

# SOUTHAMPTON OXFORD RETRIEVAL TEAM

# PICU REFERRAL/RETRIEVAL FORM

Retrieval request: ☐

Request for advice: ☐

Referring Consultant:

Safeguarding concerns? YES ☐ NO ☐

PICU Consultant:

Call taken by:

Date:

Time:

Surname:

First name:

House/number:

Town:

Post code:

GP:

Hosp No:

NHS No:

Date of birth:

Age: YEARS

MONTHS

WEEKS

DAYS

Weight:

Sex: Male ☐ Female ☐

Covid-19 Status: Pos ☐ Neg ☐

Unknown ☐

Referring hospital:

Specific location of child:

Contact details:

Referring doctor:

Specialty:

Grade of referring doctor/nurse:

☐ Consultant/AS/SG ☐ GP

☐ ST4-8 ☐ ANP

☐ ST1-3 ☐ Nurse

☐ F1/F2 ☐ Unknown

Primary diagnosis:

## DASHBOARD DATA

### Retrieval accepted

### Time we left PICU

### If delay >30mins state why

- ☐ Technician availability
- ☐ Nursing availability
- ☐ Doctor's availability
- ☐ Retrieval team out
- ☐ Shift change
- ☐ Ambulance availability
- ☐ Other

## HISTORY (use obs box below)

### ABC AT REFERRAL

A/B		C			D			
Saturations		Heart rate			A	V	P	U
Pre/Post Ductal SpO <sub>2</sub>		BP						
FiO <sub>2</sub> /Flow		CRT		T°C	GCS TOTAL		/15	
Resp rate		Access				E/M/V		
WOB		Fluid boluses			Pupils/Focal signs			
IF VENTILATED								
Tube details		Inotropes			Sedation/Muscle relaxants			
Ventilator settings		Antibiotics						
		Urine Output						
		CXR						

### Laboratory results

Blood gas analysis						Other results				
Time(C/V/A)	pH	PaO <sub>2</sub>	PaCO <sub>2</sub>	BE/HCO <sub>3</sub>	Lactate	Glucose	Hb		Na <sup>+</sup>	
:							WC		K <sup>+</sup>	
:							INR		Ur/Cr	
:							Plat		CRP	

PICU ADVICE:

FOLLOW UP CALL:

DATE:

TIME:

NAME OF CALLER:

Was the patient receiving invasive ventilation (by ET tube LMA or tracheostomy) at the time of the referral call?

- ☐ Yes
- ☐ No – not indicated
- ☐ No – advised to intubate
- ☐ Unknown

Transport team

Destination unit

#### Outcome of this referral event

##### Transport outcome

- ☐ Accepted for transport
- ☐ Refused - no transport team available
- ☐ Refused - time critical transfer
- ☐ Refused - out of scope of care
- ☐ Transport not requested

##### Admission outcome

- ☐ Accepted for admission
- ☐ Refused - no staffed beds available
- ☐ Refused - out of scope of care
- ☐ Admission not requested

#### Date and time accepted for transport

		:					

#### Transport number

#### Type of transport team

- ☐ PICU
- ☐ Centralised transport service
- ☐ Transport team from neonates
- ☐ Other specialist team
- ☐ Other non-specialist team

#### Transport team

#### Grade of clinical team leader:

- ☐ Consultant/AS/SG
- ☐ ST4 – 8
- ☐ ST1 – 3
- ☐ Nurse practitioner

#### Speciality of clinical team leader

#### Grade of most senior nurse

- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ not present

#### Collection area

- ☐ X-ray/endoscopy/CT
- ☐ Recovery only
- ☐ HDU
- ☐ Other intermediate care area
- ☐ Theatre & recovery

#### Collection unit / location

#### Most senior member of medical staff at collection unit

- ☐ Consultant/AS/SG
- ☐ ST4 – 8
- ☐ ST1 – 3
- ☐ None

#### Did a medical technician accompany the patient?

- ☐ Yes
- ☐ No

#### Did a parent accompany patient on transport?

- ☐ Yes
- ☐ No - parent not present
- ☐ No - parent declined to accompany
- ☐ No - parent not permitted to accompany

#### Outcome of this transport event

- ☐ Patient transported
- ☐ Not transported-condition improved
- ☐ Not transported-condition deteriorated
- ☐ Not transported-other reason
- ☐ Patient died before team arrived
- ☐ Patient died while team present
- ☐ Patient died during transport

#### Destination type

- ☐ PICU
- ☐ NICU
- ☐ ICU
- ☐ HDU
- ☐ Ward
- ☐ Theatre
- ☐ Other transport service
- ☐ Normal residence
- ☐ Hospice

#### Destination Unit / location

### ABC ON ARRIVAL OF SORT TEAM AT COLLECTION AREA

A/B		C			D			
Saturations		Heart rate			A	V	P	U
Pre/Post Ductal SpO <sub>2</sub>		BP						
FiO <sub>2</sub> /Flow		CRT		T°C	GCS TOTAL		/15	
Resp rate		Access			E/M/V			
WOB		Fluid boluses			Pupils/Focal signs			
IF VENTILATED								
Tube details								
		Inotropes			Sedation/Muscle relaxants			
Ventilator settings		Antibiotics						
		Urine Output						
		CXR						

<p><b>Interventions by local team prior to team's arrival (tick all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Primary intubation</li> <li><input type="checkbox"/> Re-intubation</li> <li><input type="checkbox"/> Other airway</li> <li><input type="checkbox"/> Non-invasive ventilation</li> <li><input type="checkbox"/> Primary central venous access</li> <li><input type="checkbox"/> Additional central venous access</li> <li><input type="checkbox"/> Arterial access</li> <li><input type="checkbox"/> Inotrope or vasopressor infusion</li> <li><input type="checkbox"/> Prostaglandin infusion</li> <li><input type="checkbox"/> Primary intraosseous access</li> <li><input type="checkbox"/> Additional intraosseous access</li> <li><input type="checkbox"/> Chest drain insertion</li> <li><input type="checkbox"/> ICP monitoring</li> <li><input type="checkbox"/> ECMO</li> </ul> <p><b>Interventions while the transport team in attendance</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Primary intubation</li> <li><input type="checkbox"/> Re-intubation</li> <li><input type="checkbox"/> Other airway</li> <li><input type="checkbox"/> Non-invasive ventilation</li> <li><input type="checkbox"/> Primary central venous access</li> <li><input type="checkbox"/> Additional central venous access</li> <li><input type="checkbox"/> Arterial access</li> <li><input type="checkbox"/> Inotrope or vasopressor infusion</li> <li><input type="checkbox"/> Prostaglandin infusion</li> <li><input type="checkbox"/> Primary intraosseous access</li> <li><input type="checkbox"/> Additional intraosseous access</li> <li><input type="checkbox"/> Chest drain insertion</li> <li><input type="checkbox"/> ICP monitoring</li> <li><input type="checkbox"/> ECMO</li> </ul>	<p><i>PIM2 / PIM3 applies to observations recorded in the 1<sup>st</sup> hour after face to face contact with the transport team doctor</i></p> <p>Elective admission  <input type="checkbox"/> Tick if this is an elective admission</p> <p><b>Main reason for admission</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bronchiolitis</li> <li><input type="checkbox"/> Croup</li> <li><input type="checkbox"/> Obstructive SA</li> <li><input type="checkbox"/> Recovery from surgery</li> <li><input type="checkbox"/> Diabetic ketoacidosis</li> <li><input type="checkbox"/> Seizure disorder</li> <li><input type="checkbox"/> Other (none of the above)</li> </ul> <p><b>Is there evidence available to assess past medical history?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes, tick all that apply</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cardiac arrest before admission</li> <li><input type="checkbox"/> Cardiac arrest OUT of hospital</li> <li><input type="checkbox"/> Cardiomyopathy or myocarditis</li> <li><input type="checkbox"/> SCID</li> <li><input type="checkbox"/> Hypoplastic left heart syndrome</li> <li><input type="checkbox"/> Leukaemia/lymphoma after 1<sup>st</sup> induction</li> <li><input type="checkbox"/> Liver failure main reason for admission</li> <li><input type="checkbox"/> Acute NEC main reason for admission</li> <li><input type="checkbox"/> Spontaneous cerebral haemorrhage</li> <li><input type="checkbox"/> Neurodegenerative disorder</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Bone marrow transplant recipient</li> </ul>	<p><b>Systolic blood pressure</b></p> <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; background-color: #ccc;"></div> <div style="width: 10px; height: 10px; background-color: #ccc;"></div> <div style="width: 10px; height: 10px; background-color: #ccc;"></div> </div> mmHg
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<p><b>Pre transfer Management</b></p> <p><b>Pre transfer checklist</b></p> <ol style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> </ol>	<p><b>Pre transfer checklist</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Airway</li> <li><input type="checkbox"/> Ventilation</li> <li><input type="checkbox"/> Bagging Circuit</li> <li><input type="checkbox"/> Mask</li> <li><input type="checkbox"/> Enough Vascular Access</li> <li><input type="checkbox"/> Blood Sugar</li> <li><input type="checkbox"/> Maintenance Fluid</li> <li><input type="checkbox"/> NMB</li> <li><input type="checkbox"/> NG Tube</li> <li><input type="checkbox"/> Urinary Catheter</li> <li><input type="checkbox"/> Temperature Probe</li> <li><input type="checkbox"/> Eyes Taped</li> <li><input type="checkbox"/> Emergency Drugs</li> <li><input type="checkbox"/> Intubation Drugs</li> <li><input type="checkbox"/> Spoken to Family</li> </ul>
<p><b>PARENTS CONTACT DETAILS</b></p>	
<p><b>Mother's name:</b></p>	<p><b>Father's name:</b></p>
<p><b>Contact No:</b></p>	<p><b>Contact No:</b></p>
<p><b>Transport:</b> <input type="checkbox"/> Ambulance <input type="checkbox"/> Own Transport</p>	<p><b>Transport:</b> <input type="checkbox"/> Ambulance <input type="checkbox"/> Own Transport</p>



Drug and other Allergies/Sensitivities						Signature		
						Name		

Date	Time	MAINTENANCE FLUIDS	Rate	Route	Prescriber's Signature/name	Time started	Given by	Checked by

Date	Time	Drug/Fluid (approved name)	Dose	Route	Prescriber's Signature/name	Time given	Given by	Checked by

Drug (Approved name)		Infusion Fluid	Signature		Administration		
Heparin					Date		
Dose	Volume	0.9% Saline	Name		Start		
500 I.U.	500 mls				Finish		
Instruction		Rate	Date/Time		Initials		
Arterial/ CVP flush							

Drug (Approved name)		Infusion Fluid	Signature		Administration		
					Date		
Dose	Volume		Name		Start		
					Finish		
Instruction		Rate	Date/Time		Initials		

Drug (Approved name)		Infusion Fluid	Signature		Administration		
					Date		
Dose	Volume		Name		Start		
					Finish		
Instruction		Rate	Date/Time		Initials		

Drug (Approved name)		Infusion Fluid	Signature	Administration		
				Date		
Dose	Volume		Name	Start		
				Finish		
Instruction		Rate	Date/Time	Initials		

Drug (Approved name)		Infusion Fluid	Signature	Administration		
				Date		
Dose	Volume		Name	Start		
				Finish		
Instruction		Rate	Date/Time	Initials		

Drug (Approved name)		Infusion Fluid	Signature	Administration		
				Date		
Dose	Volume		Name	Start		
				Finish		
Instruction		Rate	Date/Time	Initials		

**Management during transfer:**

#### HANDOVER DETAILS

RECEIVING NURSE

PICU CONSULTANT

RECEIVING DOCTOR

NOMINATED PAED CONS

Time																	
TEMPERATURE																	
<div>Blood Pressure</div> <div>V</div> <div>Pulse</div> <div>●</div> <div>CVP</div> <div>✕</div> <div>Respiratory Rate</div> <div>□</div>	200																200
	190																190
	180																180
	170																170
	160																160
	150																150
	140																140
	130																130
	120																120
	110																110
	100																100
	90																90
	80																80
	70																70
	60																60
	50																50
	40																40
	30																30
	20																20
	15																15
10																10	
5																5	

Arrival

PICU

O <sub>2</sub> Sats
E <sub>T</sub> CO <sub>2</sub>
FiO <sub>2</sub>
Rate
PIP/PEEP
I <sub>TIME</sub>


pH
PO <sub>2</sub>
PCO <sub>2</sub>
BE
Lactate
Glucose
