

**Date:** [Date]

**To:** [Receiving Physician/MFM Specialist Name]

**Facility:** [Receiving Hospital Name]

**Department:** Maternal-Fetal Medicine / Labor & Delivery

**From:** [Referring Physician Name]

**Facility:** [Referring Hospital Name]

**Contact Number:** [Phone Number]

---

## Patient Identification

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Gestational Age:** [Weeks/Days] (Based on [LMP/Ultrasound])

**Gravity/Parity:** G[#] P[#]

## Reason for Transfer

[State primary diagnosis, e.g., Preterm Premature Rupture of Membranes (PPROM), Severe Preeclampsia, Fetal Anomaly, or Threatened Preterm Labor].

## Clinical Summary & Current Status

**Presenting Symptoms:** [Brief description of symptoms and onset]

**Vital Signs:** BP: [BP], HR: [HR], Temp: [Temp], O2 Sat: [Sat%]

**Fetal Status:** [FHR, Variability, Accelerations/Decelerations]

**Cervical Exam:** [Dilation/Effacement/Station]

## Interventions Provided

- **Corticosteroids:** [Dose/Time administered or "Not given"]
- **Magnesium Sulfate:** [Bolus/Maintenance rate or "Not given"]
- **Tocolytics:** [Medication/Dose or "None"]
- **Antibiotics:** [Medication/Dose for GBS or PPROM]
- **Other:** [IV fluids, Oxygen, etc.]

## Laboratory & Imaging Results

**Labs:** [Relevant CBC, CMP, Protein/Creatinine Ratio, Bedside Type & Screen]

**Ultrasound:** [Biophysical Profile score, AFI, EFW, or Placental location]

## Mode of Transport

The patient is being transferred via [Ground Ambulance/Air Transport] with [BLS/ALS/Critical Care] nursing/paramedic support.

Please contact me at [Phone Number] if you require further information prior to arrival.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Pager/Direct Dial]