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# POTENTIALLY VIABLE LIVE BIRTH CARE RECORD - PHYSICIAN NOTES

## PATIENT IDENTIFICATION

NAME:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE:	WEIGHT: _____ GRAMS
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## MATERNAL HISTORY

AGE:	G:	PARA:	EDC:	GA:
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DELIVERY / CONDITION AT BIRTH / PE:      APGAR:    1 Min \_\_\_\_\_      5 Min \_\_\_\_\_      10 Min \_\_\_\_\_


### Hospitalization Course:


PRONOUNCED AT: _____ / _____ / _____ at: _____ (Time)
BY: _____, MD ( Physician's Signature )

**WHITE = Infant Record      YELLOW = Maternal**

**PLACE WHITE COPY WITH INFANT RECORD AND TAKE TO ADMITTING OFFICE**

**PART OF THE MEDICAL RECORD**