotransfers)

Paediatrician Signature: _____ Date: _____

Print Name: _____