


YORKSHIRE NEONATAL NETWORK TRANSPORT TEAM
INFORMATION & AUDIT SHEET - REFERRING UNIT

Date Time

Doctor receiving call:..... Receiving hospital:.....

Consultant on-call (rec. end):.....  Receiving hospital:.....

FAX COMPLETED FORM TO TRANSPORT TEAM IF RECEIVING UNIT NOT LGI TO : 0113 3926068

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

AIRWAY BREATHING	Ventilation	ADVICE	BLOOD GAS	ADVICE		ADVICE
	Mode =		Art /Cap		Chest X-Ray	
	Press. =/....		pH =		ETT Position	
	Rate = /min		CO ₂ = kPa		Length	
	T _i =		O ₂ = kPa		Diameter	
FiO ₂ = %		BXS = mmol/L		Ng Tube		
CIRCULATION	BP	Arterial or Non-Invasive		DRUGS	Opiate sedation	
	Mean mm Hg			Muscle relaxants	
	SaO ₂			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 fluidsmls/hrmls/kg/day			Anti-Convulsants.	
Bolustotal mls/kg Saline / HAS / blood		Other			
ENVIRONMENT	Core		Blood Sugar		

Temperature			
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RESULTS AVAILABLE

Haemoglobin
WCC
Neutrophils
Platelets

CRP

Na
K
Urea
Creat

Any others:

Number of infusion pumps in use: