COMMUNICATION DOCUMENT FOR OBSTETRICAL SERVICES

FROM: Ob/Gyn Physician:	**Telephone #**
TO: Name of PCP	
Patient Name:	**ID Number:**

Medical/Surgical/Family/Social History

Medical History:								
Immunizations:	☐Td	☐Hep B	☐Varicella	☐MMR	☐Flu	☐Pneumovax	☐PPD	
Surgical History:								
						Transfusions:		
Family History:								
Social History:	Lives with:			Occupation:			Smoking:	ppd
	Alcohol:	/wk	Drugs:			Victim of Abuse?:	☐Yes	☐No

Obstetrical History

Number of previous pregnancies:	Vaginal Deliveries/Cesarean Sections:
Number of live births:	Number of miscarriages or elective abortions:
Dates:	Dates:
Complications during previous pregnancies:	

Clinical Information

Date of first prenatal visit:		Expected date of delivery:
Hospital where delivery is scheduled:		
Name of network physician to be utilized at hospital:		
(please check one)	☐Vaginal delivery expected	☐Cesarean section expected
Complications anticipated/experienced:		
Name of selected network physician for routine care:		
Diagnostic testing:		
Surgical procedure done:		
Findings:		
Consultation with other specialists:		
Reason for specialty care:		

Summary/Plan

Signature/Title