Steward Health Care Network

HEALTH CHOICE ARIZONA

NEWBORN NOTIFICATION

To report a newborn to Steward Health Choice, **fax in the completed form to (480) 760-4867 within twelve (12) hours of the delivery.**
ALL information must be completed.

Facility: _____
Facility Provider ID # _____
Facility Contact Person:_____
Facility Phone Number: _____
Facility Fax Number: _____

Auto Assigned ☐ **HCA Mom** ☐

MOTHER'S INFORMATION

Mother's Name:_____ **DOB:**_____

Mother's AHCCCS ID: A _ _ _ _ _ _ _ _ _

Induction of Labor? Yes ☐ **No** ☐ **Reason for induction**_____

Type of Delivery: VAG ☐ **VBAC** ☐ **C/SECT** ☐
Reason for C/Sect: _____
Tubal Ligation at Delivery? Yes ☐ **No** ☐

Prenatal Medical Complications:_____

NEWBORN INFORMATION

Newborn's Name: _____ **Male** ☐ **Female** ☐ **DOB:** _____
AHCCCS ID: _____**Medical Record Number** _____
Birth Weight: _____ **grams Gestational Age:** _____ **weeks APGARS:** _____

Twin A: Male or Female Twin B: Male or Female
(Each newborn requires a separate form.)

Well ☐ **Sick** ☐ **If Sick, Diagnosis:**_____

NICU Admit? Yes ☐ **No** ☐

Hospital Transferred to:_____ **Date:**_____