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