Select Health of South Carolina

Healthy Connections

BRIGHTSTART®

Delivery Notification Form

Facility information	
Facility name:	
Facility contact person:	
Phone:	Fax:

Member information		
Member name:		
Member date of birth:	Medicaid ID number:	
Admission date:	Delivery date:	Discharge date:

Delivery information
Name of delivering practitioner:
Type of delivery: ☐ Vaginal ☐ Vaginal birth after cesarean ☐ Cesarean section ☐ Repeat cesarean section Gestational age:
Expected date of delivery: ☐ Single birth Multiple birth: ☐ Twins ☐ Triplets ☐ Other:
Baby A name: Sex: ☐ Male ☐ Female Weight (grams):
Well nursery: ☐ Yes ☐ No If no: ☐ Neonatal intensive care unit (NICU) ☐ Special care nursery (SCN) Baby A discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby A physician:
Baby A has been referred for newborn home visit: ☐ Yes ☐ No If yes, which agency:
Baby B name: Sex: ☐ Male ☐ Female Weight (grams):
Well nursery: ☐ Yes ☐ No If No: ☐ NICU ☐ SCN Baby B discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby B physician:
Baby B has been referred for newborn home visit: ☐ Yes ☐ No If yes, which agency:
Baby C name: Sex: ☐ Male ☐ Female Weight (grams):
Well nursery: ☐ Yes ☐ No If no: ☐ NICU ☐ SCN Baby C discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby C physician:
Baby C has been referred for newborn home visit: ☐ Yes ☐ No If yes, which agency:

This information may be called or faxed to Bright Start® – Phone: **1-888-559-1010** Fax: **1-866-533-5493**

www.selecthealthofsc.com