# NEWBORN REPORTING SHEET

To report a newborn to Health Choice **fax in the completed form to (480) 760-4867**

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

## MOTHER'S INFORMATION

**Mother's Name:** _____ **DOB:** _____

**Mother's UDOH ID:** _____

**Induction of Labor:** ☐ **YES** ☐ **NO** **Reason for Induction:** _____
**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:** _____
**UDOH ID:** _____ **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:** _____