Parent Information Form

A parent of a newborn, who transfers the newborn to a "qualified person" at an "appropriate location" pursuant to RCW 13.34, is not required to provide ANY identifying information in order to transfer the newborn. The intent of this form is to prove an opportunity for the parent to anonymously provide information about the newborn and his/her family medical history.

Parent unwilling to provide information: check here ☐

TRANSFER INFORMATION		
Date Newborn Transferred:	Hospital/Fire Department:	Patient ID Band Number:

DELIVERY INFORMATION				
Date and time of birth:	Date:		Time:	
Place of birth:	☐ Hospital	☐ Home	☐ Other	
Delivered by: *(If not hospital delivery)*	☐ Midwife	☐ Mother	☐ Father/family/friend	
Position at birth:	☐ Head first	☐ Bottom first	☐ Other:	
Cried at birth:	☐ Soon after birth, right away	☐ Delayed, but soon	☐ Other: Seconds after birth: ___ Minutes after birth:	
Baby moving arms/legs at birth:	☐ Yes	☐ No		
Baby's coloring shortly after birth:	☐ Pink lips and chest, hands and feet	☐ Pink lips and chest with bluish hands and feet	☐ Bluish lips and chest ☐ Not blue but very pale	☐ Other:
Placenta (afterbirth) delivered within 10-15 minutes after baby:	☐ Yes	☐ No If no, when?		

LABOR INFORMATION			
Date/time mother's water broke:	Date:	Time:	
What color was the fluid:	☐ Clear	☐ Greenish or brownish	☐ Other
Any odor to the fluid:	☐ Yes Describe:	☐ No	
Date/time contractions *(labor pains)* **started:**	Date:	Time:	

PREGNANCY INFORMATION		
How far along was the pregnancy:	Months _____ or weeks _____ or date of last period _____	
Mother's approximate age:	☐ Under 17 years old ☐ 17 – 35 years old ☐ Over 35 years old	
Prenatal care:	☐ Yes ☐ No	
Other pregnancies:	# of pregnancies: _____ Born alive: _____ Premature births *(more than 3 weeks early):* _____	Low birth weight (under 5 ½ lbs): _____ Still born: _____ Miscarried/abortions: _____
Complications of this pregnancy*: (Bleeding before labor, high blood pressure, high weight gain, infections, morning sickness more than 3 months, etc.)*	Describe:	
Complications of past pregnancies:	Describe:	

Substance use during pregnancy:	☐ Alcohol: ____ Drinks/day *for* ____ Months of pregnancy	☐ Tobacco: ____ packs/day *for* ____ Months of pregnancy	☐ Prescription drugs: Names:	☐ Other drugs: *(street drugs)* Names:

References: Parent Information Packet
Parent Information Packet: The Legal Process
Newborn Safety Act Policy

Patient Information Form – Newborn Transfer

*NUR-XXX (09/2010)

EMS Personnel:
Original form to Hospital w/patient **Copy** for to keep w/MIR

Parent Mail to:
Adoptions Program Manager
Children's Administration
Department of Social and Health Services
PO Box 45710
Olympia, WA 98504-5710

Parent Information Form

PARENTS' MEDICAL HISTORY INFORMATION			
Personal or family history of:	**Mother:**	**Father:**	**Don't Know:**
▪ **Diabetes**	☐	☐	☐
▪ **High blood pressure**	☐	☐	☐
▪ **Heart Disease**	☐	☐	☐
▪ **Lung disease** *(asthma, etc.)*	☐	☐	☐
▪ **Allergies**	☐ *(List allergies and reactions):*	☐ *(List allergies and reactions):*	☐ *(List allergies and reactions):*
▪ **Sexually transmitted diseases** *(HIV, herpes, gonorrhea, etc.)*	☐	☐	☐
▪ **Depression or other mental illness**	☐	☐	☐
▪ **Glaucoma or other eye problems**	☐	☐	☐
▪ **Cancer**	☐	☐	☐
▪ **Hearing problems**	☐	☐	☐
▪ **Hemophilia or bleeding problems**	☐	☐	☐
▪ **Cystic fibrosis**	☐	☐	☐
▪ **Muscular dystrophy**	☐	☐	☐
▪ **Huntington's disease**	☐	☐	☐
▪ **Down syndrome/other mental retardation**	☐	☐	☐
Personal or family history of birth defect: *(heart, cleft lip/palate, etc.)*	☐ **Mother:** *(Please describe)*	☐ **Father:** *(Please describe)*	☐ **Don't Know:** *(Please describe)*
Ethnic Background: *(this can sometimes provide important health information)*	**Mother:**	**Father:**	**Don't Know:**
▪ **Caucasian**	☐	☐	☐
▪ **African American**	☐	☐	☐
▪ **European (Ashkenazi)**	☐	☐	☐
▪ **Jewish**	☐	☐	☐
▪ **Italian/Greek/Middle Eastern**	☐	☐	☐
▪ **Latino/Hispanic/Puerto Rican**	☐	☐	☐
▪ **Native American**	☐	☐	☐
▪ **Southeast Asian/Taiwanese/Chinese/ Filipino**	☐	☐	☐
▪ **Pacific Islander**	☐	☐	☐
Any other medical or family history information that you think might be important in your baby's future?			

Patient Label

Parent Information Form

Descriptions and Characteristics of Birth Family				
	Mother	**Father**	**Sibling of Newborn**	**Other – Identify Relationship**
Height				
Weight				
Age *(at time of newborn's birth)*				
Build/bone structure				
Complexion color *(fair, medium, dark, olive, light brown)*				
Hair color				
Hair texture				
Eye color				
Right or left handed				
Blood type				
Education *(to date)*				
Glasses worn? *If yes, what for what condition?*				
Acne? **Age at onset?** **Treatment?**				
Distinguishing characteristics *(birthmarks, scars, tattoos, etc.)*				
Occupation				
Talents/hobbies/skills				
Family religion				
Addictions *(Drug, alcohol, tobacco, etc.)*				
Deceased: ▪ **Age** ▪ **Cause of death**				

Patient Label