



Provincial Maternal Transfer Record

Addressograph stamp or electronic patient record label

Antepartum Intrapartum Postpartum

MT or PTAC #:
 Date of transfer (YYYY/MM/DD): / /
 Transfer From: (Institution)
 Referred By:MD/RM
 Obstetrical care provider:MD/RM
 Transfer To: (Institution)
 Name of Accepting MD:
 Send Copy of Discharge Summary to:

Health Card #: Version Code
 Next of Kin:
 Relationship:..... Telephone #: (.....)

REASON FOR TRANSFER

Maternal (describe)

Retro-transfer Acute Transfer Fetal (describe)

ALLERGIES

No Known Allergies Specify (drug, food, tape, dyes, latex, other) and reactions:

OBSTETRIC HISTORY

Copy of chart with patient and additional information, such as fetal monitor strips, if indicated.

Gravida: Para: LMP: EDB/C: Gestation (weeks + days)
 Past C-Section or Uterine Surgery: Incision Type:

LABOUR & BIRTH

Onset of Labour: Membranes Ruptured: Yes No Time: Colour:

Cervical Exam: / / Fetal Position: A: B: C:

Placenta (multiples): DI/DI MONO/DI MONO/MONO Other:

Maternal Vital Signs: BP / Pulse: Resp: Temp: Fetal Fibronectin: Positive Negative

MEDICATIONS

Regular medications:

Antibiotics:	Date:	Time:	Other:
Steroids:	Date:	Time:	
Magnesium Sulfate for: <input type="checkbox"/> Seizure prophylaxis <input type="checkbox"/> Neuroprotection	Date:	Time:	

MEDICAL/SURGICAL HISTORY

See chart

Relevant medical / surgical history

SOCIAL ISSUES

See chart

IN TRANSIT

SEE TRANSPORT RECORD IV: TBA on arrival mL Rate mL/hr

Time	FHR	Pulse	Resp	BP	Contractions			Medications (Dose / Route)	Comments
					Frequency	Duration	Intensity		

TRANSFER INFORMATION

Departure Time: Time of Arrival at Receiving Hospital:

SEE TRANSPORT RECORD Accompanied By: Relationship: Attendant During Transfer:

Signature/Status: Print Name: