



MEDICAL BOARD OF CALIFORNIA
Executive Office



Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form

Business and Professions Code section 2510 requires a hospital to report each transfer by a licensed midwife of a planned out-of-hospital birth to the Medical Board of California and the California Maternal Quality Care Collaborative. The hospital must complete this form and submit as follows:

- Send the full completed form to: Medical Board of California, Attn: Licensed Midwifery Program, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 or fax to (916) 263-8936; and
- Send page one of the form to the California Maternal Quality Care Collaborative, Medical School Office Building, 1265 Welch Road, MS 5415, Stanford, CA 94305 or fax to (650) 721-5751.

Hospital and Admission Information	
Hospital Name:	
Hospital Address:	
Date of Admission:	Time of Admission:
Name of Healthcare Provider Assuming Care: (First, Middle, Last)	License No.:
Person(s) admitted: <input type="checkbox"/> Pregnant Mother <input type="checkbox"/> Delivered Mother <input type="checkbox"/> Newborn(s)	
Patient *Pre-Registered at this Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient was Pre-Registered at Another Hospital Name of other Hospital: _____ <small>*Pre-Registered means the mother had been previously registered at the hospital for possible delivery.</small>	
Transport/Transfer Information	
Reason for Transfer: _____ _____ _____	
Name of Licensed Midwife Treating Patient Prior to Transfer: (First, Middle, Last)	License No.:
Licensed Midwife Called in to Report Transfer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed Midwife Arrived with Patient:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed Midwife Provided Hospital with Medical Records, including Prenatal Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed Midwife Spoke with and Provided Report to Physician Regarding Care up to the Point of Transfer: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Reason no Report was Given: <input type="checkbox"/> Physician Unavailable <input type="checkbox"/> Licensed Midwife Unavailable <input type="checkbox"/> Other: _____ _____	

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Patient Name: (First, Middle, Last)