

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	HPV	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