

Date: [Insert Date]

To: [Pediatrician Name/Primary Care Provider]

Clinic Name: [Clinic Name]

Fax/Phone: [Insert Number]

RE: Newborn Discharge Summary and Follow-Up Request

Patient Name: [Infant Name]

Date of Birth: [DOB] | **Time:** [Time]

Gestational Age: [Weeks/Days]

Birth Weight: [Weight] | **Discharge Weight:** [Weight]

Maternal History:

[Insert Brief Maternal History, e.g., GBS Status, Blood Type, Complications]

Delivery Details:

Type of Delivery: [Vaginal/C-Section]

Apgar Scores: [1 min] / [5 min]

Feeding Method: [Breast/Formula/Mixed]

Hospital Course & Screenings:

Hearing Screen: [Pass/Fail/Pending] - [Left/Right]

CCHD Screen: [Pass/Fail]

Bilirubin at Discharge: [Level] at [Age in Hours]

Metabolic Screen (PKU): [Completed/Pending]

Immunizations Given: [Hepatitis B / Other]

Discharge Instructions:

The patient was discharged on [Discharge Date] in stable condition. The parents have been instructed to follow up with your office for a newborn exam.

Requested Follow-Up Appointment:

Within [24/48/72] hours of discharge.

Concerns/Outstanding Labs:

[Insert any specific concerns or labs for the pediatrician to review]

Sincerely,

[Signature]

[Printed Name of Discharging Provider]

[Hospital/Birth Center Name]

[Contact Phone Number]