East Texas Gulf Coast Regional Trauma Advisory Council

Perinatal Needs Assessment

FY 2019 (09/01/18-08/31/19)

Agency
Name:_____

Date Completed: ____/____/_____

1. Annual number of deliveries per year? _____
2. Anticipated Maternal Level of Care? _____
3. Number of LDR/LDRP Beds? _____
4. Number of PP/MBU Beds? _____
5. Maternal Transport Service? _____
6. Maternal Transfers – In_____ Out_____
7. Designated Neonatal Level of Care? _____
8. Annual NICU admits _____
9. Number of NICU Beds _____
10. Neonatal transfers – In _____ Out _____
11. Does your facility offer educational programs? Y or N
    a. Please supply us with the number of instructors for each educational program
        i. NRP _____
        ii. STABLE _____
        iii. Intermediate/Advanced Fetal Monitoring _____
        iv. Car Seat Inspector _____
        v. Other Perinatal Courses
        _____

If you have needs, please fill out the tables below.

Equipment Needs

Equipment	#1 Priority	#2 Priority	#3 Priority	Do you have plans to meet these needs	Matching funds available Y/N

Educational Needs

Course needed	Training Equipment Needed	# Students Needing Initial Training	# Students Renewing	Do you have plans to meet these needs	Matching funds available Y/N

Maternal Program Manager Name and email?

_____

Neonatal Program Manager Name and email?

_____

Who completed this form?

Print: _____ Sign: _____

TSA "R" Member Signature:

_____