



Perinatal Institute

[Patient label]

NCA Referral Form for Follow up

Referring NCA Physician _____ Date: _____

Delivery Hospital: **GSH TCH BN MA TUH SES MFF FHH**

Mother's First/Last Name _____ Mother's Blood Type: ____ Weeks: _____

Baby's Last Name @ D/C _____ Baby's Blood Type: ____ Coombs: _____

Breastfeeding Bottle Both Feeding well: **YES NO** Birth Wt. _____ grams D/C Wt. _____ grams

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** _____ **Agency:** _____

Home Phototherapy: **YES NO** **Agency Providing Therapy** _____

****Call the NCA Physician with Bili Results** \geq _____

Physician's Signature _____ **Date** _____

Relevant lab values (TCB or TSB) include hours old: _____

Follow-up Labs/Clinic Appointments: _____

PLEASE FAX: REFERRAL FORM, DEMOGRAPHIC SHEET, AND EXAM SHEET TO:

FAX NUMBER: 513-803-2633

Questions? 9am - 5pm, call Clinical Coordinators: @ **513-803-2681** or page: @ **513-736-0571**

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