FirstChoice℠ Next
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BRIGHTSTART®

Delivery Notification Form

Facility information

Facility name:	
Facility contact person:	
Phone:	Fax:

Member information

Member name:		Medicaid ID number:
Admission date:	Delivery date:	Discharge date:

Delivery information

Name of delivering practitioner:	
Type of delivery: ☐ Vaginal ☐ Vaginal birth after cesarean ☐ Cesarean section ☐ Repeat cesarean section	Gestational age:
Expected date of delivery: ☐ Single birth Multiple birth: ☐ Twins ☐ Triplets ☐ Other:	
Baby A name: Sex: ☐ Male ☐ Female	Weight (grams):
Well nursery: ☐ Yes ☐ No If **No**: ☐ Neonatal intensive care unit (NICU) ☐ Special care nursery (SCN)	Baby A discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No	Baby A physician:
Baby A has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:	
Baby B name: Sex: ☐ Male ☐ Female	Weight (grams):
Well nursery: ☐ Yes ☐ No If **No**: ☐ NICU ☐ SCN	Baby B discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No	Baby B physician:
Baby B has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:	
Baby C name: Sex: ☐ Male ☐ Female	Weight (grams):
Well nursery: ☐ Yes ☐ No If **No**: ☐ NICU ☐ SCN	Baby C discharge date:
Transfer to facility: Clinical sent: ☐ Yes ☐ No	Baby C physician:
Baby C has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:	

This information may be called or faxed to Bright Start®:
Phone: **1-833-472-7708**
Fax: **1-866-477-7229**

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