

Job Number Name..... Date

Patient details		NHS No:
Name:		Sex:
D.O.B:	Birthweight	Gestation:
Time of birth:	Current weight:	Current gestation:
Parents Names:		Phone:

Referral details:	Referring hospital:
Date:	Referrer name:
Start time of referring phone call:	Referrer designation:
Call taken by:	Referring consultant
Location of patient (ward)	Contact number:

Reason for Transfer:	Planned <input type="checkbox"/> Unplanned <input type="checkbox"/>
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<input type="checkbox"/> Ventilated Tracheo-oesophageal Fistula +/- atresia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Suspected Cardiac Lesion not responding to prostin <input type="checkbox"/> Intestinal Perforation <input type="checkbox"/> Unstable respiratory or cardiac failure not responding to appropriate management:- - Pneumothorax despite chest drain - Requiring FiO2 100% - PaO ² < 5 KPa on 2x arterial gases - Invasive MBP <GA - PH <7.1 & pCO2 > 9Kpa <p style="text-align: center;">These moves are deemed TIME CRITICAL – Please initiate team ASAP</p>
Criteria not met but consultant decision to treat as time critical Details:

TRANSFER CATEGORISATION (Clinical team to fill in)

CATEGORY OF CARE	ITU	HDU	SCBU			
CLINICAL	General Medical	General Surgical	Specialist Medical	Cardiac	Specialist Surgical	Neurosurgery
				Neurology		ENT
				Respiratory		Cardiothoracic
				Endocrine		
OPERATIONAL	Uplift	Capacity	Repatriation	Palliative Care		
TIME CATEGORY	Time-critical	Immediate	Urgent	Non-urgent		

Receiving Hospital:	
Ward:	Accepting Consultant:
Contact details:	

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REFERRAL

Antenatal History and current problems			
Resus:	Cord Gases		Antenatal steroids?
	Arterial:	Venous:	Full <input type="checkbox"/> Incomplete <input type="checkbox"/>
Apgars:	pH	pH	MgSO4: Yes <input type="checkbox"/> No <input type="checkbox"/>
	BE	BE	Vit K: Yes <input type="checkbox"/> No <input type="checkbox"/>

Respiratory support:	ETT size:	Length:	Tracheostomy type:	Size:
Surfactant 1 st dose: mg/kg	Date/Time:	Additional doses?		
SIMV <input type="checkbox"/> SIPPV/ PC/AC <input type="checkbox"/> VG <input type="checkbox"/> CMV <input type="checkbox"/> HFOV <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> HF/ VT <input type="checkbox"/> LF <input type="checkbox"/> None <input type="checkbox"/>				
Ventilator Settings:		Pre/post ductal SaO2	Ventilation comments:	
PIP / MAP		Nitric <input type="checkbox"/>		
PEEP / Δ P		Date/Time started:		
Ti / Hz		PPM:		
VG ml/kg		Response:	Apnoeas & Bradys?	
Rate				
Fio2				

Clinical observations:					
Heart rate:	/bpm	Temperature:	°C	Respiratory Rate:	/bpm
BP (mean):	mmHg	Urine output:	ml/kg/hr	CRT	secs

Blood gases										
Date	Time	Site	pH	pCO2	pO2	HCO3	BE	Lac	Glucose	Hb

Blood / Investigation Results:

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CVS & Access: ECG <input type="checkbox"/> ECHO <input type="checkbox"/>	
Peripheral IV x <input type="checkbox"/> UAC <input type="checkbox"/> UVC single lumen <input type="checkbox"/> UVC Double lumen <input type="checkbox"/> Long line <input type="checkbox"/> Peripheral art line <input type="checkbox"/>	
Other tubes: NGT <input type="checkbox"/> Size: OGT <input type="checkbox"/> Size: Urinary catheter: <input type="checkbox"/> Replogle tube: <input type="checkbox"/> Size: Chest drain: <input type="checkbox"/> Details:	

Infusions and drugs:	Gastro / surgical :
Maintenance:	Feeds:
Bolus / Inotropes / Infusions:	Last fed:
Medications:	Gastric Aspirate:
Antibiotics	Surgical:

Neurology:
Cooling: Active <input type="checkbox"/> Passive <input type="checkbox"/> Date/time started: Age (in hrs) at 33-34°C (May be before referral) Seizures <input type="checkbox"/> CRUSS <input type="checkbox"/> Anticonvulsants <input type="checkbox"/> Rectal probe Yes / No
Notes:

Imaging / line position:	Parents: Aware of transfer Y / N Maternal transfer required? Y/N Parent wishes to travel? Y/N Parent accommodation needed? Y/N	Safeguarding:
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Clinical Advice given: Date/ Time:	Reminders: Referral unit pre transfer checklist and print drug chart (SONeT website) <input type="checkbox"/> Maternal blood sample <input type="checkbox"/> Preterm birth – request placental swab <input type="checkbox"/> Chest compressions and adrenaline required at delivery – request placental histology <input type="checkbox"/> Low Hb at birth – consider maternal Kleihauer test <input type="checkbox"/>
Additional notes (Page 11)	

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EXAMINATION & CLINICAL CHANGES:

INTERVENTIONS

Airway and Breathing:	Intubation	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Surfactant	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	ETT reposition	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	ETT securing	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Ventilation	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	HFOV	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	iNO	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Thoracentesis	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Chest drain	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	CXR	RH <input type="checkbox"/> SOnET <input type="checkbox"/>

Cardiovascular & Vitals:	CPR	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	ECG	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	ECHO	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Inotropes	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Defib	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Prostin	RH <input type="checkbox"/> SOnET <input type="checkbox"/>

Neuro/Pain/Sedation:	CrUss	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Cooling (passive)	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Cooling (active)	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	CFM	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Sedation	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Paralysis	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Anticonvulsant	RH <input type="checkbox"/> SOnET <input type="checkbox"/>

Gastro/Surgical:	NGT/OGT	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Urine Catheter	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	AXR	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Replegle	RH <input type="checkbox"/> SOnET <input type="checkbox"/>

Lines/Fluids:	IV periph access	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	UVC	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	UAC	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Periph art line	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Long line	RH <input type="checkbox"/> SOnET <input type="checkbox"/>
	Blood products	RH <input type="checkbox"/> SOnET <input type="checkbox"/>

Medication/Infection:	Parents: Updated <input type="checkbox"/> Travelling with baby? Y / N Details:	Safeguarding:
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Lines / Imaging:				Imaging:
Line / Tube	Type / Size	Length	Site / Tip	

NOTES/EXAMINATION

Additional notes (Page 11)

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DRUG CHART

ALLERGIES				WORKING WEIGHT (kgs)			
STAT DRUGS							
Time	Drug	Dose	Route	Prescriber (PRINT NAME AND SIGN)	Given by	Checked by	Date/Time given

Fluid Prescription									
Route	Fluid	Total vol	Additives	Rate MI/hr	Prescriber (PRINT NAME AND SIGN)	Batch no	Added by	Check by	Date/Time Started

Continuous Drug Infusions									
Route	Drug	Total amount of drug	Diluents	Total Vol	Rate	Prescriber (PRINT NAME AND SIGN)	Added by	Check by	Date/Time Started

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TRANSFER SIGN OFF

Referring Hospital

Date:	Name of person giving handover:		Signature:	
Time:	Name of person receiving handover:		Signature:	
Present at Handover : (please circle)	Referring Team:	Referring Specialist	Transport Team:	Other:
	Consultant/ Doctor / ANNP / Nurse	Parents	Consultant/ Doctor / ANNP / Nurse	

Pre departure (from referring unit)

Copies of patient notes/charts		Gas supply checked	
Copy of drug chart		Lines / tubes secured	
Discharge Summary		Name Bands x 2	
Imaging PACS linked or copy		Blood sugar / gas checked	
Maternal blood sample (if applicable)		Temperature- Transwarmer/ bubble wrap?	
Pre transfusion blood spot (if applicable)		Hospital feedback form	
Toys / clothing / cards		Parent contact details	
Child health record (red book)		Parents given Transport PIL	
Babies EBM/feeds		Parents given Feedback survey	

Uneventful transfer Parents updated

Events during transfer:

Handover at receiving hospital

Date:	Name of person giving handover:		Signature:	
Time:	Name of person receiving handover:		Signature:	
Present at Handover: (please circle)	Receiving Team:	Receiving specialist	Transport Team:	Other:
	Consultant/ Doctor / ANNP / Nurse	Parents	Consultant/ Doctor / ANNP / Nurse	

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ADDITIONAL INFORMATION/EXAMINATION

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TRANSFER TIMES:

Date of decision:		Time of Decision:	
Mode of transfer:	Road	Helicopter	Fixed wing
Location of team at time of call:	Base	Other hospital	On route
Ambulance with team		Ambulance requested:	Ambulance arrived:
Depart base/other hospital/same hospital:			
Arrive at referring unit:		Leave referring unit:	
Arrive at receiving unit:		Leave receiving unit :	
Time back at base or ready for next job:			
Any delays? Yes/No		Reason:	
Blue lights:	Agreed by Consultant? Yes / No	To referring unit Yes / No To receiving unit Yes / No	Reason:

TRANSPORT TEAM:

Transport Doctor:	
Transport ANNP:	
Transport Nurse:	
Driver:	
Transport Consultant:	On transfer? Yes/No

TEAM UNABLE TO COMPLETE TRANSFER

Reason:		
Other teams asked for support:		
Name	Person contacted/time	Able to transfer? Time of decision
Oxford SONeT		
SORT		
Other team(s)		
Transfer refused/cancelled:		Reason:

Significant issue: Yes / No		Incident form completed: Yes / No	
Category:	Administrative	Communication	Vehicle
	Equipment	Delays	Other
	Clinical	Training	

CASE REVIEW

Present:
Good points:
Learning points: