

Date: [Insert Date]

RECIPIENT INFORMATION

To: [Specialist Name/GP Name]

Facility: [Clinic/Hospital Name]

Address: [Street Address, City, Postcode]

PATIENT DETAILS (MOTHER)

Name: [Mother's Full Name]

Date of Birth: [DOB]

Hospital ID: [ID Number]

Address: [Home Address]

NEWBORN DETAILS

Name: [Baby's Name/Gender]

Date of Birth: [DOB] at [Time]

Birth Weight: [Weight in kg/grams]

Gestational Age: [Weeks/Days]

DISCHARGE SUMMARY

Date of Admission: [Date]

Date of Discharge: [Date]

Type of Delivery: [e.g., Vaginal, Emergency CS, Elective CS]

Indication (if applicable): [Reason for intervention]

Pregnancy/Birth Complications:

[List any complications, e.g., Preeclampsia, GDM, PPH, Perineal Tears]

Neonatal Outcomes:

[Apgar Scores, Resuscitation required, Neonatal Jaundice, Feeding method]

MEDICATIONS & FOLLOW-UP

Current Medications (Mother): [List Medications]

Current Medications (Infant): [List Medications/Vitamin K/Hepatitis B]

Follow-Up Requirements:

[List appointments, e.g., 6-week check, wound review, specialist pediatric review]

Reason for Specialist Referral:

[State specific reason for ongoing care/referral]

Sincerely,

[Doctor/Midwife Signature]

Name: [Printed Name]

Designation: [Title]

Contact Number: [Phone Number]