HEALTHCARE REVIEW CORPORATION
OBSTETRIC NOTIFICATION FORM
(502) 426-4888 FAX (502) 429-5233

PT ID NAME DOB

ADDRESS CITY/ST/ZIP

FACILITY NAME PROV NUMBER

ADDRESS CITY/ST/ZIP

MD NAME LIC# SPEC

ADDRESS PHONE CITY/ST/ZIP

ADMIT DATE/TIME TYPE: URGENT SCHEDULED

ADM DX PROC PROC DATE

ADM DX PROC PROC DATE

CLINICAL INFORMATION

EDC OR GESTATIONAL AGE _____
G_____ P_____

Normal Vaginal Delivery_____ Cesarean Section_____ Sex_____

Delivery Date_____ Delivery Time_____

Birth weight in grams _____ Apgars 1 Minute_____ 5 Minutes_____

For Cesarean Sections-Document
Reason for the C-Section

Describe Pre-Delivery Hospital Care: (Include All Stages of Labor)

CONTACT NAME

CONTACT TELEPHONE NUMBER

CONTACT FAX NUMBER