QUESTIONS? CALL HEALTHY BABIES, HAPPY MOMS INC. @ 508-203-1521

HOME PHOTOTHERAPY PRESCRIPTION

Date:

Name of Baby:_____ DOB:_____

Name of Mother:_____ Time of Birth:_____

Address:_____

Home Phone:_____ Cell Phone: _____

Baby's Birth Weight: _____ Gestational Age: _____

Baby's Current Weight: _____ ABO Incompatibility: YES / NO

Total/Direct Bili Level:_____ DAT: YES / NO

Date and Time of the Bili Draw: _____ Previous phototherapy: YES / NO

HOME PHOTOTHERAPY

☐ HBHM provides phototherapy via the Little Sparrows bili-hut™. HBHM RNs will provide parents with instruction in the use and care of the equipment.

*A daily nursing assessment with a weight, vital signs and a STAT Neonatal Bilirubin T/D via heel stick will be performed each morning the baby is under our care and is included with this service. Patient's primary care provider will be consulted daily to determine length of home care services needed based on results.

REASON:

☐ Neonatal Jaundice (P59.9)

DATE NEEDED: _____

Contact information and preferred method for primary care provider to receive results:

Name: _____

☐ Phone: _____

☐ Fax: _____

PROVIDER AUTHORIZATION:

Or Include PROVIDER STAMP or LABEL for Contact Info.

SIGNATURE:_____ MD / DO / NP / PA/ CNM

Printed name: _____

Practice: _____

Phone #: _____

Fax #: _____

NPI #: _____

PLEASE FAX TO HBHM @ 844-816-4610 BY 3:00 PM TO RECEIVE SAME DAY SERVICE.