



## 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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