

Date: [Date of Transfer]

From: [NICU Name/Hospital]

To: [Pediatrician Name/Practice Name]

Subject: Neonatal Transfer Summary: [Infant Name]

Patient Details:

Name: [Infant Name]

Date of Birth: [DOB]

Birth Weight: [Birth Weight in grams] (ELBW)

Gestational Age at Birth: [Weeks/Days]

Current Weight: [Current Weight in grams]

Corrected Gestational Age: [Weeks/Days]

Birth History:

Delivery Method: [Vaginal/C-Section]

Reason for Prematurity: [e.g., PPRM, Preeclampsia]

Apgar Scores: [1 min] / [5 min] / [10 min]

NICU Course Summary:

Respiratory: [e.g., Duration of ventilation, surfactant used, current O2 needs]

Cardiovascular: [e.g., PDA status, blood pressure management]

Neurological: [e.g., Head ultrasound results, IVH grade if any]

Gastrointestinal/Nutrition: [e.g., Type of feed, fortification, NEC history]

Infectious Disease: [e.g., Sepsis workup, antibiotic courses]

Hematology: [e.g., Transfusion history, ROP screening status]

Current Medications:

1. [Medication Name, Dose, Frequency]

2. [Medication Name, Dose, Frequency]

Discharge Status:

Hearing Screen: [Pass/Fail]

Car Seat Challenge: [Pass/Fail]

Immunizations Given: [List Vaccines]

Follow-up Requirements:

Pediatric Appointment: [Date/Time]

Ophthalmology (ROP): [Date/Time]

Early Intervention Referral: [Status]

Specialist Referrals: [e.g., Cardiology, Pulmonology, PT/OT]

Provider Contact:

Discharging Physician: [Name]

Phone Number: [Phone Number]