Sentara®
Health Plans

Newborn Notification Form

Fax: 757-837-4701/844-883-6064

Mother Information:	
Mother Name:	
Mother ID:	Mother DOB:
Infant Information:	
Infant Name:	
DOB:	
EGA:	Weight (Kg):
☐ Male ☐ Female	
Delivery Type: ☐ C-section ☐ Vaginal	
Apgar:	
1st Hep B vaccination date:	
Feeding Type: ☐ Breast ☐ Bottle	
Admit Date: _____ DC Date:_____	
Pediatrician: _____	
Contact name:_____ Ph:_____ Fax:_____	