



## 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**

The information contained in this fax message maybe confidential and protected information intended only for the use of the individual or entity named above. As the recipient you maybe prohibited by *State and Federal Law* from disclosing the information to any party without specific written authorization from the individual to whom it pertains. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, dissemination, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this communication in error, please notify immediately by telephone and shred or otherwise destroy the documents received.