

**YORKSHIRE NEONATAL NETWORK TRANSPORT TEAM  
INFORMATION & AUDIT SHEET - RECEIVING UNIT**

Date ..... Time of first telephone call/contact.....  
Doctor receiving call:..... Referring hospital:.....  
Consultant on-call (rec. end):..... ☎ Referring hospital:.....

---

**FAX COMPLETED FORM TO TRANSPORT TEAM IF RECEIVING UNIT NOT LGI TO : 0113 3928498**

**PATIENT DETAILS**

Patient Name: .....

DOB: ...../...../200... Time ..... Current age .....

Gestation: ..... weeks

Sex: M / F

Birth Weight: ..... grams Current weight:..... grams

Apgar Score: ..... @ 1 min .....@ 5 min .....@ 10 min

Surgical  Medical  Cardiac

Cong Abnormality .....

PROM: Y N If yes for how long ?.....

Maternal steroids: Y N Maternal antibiotics ?.....

Surfactant given: Y N

MRSA status Known Positive  negative  Unknown

Diagnosis/Current  
problem(s):.....

Reason for transfer:.....

## CURRENT MANAGEMENT/STATUS PRIOR TO TRANSFER

PLEASE REFER TO THE YORKSHIRE REGION GUIDELINES FOR NEONATAL STABILISATION PRIOR TO TRANSFER

	<b>Ventilation</b>	<b>ADVICE</b>	<b>BLOOD GAS</b>	<b>ADVICE</b>		<b>ADVICE</b>
<b>AIRWAY</b>	Mode = .....		Art /Cap		Chest X-Ray	
<b>BREATHING</b>	Press. = ...../....		pH = .....		ETT Position .....	
	Rate = ..... /min		CO <sub>2</sub> = ..... kPa		Length .....	
	T <sub>i</sub> = .....		O <sub>2</sub> = ..... kPa		Diameter .....	
	FiO <sub>2</sub> = ..... %		BXS = ..... mmol/L		Ng Tube	
<b>CIRCULATION</b>	BP	Arterial or Non-Invasive		<b>DRUGS</b>	Opiate sedation	
	Mean	..... mm Hg			Muscle relaxants	
	SaO <sub>2</sub>	.....			Surfactant	Type
	Heart rate					No. of doses .....
	Arterial Access	UAC ..... Position..... Peripheral R / L radial / post tibial			Inotropes (add dosage)	Dopamine..... Dobutamine..... Hydrocortisone..... Noradrenaline.....
	IV access	UVC..... Position..... Long Line Position..... Peripheral			Antibiotics (name and dosage)	
	Fluid Type	Tick all that apply 10% dextrose ..... TPN ..... Morphine ..... Midazolam ..... Dopamine ..... Dobutamine .....			Prostin	
	Total fluids	.....mls/hr .....mls/kg/day			Anti-Convulsants.	
	Bolus	.....total mls/kg Saline / HAS / blood			Other	

ENVIRONMENT				
	Core Temperature	.....	Blood Sugar	

**Results if available:**

Hb	CRP	Na	Others:
WCC		K	
Neut		Urea	
Platetlets		Creat	

**Number of infusion pumps required:**

**Any details/ information:**