

Date: [Date]

To: [Pediatrician Name]

Clinic: [Clinic Name]

Fax/Phone: [Contact Details]

RE: NEONATAL DISCHARGE SUMMARY / TRANSFER OF CARE

Patient Name: [Infant Name]

Date of Birth: [DOB]

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

Gestational Age at Birth: [Weeks/Days]

Corrected Gestational Age: [Weeks/Days]

Mother's Name: [Name]

NICU Stay Dates: [Admission Date] to [Discharge Date]

1. PRIMARY DIAGNOSES

- [e.g., Prematurity / Very Low Birth Weight]
- [e.g., Bronchopulmonary Dysplasia (BPD)]
- [e.g., Intraventricular Hemorrhage (Grade)]
- [e.g., Neonatal Opioid Withdrawal Syndrome]
- [e.g., Retinopathy of Prematurity (ROP)]

2. CLINICAL COURSE SUMMARY

Respiratory: [Details on ventilation, oxygen requirements at discharge]

Cardiovascular: [Details on ECHO results, PDA management]

Neurological: [Details on Head Ultrasound, MRI, Tone]

Gastrointestinal/Nutrition: [Feeding type, Fortification, Growth curve]

3. MEDICATIONS AT DISCHARGE

[List all medications with dosage, frequency, and indication]

4. DISCHARGE SCREENING RESULTS

Hearing Screen: [Pass/Fail/Pending]

CCHD Screen: [Pass/Fail]

Car Seat Challenge: [Pass/Fail]

Last Hemoglobin/Bilirubin: [Values]

5. REQUIRED FOLLOW-UP APPOINTMENTS

- **Pediatrician:** Within [24-48] hours
- **Ophthalmology (ROP):** [Date/Time]
- **Pulmonology:** [Date/Time]
- **NICU Follow-up Clinic:** [Date/Time]
- **Early Intervention/PT/OT:** [Referral Status]

6. PROVIDER CONTACT INFORMATION

Discharging Neonatologist: [Name]

Hospital: [NICU Name]

Direct Phone: [Phone Number]