YORKSHIRE NEONATAL NETWORK
TRANSPORT TEAM DOCUMENTATION

To be filled in by transport ANNP/doctor on acute transfer or by nurse on non-acute

PLEASE PHOTOCOPY ALL SHEETS AND PUT 1 COPY IN BABY'S NOTES AS RECORD OF TRANSFER AND 1 COPY IN TRANSPORT FOLDER

Date ……………………… **Time** ……………………………………

Transport team doctor/ ANNP …………………… **Transport team nurse** ……………………

Referring hospital: ………………………….. ☎ ………………………………………

Receiving hospital / ward :…………………… ☎ ………………………………………

Consultant on-call (rec. end):…………………………………

Name of infant:……………………………… **DOB**……………………………………

Gestation: …………………………………… **Sex : M / F**

Birth weight………………… **Current weight** ………………………

Reason for transfer/Diagnosis……………………………………….

Category of transfer: (circle one)

Planned
Transfers which are anticipated including elective surgery (PDA), transfers back to local units, or patient attendances

Or

Unplanned transfers not anticipated. Any transfer for on-going care where referring unit is unable to provide care for whatever reason

Reason for transfer: (circle one)

Ongoing neonatal care
OR
Transfer back to local units
OR
Out patient attendance transfer for specialist opinion, investigation or treatment where infant returns to base unit afterwards

Time of 1st contact with referring hospital	Ambulance called at	Ambulance called for (category of call)	Booking reference number	Ambulance arrived at base (LGI)
Left base (LGI)	**Arrived referring hospital**	**Left referring hospital**	**Arrived receiving hospital**	**Arrived back at base**

CONDITION OF INFANT

	Acute transfers	Acute transfers	Acute transfers	Back transfers
	ON ARRIVAL AT REFERRING UNIT	IMMEDIATELY PRIOR TO TRANSFER	ON COMPLETON OF TRANSFER PRIOR TO MOVING TO COT	TO BE FILLED IN WITH 1ST DAY POST TRANSFER PHONE CALL FOR NATIONAL AUDIT PURPOSES
Date / Time				
Temperature				
Mean BP				
Blood Sugar				
Ventilation CPAP or ventilated				
Pressures				
FiO_2				
Rate (if ventilated)				
Low flow oxygen				
Blood gases (if applicable) pH				
$PaCO_2$				
End Tidal CO_2 if applicable				
PaO_2				
HCO_3				
BE				
Saturations				

Clinical examination at referring unit:

Colour: Temp ……………. ^{O}C

Sats: ………… in …% O2 ETT in situ Y / N oral / nasal size.............

Access:

Arterial UAC Periph

Venous UVC Long line Peripheral 1 / 2 / 3

Have you reviewed X-ray position of central lines?

Cranial USS : Y / N Date………………….

Result…………………………………………………………………………………………
……

Infusions: Inotropes Y /N TPN Y /N

Morphine Y /N Dextrose solution Y /N

i.v. Prostin Y /N Paralysed Y /N

Management / changes at referring hospital:

Ventilation:

Circulation / Fluids:

Nitric oxide: **Y / N …….. ppm**

Medications:

Other procedures:

Advice from receiving consultant
If needed

CHECKLIST

Informed parents	☐	Consent (if applicable)	☐
Parent info leaflet given	☐	Photo of baby for parents	☐
Copies of x Rays	☐	Copies of Notes	☐
Informed receiving hospital of baby's condition	☐	Maternal blood sample	☐
Study forms/documentation e.g.EPICURE	☐	Informed receiving hospital when leaving	☐

Transfer

PROBLEMS

	YES	NO
Ambulance	☐	☐
Equipment	☐	☐
Staff	☐	☐

DELAY

	YES	NO
Ambulance	☐	☐
Equipment	☐	☐
Procedures	☐	☐
Infant	☐	☐
Staff	☐	☐

DESCRIPTION IF YES TO ANY OF THE ABOVE

Other comments/Problems
e.g.,
Drugs not available

Transport doctor signature………………………… Name PRINTED…………………………

Transport nurse signature …………………………. Name PRINTED…………………………..
Date ....