

# Neonatal/Paediatric Nurse Led Request

## Request Details

Date  Time  (24hrs) Call-handler

## Patient Details

Name  
Address  
Post Code  
H&C Number  
Hospital Number  
D.O.B.

(Please tick the relevant boxes)

Male  Age   
 Female   
 Ambiguous  Weight  (kg)

|             | Referring Hospital Details | Receiving Hospital Details |
|-------------|----------------------------|----------------------------|
| Hospital    |                            |                            |
| Ward/Site   |                            |                            |
| Consultant  |                            |                            |
| Specialty   |                            |                            |
| Contact No. |                            |                            |

## Patient Summary

Please give details including PMH, diagnosis, interventions/treatments and reason for transfer.

|  |   |  |
|--|---|--|
| <p><b>Allergies</b> No <input type="checkbox"/><br/>Yes <input type="checkbox"/> (Please give details)</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> | <p><b>Infection</b> No <input type="checkbox"/><br/>Yes <input type="checkbox"/> (Please give details)</p> <p>e.g. Isolation, PPE</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> | <p><b>Resuscitation Status</b><br/>(Please give details)</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> |
|--|---|--|

## Family Details

Parents  Names  Contact No.   
 Guardians

Travelling with Patient No   
Yes  Language  Interpreter Required No   
Yes

## Safeguarding Details

Safeguarding concerns No   
Yes

(If yes, please give details)

# Neonatal/Paediatric Nurse Led Request



## Patient Assessment

### Airway Assessment

Airway concerns    No    
    Yes  (Please give details)

Airway adjunct    No    
    Yes  (Please give details)

Suction required    No    
    Yes  (Please give details)

### Breathing Assessment

Respiratory rate  (bpm)    SpO<sub>2</sub>  (%)    Acceptable parameters

Supplemental O<sub>2</sub>    No    
    Yes  (Please give details)  e.g. flow, percentage and device

Chest drain    No    
    Yes  (Please give details)  e.g. site, reason for insertion, date of removal and CXR post removal

Chest physio required    No    
    Yes  (Please give details)

### Circulation Assessment

HR  (bpm)    BP  (mmHg)    CRT  (sec)    Colour     Peripheral perfusion

Pacing wires/ pacemaker    No    
    Yes  (Please give details)  e.g. date of insertion/date of removal

### Disability Assessment

GCS    E  /4   
    V  /5   
    M  /6   
     /15

Pupils    L  R     Blood glucose  (mmol/l)     (time)   
    - size   
    - reactivity

Pain    No    
    Yes  (Please give details)  e.g. site and severity

Seizure activity    No    
    Yes  (Please give details)

### Exposure Assessment

Temp.  (°C)

Temp. site

Temp. regulation concerns    No    
    Yes  (Please give details)

Skin assessment

Eye assessment

Wounds    No    
    Yes  (Please give details)  e.g. sites, dressings and drains

Mouth assessment

# Neonatal/Paediatric Nurse Led Request

## Fluid Assessment

Total daily fluid allowance  mis/kg/day    Type     Rate  (mls/hr)    Route  (sec)

Urinary output    • Catheter   
                           • Nappies   
                           • Other  (Please give details)

## Feed Assessment

| Mode of feeding | Type of feed | Frequency | Volume |
|-----------------|--------------|-----------|--------|
| Bottle          |              |           |        |
| Breast          |              |           |        |
| TPN             |              |           |        |
| Tube            |              |           |        |

EBM for transfer    No   
                           Yes  (Please give details)

Eating & drinking    No   
                               Yes  (Please give details)

Food intolerances    No   
                               Yes  (Please give details)

Nausea/vomiting    No   
                            Yes  (Please give details)

Last bowel motion     (type)    Date     Time

## Current Medication

| Infusions | Regular Meds. | PRN Meds. | Stat. Meds. |
|-----------|---------------|-----------|-------------|
|           |               |           |             |

## Recent Imaging/Investigations

Please give details of dates performed and any concerns  
 e.g. CXR, ECG, ECHO

## Current Invasive Lines/Devices

Please give details of sites and dates inserted.

# Neonatal/Paediatric Nurse Led Request

## Transfer Advice

### Documentation required

- |                     |                          |                         |                          |                        |                          |
|---------------------|--------------------------|-------------------------|--------------------------|------------------------|--------------------------|
| Identity bands (x2) | <input type="checkbox"/> | Fluid balance chart     | <input type="checkbox"/> | Doctor transfer letter | <input type="checkbox"/> |
| Observation chart   | <input type="checkbox"/> | Drug prescription chart | <input type="checkbox"/> | Nurse transfer letter  | <input type="checkbox"/> |

Other docs.

### Plan for IV fluids for transfer

No    
 Yes  (Please give details)

### Plan for analgesia prior to transfer

No    
 Yes  (Please give details)

### Plan for feeding prior to transfer

No    
 Yes  (Please give details)

Other advice given

Signed  Date  Time  (24hrs)

## Pre Transport Checklist

### Ambulance

Ambulance booked  Time  (24hrs) Ref. No.

### Equipment

- |  |                          |                         |                          |                          |
|--|--------------------------|-------------------------|--------------------------|--------------------------|
| Trolley  | <input type="checkbox"/> | Monitor:                | • ECG leads              | <input type="checkbox"/> |
| Restraint:                                     |                          |                         | • BP cuff                | <input type="checkbox"/> |
| • Pod & straps                                 | <input type="checkbox"/> |                         | • SpO <sub>2</sub> probe | <input type="checkbox"/> |
| • Pedi-mate plus                               | <input type="checkbox"/> | Mains lead              |                          | <input type="checkbox"/> |
| • Black Ferno harness                          | <input type="checkbox"/> | Syringe drivers         |                          | <input type="checkbox"/> |
| • Car seat                                     | <input type="checkbox"/> | Transport folder        |                          | <input type="checkbox"/> |
| Defibrillator                                  | <input type="checkbox"/> | Other teams informed    |                          | <input type="checkbox"/> |
| Checked trolley bag                            | <input type="checkbox"/> | Phone                   |                          | <input type="checkbox"/> |
| Transwarmer/ Medwarmer                         | <input type="checkbox"/> | Money (sterling/euro)   |                          | <input type="checkbox"/> |
| O <sub>2</sub> cylinder (x2)                   | <input type="checkbox"/> | Call referring hospital |                          | <input type="checkbox"/> |
| O <sub>2</sub> flow meters (reg/ low/ low-low) | <input type="checkbox"/> | Team brief              |                          | <input type="checkbox"/> |
| Ambu bag & mask                                | <input type="checkbox"/> |                         |                          |                          |
| Portable suction/ yankeurs/ catheters          | <input type="checkbox"/> |                         |                          |                          |

Signed  Date  Time  (24hrs)

# Neonatal/Paediatric Nurse Led Transfer



## Clinical Observation Record

### Key:

- HR     •
- SBP    ^
- DBP    v
- RR     x

|            | Time (1/2 Hourly) |   |   |   |   |   |   |   |   |   |
|------------|-------------------|---|---|---|---|---|---|---|---|---|
| 200        |                   |   |   |   |   |   |   |   |   |   |
| 190        |                   |   |   |   |   |   |   |   |   |   |
| 180        |                   |   |   |   |   |   |   |   |   |   |
| 170        |                   |   |   |   |   |   |   |   |   |   |
| 160        |                   |   |   |   |   |   |   |   |   |   |
| 150        |                   |   |   |   |   |   |   |   |   |   |
| 140        |                   |   |   |   |   |   |   |   |   |   |
| 130        |                   |   |   |   |   |   |   |   |   |   |
| 120        |                   |   |   |   |   |   |   |   |   |   |
| 110        |                   |   |   |   |   |   |   |   |   |   |
| 100        |                   |   |   |   |   |   |   |   |   |   |
| 90         |                   |   |   |   |   |   |   |   |   |   |
| 80         |                   |   |   |   |   |   |   |   |   |   |
| 70         |                   |   |   |   |   |   |   |   |   |   |
| 60         |                   |   |   |   |   |   |   |   |   |   |
| 50         |                   |   |   |   |   |   |   |   |   |   |
| 40         |                   |   |   |   |   |   |   |   |   |   |
| 30         |                   |   |   |   |   |   |   |   |   |   |
| 20         |                   |   |   |   |   |   |   |   |   |   |
| 10         |                   |   |   |   |   |   |   |   |   |   |
| MAP        |                   |   |   |   |   |   |   |   |   |   |
| CRT        |                   |   |   |   |   |   |   |   |   |   |
| O2         |                   |   |   |   |   |   |   |   |   |   |
| SpO2       |                   |   |   |   |   |   |   |   |   |   |
| Temp.      |                   |   |   |   |   |   |   |   |   |   |
| GCS        | /                 | / | / | / | / | / | / | / | / | / |
| Pupils R/L |                   |   |   |   |   |   |   |   |   |   |

## Input Record

Infusion 1 & Site

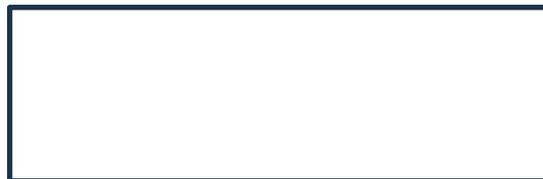
Infusion 2 & Site

|                      | Time (Hourly) |  |  |  |
|----------------------|---------------|--|--|--|
| <b>Rate</b>          |               |  |  |  |
| <b>Hourly Vol.</b>   |               |  |  |  |
| <b>Total Vol.</b>    |               |  |  |  |
| <b>Cannula Check</b> |               |  |  |  |
| <b>Rate</b>          |               |  |  |  |
| <b>Hourly Vol.</b>   |               |  |  |  |
| <b>Total Vol.</b>    |               |  |  |  |
| <b>Cannula Check</b> |               |  |  |  |
| <b>Input Total</b>   |               |  |  |  |

## Output Record

|               | Time (Hourly)       |  |  |  |
|---------------|---------------------|--|--|--|
| <b>Urine</b>  | <b>Hourly Vol.</b>  |  |  |  |
|               | <b>Total Vol.</b>   |  |  |  |
| <b>NG</b>     | <b>Hourly Vol.</b>  |  |  |  |
|               | <b>Total Vol.</b>   |  |  |  |
| <b>Bowels</b> | <b>Hourly Vol.</b>  |  |  |  |
|               | <b>Total Vol.</b>   |  |  |  |
|               | <b>Output Total</b> |  |  |  |

# Neonatal/Paediatric Nurse Led Transfer



## Packaging Checklist

- |   |                          |  |                          |
|---|--------------------------|--|--------------------------|
| Referring hospital handover received              | <input type="checkbox"/> | Restraint securely fastened            | <input type="checkbox"/> |
| Confirm allergies/ infection status/ resus status | <input type="checkbox"/> | Pressure points protected              | <input type="checkbox"/> |
| Confirm clinical OBS stable for transfer          | <input type="checkbox"/> | Blankets/ hats/ transwarmer mattress   | <input type="checkbox"/> |
| O <sub>2</sub> supply on                          | <input type="checkbox"/> | Fluid/ infusions connected and running | <input type="checkbox"/> |
| IV access, invasive devices labelled and checked  | <input type="checkbox"/> | ID bands (x2)                          | <input type="checkbox"/> |
| Monitor and leads checked                         | <input type="checkbox"/> | Soother/comforter                      | <input type="checkbox"/> |

Signed  Date  Time  (24hrs)

## Pre-Departure Checklist

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| Sufficient O <sub>2</sub>                    | <input type="checkbox"/> | Patient property         | <input type="checkbox"/> |
| Sufficient fluids, infusions, drugs          | <input type="checkbox"/> | EBM                      | <input type="checkbox"/> |
| Clinical OBS stable                          | <input type="checkbox"/> | Documents:               | <input type="checkbox"/> |
| IV cannula accessible                        | <input type="checkbox"/> | • Doctor transfer letter | <input type="checkbox"/> |
| Intro to family                              | <input type="checkbox"/> | • Transfer letter        | <input type="checkbox"/> |
| Info to family/ phone numbers checked Family | <input type="checkbox"/> | • OBS/ fluid charts      | <input type="checkbox"/> |
| mode of transport confirmed                  | <input type="checkbox"/> | • Prescription chart     | <input type="checkbox"/> |
|  |                          | Call receiving hospital  | <input type="checkbox"/> |

Signed  Date  Time  (24hrs)

## Ambulance Transfer Checklist

- |                                    |                          |                                      |                          |
|------------------------------------|--------------------------|--------------------------------------|--------------------------|
| Patient secure                     | <input type="checkbox"/> | Bags and equipment secure            | <input type="checkbox"/> |
| Trolley secure                     | <input type="checkbox"/> | Parent intro to vehicle and transfer | <input type="checkbox"/> |
| On ambulance power                 | <input type="checkbox"/> | Route confirmed                      | <input type="checkbox"/> |
| On ambulance O <sub>2</sub> supply | <input type="checkbox"/> | Parent restrained                    | <input type="checkbox"/> |
| Vehicle temperature controlled     | <input type="checkbox"/> | Staff restrained                     | <input type="checkbox"/> |

Signed  Date  Time  (24hrs)

## Notes on Transfer

# Neonatal/Paediatric Nurse Led Transfer

## Handover Checklist

- |   |                          |                                     |                          |
|---|--------------------------|-------------------------------------|--------------------------|
| Team introductions                              | <input type="checkbox"/> | Safety:                             | <input type="checkbox"/> |
| Patient details                                 | <input type="checkbox"/> | • Allergies                         | <input type="checkbox"/> |
| Patient summary                                 | <input type="checkbox"/> | • IPC issues                        | <input type="checkbox"/> |
| Patient reason for transfer/ plan of care       | <input type="checkbox"/> | Handover of patient property        | <input type="checkbox"/> |
| Observations/ fluids/ infusions during transfer | <input type="checkbox"/> | Family details                      | <input type="checkbox"/> |
| Clinical changes during transfer                | <input type="checkbox"/> | Incidents during transfer           | <input type="checkbox"/> |
|   |                          | Photocopy and leave transfer sheets | <input type="checkbox"/> |

Signed  Date  Time  (24hrs)

## Vehicle Details

Ambulance no.

Other vehicle

## Team Details

Driver

Nurse

## Blue Lights Used

No

Yes  (Please give details)

## Transfer Times

|                                    | Date | Time (24hrs) |
|------------------------------------|------|--------------|
| Decision to accept transfer        |      |              |
| Ambulance booked                   |      |              |
| Ambulance and driver arrive        |      |              |
| Team departs base                  |      |              |
| Team arrives at referring hospital |      |              |
| Team departs referring hospital    |      |              |
| Team arrives at receiving hospital |      |              |
| Team departs receiving hospital    |      |              |
| Team returns to base               |      |              |

## Neonatal/Paediatric Transfer Cancellation

### Cancellation by referring hospital

(Please give details)

### Cancellation by nurse led team

(Please give details)

# Neonatal/Paediatric Nurse Led Transfer

## Delays/ Adverse Incidents

**Delays** No   
Yes  (Please give details)

**Adverse incidents** No   
Yes  (Please give details)

**Datix to be completed** No   
Yes  (Please give details)

## Return to Base Checklist

- |                              |                          |  |             |                          |
|------------------------------|--------------------------|--|-------------|--------------------------|
| Team debrief                 | <input type="checkbox"/> | Trolley bag                                      | • Cleaned   | <input type="checkbox"/> |
| Trolley:                     | <input type="checkbox"/> |  | • Restocked | <input type="checkbox"/> |
|                              | <input type="checkbox"/> |  | • Checked   | <input type="checkbox"/> |
| O <sub>2</sub> cylinder (x2) | <input type="checkbox"/> | Inform other teams of return to base             |             | <input type="checkbox"/> |
|                              | <input type="checkbox"/> | Charge mobile phone                              |             | <input type="checkbox"/> |
|                              | <input type="checkbox"/> | Transfer form returned to transport co-ordinator |             | <input type="checkbox"/> |
|                              | <input type="checkbox"/> |  |             |                          |

Signed  Date  Time  (24hrs)

## Suggestions

Please provide any suggestions for service improvements. Your contribution is valued.