

**HOSPITAL NAME:** \_\_\_\_\_

**ADULT CRITICAL CARE RETRIEVAL TRANSFER DOCUMENTATION**

DATE \_\_\_\_\_ CALL HANDLER \_\_\_\_\_ NURSE \_\_\_\_\_ DOCTOR \_\_\_\_\_ ACA \_\_\_\_\_ TEAM BRIEF

PATIENT \_\_\_\_\_ DOB \_\_\_\_\_ H&C \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ WEIGHT \_\_\_\_\_ BARIATRIC REQUIREMENTS \_\_\_\_\_ INFECTION STATUS \_\_\_\_\_

REFERRER \_\_\_\_\_ RECEIVING ICU CONSULTANT \_\_\_\_\_  
 REFERRING CONSULTANT \_\_\_\_\_ RECEIVING SPECIALTY CONSULTANT \_\_\_\_\_  
 REFERRING SPECIALTY \_\_\_\_\_ RECEIVING SPECIALTY \_\_\_\_\_  
 PATIENT LOCATION \_\_\_\_\_ PATIENT DESTINATION \_\_\_\_\_

CONTACT NUMBER \_\_\_\_\_ CONTACT NUMBER \_\_\_\_\_

DATE \_\_\_\_\_ TIME REFERRAL \_\_\_\_\_ DECISION TIME \_\_\_\_\_ TEAM DEPART \_\_\_\_\_ CANCELLED \_\_\_\_\_

INFORM OTHER \_\_\_\_\_ REF \_\_\_\_\_ DELAY/CANCEL REASON \_\_\_\_\_  
 TEAMS  AMBULANCE BOOKED \_\_\_\_\_ NUMBER \_\_\_\_\_

NO ICU IN HOSPITAL	NO ICU BED TO MAKE A BED	TERTIARY SERVICE REPATRIATION	TREATMENT INVESTIGATION
LEVEL 1	LEVEL 2	LEVEL 3	NURSE ONLY
DIAGNOSIS			REASON
			PAST MED HISTORY

**INTERVENTIONS**

PLANNED INTERVENTIONS/TREATMENT

CURRENT DRUGS/INFUSIONS

ADVICE GIVEN

<b>ALLERGIES</b>	
URINARY CATHETER	NASOGASTRIC TUBE
CHECK LABEL FLUSH BAGS	LABEL ALL LINES
PREPARE INFUSIONS	STOP FEEDS/ INSULIN
TRANSFER LETTER	DISCUSS WITH FAMILY

OBS	TIME	PUPILS	GCS	HR	BP	SpO2	ETCo2	Temp	pH	pO2	pCO2	HCO3	BE	LACT	BM
REFERRAL															
ARRIVAL															
DEPARTURE															

HANDOVER

AT PATIENT \_\_\_\_\_ DEPART WITH PATIENT \_\_\_\_\_ ARRIVE RECEIVING \_\_\_\_\_ RETURN BASE \_\_\_\_\_

<b>SPINAL PRECAUTIONS</b>	FULLY IMMOBILISED <input type="checkbox"/>	COLLAR <input type="checkbox"/>
AIRWAY	DIFFICULT? <b>Y / N</b>	GRADE _____ ETT SIZE _____ FM/NS <input type="checkbox"/>
RESP	FiO2 _____ SIMV <input type="checkbox"/>	PS/CPAP <input type="checkbox"/> TV _____ RR _____ PS _____ PEEP _____ PIP _____
CVS	CVL <input type="checkbox"/> ART <input type="checkbox"/>	DIALYSIS <input type="checkbox"/> PERIPHERAL <input type="checkbox"/> Hb _____
GI	NASOGASTRIC TUBE <input type="checkbox"/>	DRAINS <input type="checkbox"/>
RENAL	CATHETER <input type="checkbox"/> CRRT	Na _____ K _____ Urea _____ Creat _____
INFXN	<b>SIDE ROOM NEEDED Y / N</b>	ANTIBIOTICS _____ TEMP _____ WCC _____
CXR POS	ETT <input type="checkbox"/> CVL <input type="checkbox"/> NG <input type="checkbox"/>	CHEST DRAINS <input type="checkbox"/>

CLINICAL CHANGE PRE ARRIVAL

**LINES LABELLED** PERIPHERAL  ARTERIAL  FLUSH BAG CHECK  CENTRAL  FLUSH BAG CHECK  ACCESSIBLE IV PORT

PRESSURE AREAS/SORES

PATIENT ID X 2 \_\_\_\_\_ EYES TAPED \_\_\_\_\_ ETT DEPTH \_\_\_\_\_ CM \_\_\_\_\_ COLLAR \_\_\_\_\_ PPP \_\_\_\_\_

AMBULANCE BOOKED \_\_\_\_\_ REFERENCE NO \_\_\_\_\_ CALL SIGN \_\_\_\_\_ BLUE LIGHTS \_\_\_\_\_

FAMILY INFORMED \_\_\_\_\_ PATIENT NOTES & LETTER \_\_\_\_\_ RECEIVING HOSPITAL INFORMED \_\_\_\_\_

VAC MAT \_\_\_\_\_ BLANKET/HAT \_\_\_\_\_ 5 POINT HARNESS \_\_\_\_\_

**TRANSFER OBSERVATIONS**

TIME	LOCATION	HR	Rhy	BP	FIO2	Mode	SpO2	ETCO2	RR	TV	MV	PIP	PROPOFOL				
:00																	
:15																	
:30																	
:45																	
:00																	
:15																	
:30																	
:45																	
:00																	
:15																	
:30																	
:45																	
:00																	
:15																	
:30																	
:45																	

BOLUS DRUGS	DOSE	TIME
INCIDENTS		
HANDOVER		
TEAM DEBRIEF		

BASE PRE-DEPARTURE	
TEAM BRIEF	
TROLLEY CHECK/CABLES ROLLED/ BATTERIES	
SEALED CHECKED BAG	
ADEQUATE OXYGEN & TURNED ON	
MAPLESON C CIRCUIT	
DEFIBRILLATOR	
VACUUM MATTRESS	
BARIATRIC CUSHIONS	
PATIENT DETAILS/LOCATION/RUN SHEET COMMENCED	
INFECTION CONTROL ISSUE?	
ICU BED/NAMED CONSULTANT	
OTHER TEAMS INFORMED	
OTHER AMBULANCE (RING AMBULANCE CONTROL)	
AMBULANCE O2 & SUCTION	
NURSE DOCTOR & DRIVER	
APPROPRIATE CLOTHES/NISTAR PHONE/CASH	

PACKAGING	
REFERRING HOSPITAL HANDOVER	
CONFIRM ALLERGIES/GRADE INTUB	
CONFIRM LINES/FLUSHES/LABELLING	
CHECK PUPILS, TAPE EYES	
CONFIRM ETT PLACEMENT, SECURE & RECORD DEPTH	
ADEQUATE SEDATION/RELAXANT	
OBS STABLE FOR TRANSFER	
O2 TANKS TURNED ON & APPROPRIATE VENT SETTINGS	
VAC MAT DEFLATED ON TROLLEY/SCOOP 10 DEGREE TILT	
BRAKES ON TROLLEY & BED	
DR LEAD TRANSFER TO TROLLEY/ SWITCH TO TRANSPORT VENT	
CLOSED SUCTION CATHETER	
NURSE LEAD MONITORS/ZERO	
INFUSIONS CONNECTED & RUNNING	
IV PORT ACCESSIBLE ON RIGHT SIDE	
PRESSURE POINTS PROTECTED	
SECURED IN BELTS/VAC MAT/COLLAR	
BLANKET/FOIL HAT	

TRANSFER PRE-DEPARTURE	
O2 CALCULATION	
DRUGS/INFUSIONS/ FLUIDS	
OBS STABLE	
ETT SECURE	
VENTILATING	
ABG IF CLINICALLY INDICATED	
IV PORT ACCESSIBLE RIGHT SIDE	
PATIENT SECURE	
CALL RECEIVING HOSPITAL	
TEAM INTRO TO FAMILY/ INFORMED OF TRANSFER	
IF FAMILY PRESENT UPDATED WITH CLINICAL STATUS/ DESTINATION/ CONTACT DETAILS	
PATIENT PROPERTY	

TRANSFER	
PATIENT SECURE	
ON AMBULANCE POWER	
ON AMBULANCE O2	
ROUTE CONFIRMED	
VEHICLE TEMPERATURE CONTROLLED	
EQUIPMENT & DRUGS SECURED	
STAFF BELTED	
PROGRESS DECIDED	

HANDOVER	
PT DETAILS	
PT SUMMARY	
PENDING INVESTIGATIONS/ TREATMENTS	
OBSERVATIONS/DRUGS DURING TRANSFER	
SAFETY—ALLERGIES/AIRWAY/ PRECAUTIONS/FLUSH BAGS	
INCIDENTS	
CLINICAL CHANGE	
PHOTOCOPY TRANSFER DOC	

RETURN TO BASE PRE-DEPARTURE	
LEAVE PHOTOCOPY OF DOC	
TROLLEY CLEANED/NEW VENT TUBING	
BRING TROLLEY/BAG/DEFIB	

RETURN TO BASE	
DEBRIEF	
TROLLEY CLEANED	
TROLLEY CHECKLIST	
BAG CHECKED, REFILLED & SEALED	
TANKS REPLACED & TURNED OFF	
INFORM OTHER TEAMS	