NON-CRITICAL CARE TRANSFERS

TIMES:

LIGHTS AND SIRENS: YES / NO

REFERRAL CALL MADE		TEAM ARRIVE REFERRING HOSPITAL	
REFERRAL ACCEPTED		TEAM DEPART REFERRING HOSPITAL	
A&E CONTACTED		TEAM ARRIVE RECEIVING HOSPITAL	
PICU/RICU CONTACTED		TEAM DEPART RECEIVING HOSPITAL	
AMBULANCE ARRIVAL		PARENTS OFFERED TO TRAVEL PARENTS TRAVELLED WITH BABY	Y/N Y/N
REFERER CONTACTED		FAMILY CONTACTED ON DEPARTURE FAMILY CONTACTED ON ARRIVAL	
TEAM DESPATCHED		BACK TO BASE	
DID TEAM GO ONTO ANOTHER CALL Y/N WHAT TIME ORIGINAL CALL COMPLETED:		TRANSPORT COORDINATOR CONTACTED Y/N CONSULTANT CONTACTED Y/N	
TIME FINISHED CLEANING KIT SIGNATURE:-		IR1 FORM COMPLETED Y/N	

AT RECEIVING HOSPITAL:

TEMPERATURE °C	BLOOD GLUCOSE mmol/l

TRANSPORT UNDERTAKEN BY:

SIGNATURE	PRINT	DESIGNATION	DATE

TRANSPORT NOTES (INCLUDING FEEDBACK):

Level of Care:

NON-CRITICAL CARE TRANSFERS

Name:	Date:
Referring Hospital:	Referring Consultant:
Hospital No:	H&C No:
Receiving Hospital:	Receiving Consultant:
DOB: Gestational age (wk): Corrected Gestation (wk): Age (d): Current Weight (kg): Birth Weight (kg)	Mother's Name: Mother's mobile number: Address: Partner's Name: Partner's mobile number:
Vitamin K given: Yes/No Dose: Route: ID Bands present and correct: yes/no Cot card present: yes/no	**Back transfer** ☐ **Capacity** ☐ **Treatment or investigation** ☐ Nature of treatment or investigation :
Religion: Baby baptised/blessed: yes/no Parents aware of transfer: yes/no Accommodation available: yes/no	GP Name: Address: Telephone:
ROP screening: Examination required: yes/no Date due/Carried out: Date of next review: Copy of exam form enclosed: yes/no/na	**Newborn Bloodspot Screening:** Before Blood Transfusion: Yes/No Date: Day 5: Yes/No Date: At 28 Days (If Below 32 weeks): Yes/No Date:
Vaccinations: 8 Week yes/no Date: 12 Week yes/no Date: 16 Week yes/no Date: Synagis yes/no/na Date: Copy of immunisation form: yes/no	**Hearing Screening**: Carried out: yes/no Follow up required: yes/no Date due:
Cranial Ultrasound: Date last carried out: Repeat due: yes/no Date: Copy of ultrasound results: yes/no	**Research**: Baby involved in research: yes/no Name of study: Is receiving hospital aware of research: yes/no Relevant paperwork to go with baby: yes/no
Oxygen Therapy: yes/no Method: Ambient.....% Low Flow.....ml/min CPAP.....cmH_2O	**Health Visitor Referral**: yes/no Name and address: **PHCHR ("red book")**: yes/no **UNOCINI Referral:** yes/no

Fluids/feeds: total.....ml/kg/d
Full Feeds: yes/no ..... ml..... hrly Type:
IV Fluids: yes/no .....ml.....hrly Type:
Under Care of Dietician: yes/no Diet sheet enclosed: yes/no
Mother wishes to breast feed: yes/no
Time of Last Feed:

Speech and Language Referral: yes/no
Additives: yes/no Type:
Feeding Regime:

Current medication	Dose	Frequency	Route	Last administered

PRE-TRANSPORT CHECKLIST

ENSURE THE FOLLOWING EQUIPMENT IS PRESENT AND FUNCTIONING

Air Cylinder (Full)		Monitor Leads	
O2 Cylinders (Full)		B/P Transducer	
Nitric Oxide cylinder		NeoPuff tubing and mask	
Ventilator		Self Inflating bag	
Ventilator Circuit		Suction	
Incubator charged		Suction Catheters	
Monitor		Stethoscope	
Infusion Pumps (minimum 4)		Temperature Probe	
Transport Equipment Bags		Patient Property	
Documentation **Photocopy handover sheet**		Hi Vis Jacket Food/Money	
Mobile Phone		Ambulance Booking Ref	
Emergency Drugs		INCUBATOR Pariad trolley	1 2

PRE-TRANSPORT CHECKLIST

CHECKLIST	YES	NO	N/A
THEATRE CHECK LIST			
NAME BANDS × 2			
CONSENT FORM			
BLOOD ORDERED			
CJD FORM			
INFANT'S CLINICAL NOTES			
FLUID BALANCE SHEET			
DRUG KARDEX			
BLOOD RESULTS FORM			
INVESTIGATION REQUEST FORM			
MILK			
INFECTION STATUS:	NORTHERN IRELAND NEONATAL NETWORK INFECTION CONTROL FORMS Yes/No		

NON-CRITICAL CARE TRANSFERS

OBSERVATIONS	PRE-DEPART									
HEART RATE										
RESPIRATIONS										
SpO2 Pre-ductal % Post-ductal %										
BLOOD PRESSURE (syst/diast/mean)										
COLOUR										
TEMPERATURE °C										
INCUBATOR TEMPERATURE °C										
BLOOD GLUCOSE mmol/l										
LOW FLOW OXYGEN ml/min										
CPAP Pressure cmH2O										
FiO2										
Humidity Temperature °C										

IV FLUIDS	Total (ml/kg/day):									
	PRE-DEPART									
IV/CVL INFUSION:										
CHECK SITE:-										
IV/CVL INFUSION:										
CHECK SITE:-										
IV/CVL INFUSION:										
CHECK SITE:-										
IV/CVL INFUSION:										
CHECK SITE:-										