Alberta Health Services

Site: _____

Referral to Postpartum Community Services

Section A and B to be completed by the referring physician or midwife. Call the Postpartum Community Services (PPCS) office closest to the client's home to arrange appointment time. Fax request to the PPCS office closest to the client's home:
North Hill Community Health Centre 403-282-0399, South Calgary Health Centre 403-943-9147, or East Calgary Health Centre 403-955-1390.

Section A: To be completed by Physician or Midwife

Mother's Name _____

Client's Phone # _____ Mother's AHC # _____

Infant's Name _____ Infant's ULI # _____

Infant's DOB _____ *yyyy/Mon/dd* Infant's Age (in hours) _____

The above client was assessed on Date _____ *yyyy/Mon/dd* Time _____ *hh:mm*

Request for:

☐ **Transcutaneous Bilirubin (TCB)**
Eligibility: ☐ Baby ≥35 weeks of delivery ☐ Baby ≤10 days old ☐ Baby has not received phototherapy or exchange transfusion.

☐ **Breastfeeding Support**
Detail regarding concern _____

☐ **Parenting/Social Issues**

Section B: To be completed by Physician or Midwife

TcB Requested ☐ Results to be faxed to Dr. _____ Fax # _____

Critical SB Results to be called to Dr. _____ Phone/Pager # _____

Infant Gestational Age _____ Birth Weight (BW) _____ Weight Today _____ (gm)

Loss from BW _____ (gm) _____ % Voiding _____ /24 hrs

Gain from BW _____ (gm) _____ % Stooling _____ /24 hrs

Previous Bilirubin Results: Date _____ *yyyy/Mon/dd* Result _____ ☐ NA

DAT Results if known: ☐ Positive ☐ Negative

Risk Factors: ☐ Poor Feeding ☐ Weight loss >10% ☐ Lethargy

Feeding: ☐ Breastfeeding only ☐ Breastfeeding with Supplement ☐ Formula only

Section C: To be completed by PHN

Infant age in hours at time of assessment _____ Jaundice extends to _____

TcB Result _____ umol/L Date _____ *yyyy/Mon/dd* Time _____ *hh:mm* PHN _____

Based on the above assessment:

☐ No further TcB follow up required ☐ Repeat TcB tomorrow ☐ Repeat TcB until at least 10% below peak TcB

☐ Serum Bilirubin was drawn: Result _____ umol/L Time _____ *hh:mm*

☐ Breastfeeding assessment and support provided. ☐ Referral to community agencies:

Name(s) _____

Physician/Pediatrician Recommendations:

☐ Results reported to Dr. _____ **or** ☐ Admission to PLC

PHN Name _____ PHN Signature _____ Date _____ *yyyy/Mon/dd*

☐ **North PPCS**
North Hill Community Health Centre
(Lions Park Strip Mall)
1527-19 Street NW
Calgary, Alberta
Phone: 403-944-7402 Fax: 403-282-0399

☐ **South PPCS**
South Calgary Health Centre
(Check in reception on the main floor)
31 Sunpark Plaza SE
Calgary, Alberta
Phone: 403-943-9572 Fax: 403-943-9147

☐ **East PPCS**
East Calgary Health Centre
4715-8 Avenue SE
Calgary, Alberta
Phone: 403-955-1360 Fax: 403-955-1390