NISTAR NEONATAL CRITICAL CARE TRANSFERS

AT RECIEVING HOSPITAL

TEMPERATURE:				BLOOD GLUCOSE:	
BLOOD GAS:	PH	PO2	PCO2:	HCO3:	BASE EXCESS:

TRANSPORT UNDERTAKEN BY:

SIGNATURE:	PRINT:	DESIGNATION:	DATE:

TIMINGS OF CALLS– PLEASE RECORD IN 24HR CLOCK FORMAT

REFERRAL CALL		TEAM ARRIVE REFERRAL	
REFERRAL ACCEPTED		TEAM DEPART REFERRAL	
AMBULANCE CONTACTED		TEAM ARRIVE RECIEVING	
PICU NOTIFIED		TEAM DEPART RECIEVING	
AMBULANCE ARRIVE		PARENTS OFFERED TO TRAVEL PARENTS TRAVELLED WITH BABY	Y/N Y/N
REFER CONTACTED		FAMILY CONTACTED ON DEPARTURE FAMILY CONTACTED ON ARRIVAL	Y/N Y/N
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	
KIT CLEANED AS PER PROTOCOL: SIGNATURE:			

ADVERSE INCIDENTS DURING TRANSFER

IR1 FORM COMPLETED YES/NO SIGNATURE:

INCIDENT	ACTION REQUIRED
AMBULANCE BOOKING REF	
LIGHTS AND SIRENS	YES/NO

NISTAR NEONATAL CRITICAL CARE TRANSFERS

CRITICAL CARE RETRIEVAL ☐ TREATMENT/INVESTIGATION ☐ DATE:

NAME: M/F		APGAR SCORES @ (1) (5) (10) min	
D/O/B : TIME OF BIRTH:		GESTATION: CURRENT GESTATION:	
BIRTH WEIGHT: CURRENT WEIGHT:		VITAMIN K: YES/NO	DOSE: ROUTE:
HOSPITAL No:		H&C No:	

REFERRING HOSPITAL:	RECEIVING HOSPITAL:
REFERRING CONSULTANT:	RECEIVING CONSULTANT:
REFERRING CONTACT TEL. No:	RECEIVING CONTACT TEL. No:

MOTHER'S NAME:			PARENTS AWARE OF TRANSFER: YES/NO
PARITY:	EDD:	PROM: Y/N DURATION: h	ANTENATAL STEROIDS: YES/NO
MATERNAL BLOOD GROUP:		MATERNAL ANTIBODIES:	
HEPATITIS B STATUS: Positive/negative	HIV STATUS: Positive/negative	RUBELLA STATUS: Positive/negative	GBS: YES/NO
MODE OF DELIVERY & INDICATIONS:			RELEVANT ANTENATAL EVENTS: (Umbilical Dopplers, anomaly scan, maternal drugs, antibiotics in labour, etc.)
FETAL DISTRESS YES/NO	CORD pH:		
LIQUOR:			
RESUSCITATION REQUIRED:			RELEVANT MEDICAL HISTORY:

AIRWAY:	PATENT ☐ INTUBATED ☐ SIZE..... TAPED AT.....cm	**BREATHING:**	SPONTANEOUS ☐ RESPIRATORY RATE..... $Sp0_2$.....in.....O_2 CPAP ☐ CPAP PRESSURE.....cmH_2O IPPV ☐ VENTILATOR: RATE:.....PIP.....PEEP.....$FI0_2$.....
CIRCULATION:	IV LINES ×..... CVL: Y/N IA LINE: Y/N	HEART RATE.....	CAPILLARY REFILL TIME:..... BP...../..... MEAN BP.....
DISABILITY:	BLOOD GLUCOSE.....mmol/l	TEMPERATURE.....°C	PUPILS: (R).....(L).....
DRUGS:	INOTROPES: DOPAMINE/DOBUTAMINE/ADRENALINE (circle) ANTIBIOTICS:	OTHER DRUGS:	
FLUIDS:	.....ml of .....BOLUS GIVEN .....ml/hr.....INFUSION .....ml/hr.....INFUSION .....ml/hr.....INFUSION	**INFECTION STATUS:**	

ADVICE GIVEN BY NISTAR (in order of priority): **ADVICE GIVEN BY.....**

1)	3)
2)	4)

SIGNATURE: DATE: TIME:

PRE-TRANSPORT CHECKLIST			
ENSURE THE FOLLOWING EQUIPMENT IS PRESENT AND FUNCTIONING			
AIR CYLINDERS (FULL)		MONITOR LEADS	
O_2 CYLINDERS (FULL)		BP TRANSDUCER**CHECK ALL BUNGS**	
NITRIC OXIDE CYLINDER/CIRCUIT		O_2 BAGGING SET	
VENTILATOR		SELF INFLATING BAG	
VENTILATOR CIRCUIT		SUCTION	
INCUBATOR (FULLY CHARGED)		SUCTION CATHETERS	
MONITOR		STETHOSCOPE	
INFUSION PUMPS (AT LEAST 4)		TEMPERATURE PROBE	
TRANSPORT EQUIPMENT BAGS		HUMIDIFICATION	
EMERGENCY DRUGS		WARM CLOTHING	
DOCUMENTATION **Photocopy handover sheet**		FOOD	
MOBILE PHONE		MONEY	

PRE-TRANSPORT CHECKLIST			
	YES	NO	N/A
THEATRE CHECK LIST			
NAME BANDS × 2			
CONSENT FORM			
BLOOD ORDERED			
CJD FORM			
INFANT'S NOTES			
FLUID BALANCE SHEET			
DRUG KARDEX			
BLOOD RESULT FORM			
INVESTIGATION REQUEST FORM			
MILK			
BABY PERSONAL ITEMS			
INFECTION STATUS: **TROLLEY 1 2**	**NORTHERN IRELAND NEONATAL NETWORK INFECTION CONTROL FORMS** Yes/No		

NISTAR NEONATAL CRITICAL CARE TRANSFERS

POST TRANSFER NOTES:

DURING TRANSFER NOTES:

NISTAR NEONATAL CRITICAL CARE TRANSFERS

MOTHER'S NAME:	MOTHER'S MOBILE NUMBER:
PARTNER'S NAME:	PARTNER'S MOBILE NUMBER:
ADDRESS: POST CODE:	GP NAME : ADDRESS: TELEPHONE NUMBER:
PARENTS HAVE PHOTOGRAPH OF BABY: YES/NO	ACCOMODATION AVAILABLE FOR PARENTS: YES/NO
RELIGION:	**PHCHR** (Red Book): YES/NO **UNOCINI** : YES/NO

IS THE INFANT INVOLVED IN ANY RESEARCH: Yes/No **RELEVANT PAPER WORK TO GO WITH INFANT** :Yes/No

CURRENT MEDICATION

DATE STARTED	NAME	DOSE	TIMES DUE	LAST GIVEN

BLOOD GASES

ON ARRIVAL @.....h cap/art	RESULTS	AT DEPARTURE @ .....h cap/art	RESULTS
pH		pH	
PCO_2		PCO_2	
PO_2		PO_2	
$HC0_3$		$HC0_3$	
BE		BE	

BLOOD RESULTS

DATE AND TIME OF FBP	DATE AND TIME OF U&E .....
Hb	Na
PCV	K
WCC	Urea
PLTS	Creatinine
	SBR
	Glucose
	Ca++
	Mg
	PO_4
	Albumin
	CRP

CLOTTING SCREEN:	BLOOD GROUP:
PT	
APPT	MATERNAL ANTIBODIES:
TCT	
FIB	

ANTIBIOTIC LEVELS

VANCOMYCIN
GENTAMICIN
AMIKACIN

IV FLUIDS AND ENTERAL FEEDS

Fluids/feeds: total.....ml/kg
Full feeds: yes/no ..... ml..... hrly Type: Additives: yes/no Type:
IV fluids: yes/no .....ml.....hrly Type:
Under Care of Dietician?: yes/no Diet sheet enclosed: yes/no Feeding Regime:
Speech and Language Referral: yes/no
Mother wishes to breast feed: yes/no

ANY RECENT INVESTIGATIONS (X-rays, Echo, Ultrasound, CT or MRI): Copies of Results.

NEWBORN BLOOD SPOT SCREENING

Before Blood Transfusion Date:		Day 5 Date:		Day 28 (If Born Below 32 Weeks) Date:	

NISTAR NEONATAL CRITICAL CARE TRANSFERS

HSC nistar northern ireland specialist transport & retrieval

INFANT'S NAME:	H&C No:	DATE:

TYPE OF RESPIRATORY SUPPORT:

VENTILATED ☐	SIZE OF TUBE	TAPED AT :	NASAL, ORAL OR TRACHEOSTOMY
CPAP ☐	PRONG/MASK SIZE:		
O_2 VIA NASAL SPECS ☐ O_2 VIA TRACHEOSTOMY ☐	HIGH/LOW FLOW	 cc	HUMIDIFIED: YES/NO
AMBIENT O_2 ☐	.....................................%	HUMIDIFIED: YES/NO	
ROOM AIR ☐	CYCLING OFF O_2: YES/NO	NEEDS O_2 FOR FEEDING: YES/NO	

TIME (24 h)	PRE-DEPART											
FiO_2												
PRESSURES												
MAP (cmH_2O)												
RATE												
INSPIRATORY TIME (s)												
I:E RATIO												
END TIDAL CO_2												
NO (ppm)												
NO_2 (ppm)												
Humidity Temperature (°C)												
OBSERVATIONS												
Heart rate												
Respiration rate												
Pre-ductal SpO_2												
Post-ductal SpO_2												
Blood pressure Invasive/NIBP												
Colour												
Temperature (°C)												
Incubator Temperature (°C)												
Capillary blood glucose (mmol/l)												
Pupil Reaction												

NISTAR NEONATAL CRITICAL CARE TRANSFERS

HSC nistar northern ireland specialist transport & retrieval

INFANT'S NAME :	H&C No:	DATE:

TOTAL FLUIDS: ml/kg/day **TOTAL INPUT PRIOR TO DEPARTURE:** ml

TIME (24 h):												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
INFUSION: IV/CVL/UVC												
CHECK SITE SECURITY												
ARTERIAL INFUSION: UAC/PERIPHERAL												
CHECK SITE SECURITY												

OGT ☐ JT ☐ TAPED AT: cm. GASTRIC VOLUME TOTAL PRIOR TO DEPARTURE: ml

GASTRIC VOLUME												

BOWELS OPEN: YES/NO BLOOD IN STOOLS: YES/NO URINE VOLUME PRIOR TO DEPARTURE: ml

URINE OUTPUT (ml) CATHETERISED: Y/N												
DRAIN 1 VOLUME:												
DRAIN 2 VOLUME:												

NAME OF FLUID	ADDITIVES	RATE ml/h	TIME TO BE STARTED	TIME TO BE COMPLETED	PRESCRIBED BY:	ERECTED BY:	CHECKED BY:

PLEASE PRESCRIBE ANY DRUGS GIVEN DURING TRANSFER ON MEDICINE KARDEX