Job Number ..... Name..... Date .....

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

Referral details:	**Referring Hospital:**
Date:	Referrer name:
Time of request:	Referrer designation:
Call taken by:	Referring consultant
Location of patient (ward)	Contact number:
Transfer requested for (date/time):	

Reason for Transfer:

Planned □ Unplanned □

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	Further discussion	
Timescale	< 1 hour	< 6 hours	< 24 hours	≥ 24 hours		

Receiving Hospital/Hospice:	
Ward:	Accepting Consultant:
Contact details:	
Bed available when referred? Yes/No Updates:	
Bed available (date):	Bed confirmed prior to departure ☐

Job Number ..... Name..... Date .....

Main clinical problems:

Respiratory Support: None □ Low flow □ High flow / Vapotherm □ CPAP □ Ventilation □ Tracheostomy type: Size	
Settings: FiO2:	**Cardiovascular:**
IV / Central lines: **NG / OG / Other:**	**Resuscitation status:** **Advanced care plan** □

Clinical observations: (if appropriate)									
Heart rate:	/bpm	Temperature:	^{o}C	Resp rate:	/bpm	BP (mean):		Sats:	%

Medications:	Total Fluids (mls/kg/day):	
	Fluid/feed type and route:	
	Feed frequency:	Last fed:
Allergies:	NG Aspirate:	Consent for dummy: Yes / No

Parents: Aware of transfer Y / N Maternal transfer required? Y/N Parent wishes to travel? Y/N Parent accommodation needed? Y/N	**Specific parental wishes:**	**Safeguarding:**

Plan at receiving unit: Compassionate extubation: Yes / No

Job Number ..... Name..... Date .....

OBSERVATION CHART (if appropriate):

A = Arrival at referring unit S= Stabilisation T = Transport R = Receiving unit

Time											
A S T R											
Heart Rate											
Respiratory rate											
BP											
BP (Mean)											
SpO_2 (pre/post)											
Temp	Axilla										
	Surface										
Inc set	Inc temp										
Transwarmer (T) Bubble wrap (B)											
Respiratory Support	Mode										
	Ppeak/ΔP										
	Pinsp										
	PEEP										
	RATE/Hz										
	MAP										
	I Time										
	TV/VG										
	O_2										
	Flow										
	NO/NO_2										
	$ETCO_2$										
Humidifier temp °C											
Suction											
Comments											

Assessment/examination:

Job Number ..... Name..... Date .....

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

Infusions:

	INFUSION 1				INFUSION 2				Gastric aspirate
FLUID TYPE									
LOCATION									
PUMP NO.									
TIME	Rate	Hourly	Total	Pressure / VIP	Rate	Hourly	Total	Pressure / VIP	

Use additional fluid charts if necessary

Job Number ..... Name..... Date .....

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		Confirm doctor will be present to receive infant	
Advanced care plan		Relevant speciality teams informed	
Copy of drug chart		Social worker/family support contacted	
Discharge Summary		**Transfer after death**	
TTOs (if required)		Letter of authority from hospital	
Toys / clothing		Cremation form 4 (neonatal death) OR	
Babies EBM/feeds		Cremation form 9 (still birth)	
Lines / tubes secured		Baby signed out of hospital by referring team	
Gas supply checked		Death certificate/still birth certificate	

Transfer summary:

Uneventful transfer ☐ Parents updated ☐ Parents travelled ☐

Events during transfer:

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	

Job Number ..... Name..... Date .....

Children's hospices in Wessex (www.togetherforshortlives.org.uk)

Naomi House and Jack's Place Stockbridge Road Sutton Scotney, Winchester SO21 3JE 01962 760555 www.naomihouse.org.uk	**Julia's House Hospice**. 135. Corfe Mullen Road. Wimbourne Dorset 01202389837 www.juliashouse.org	**Chestnut Tree House.** Dover Lane. Arundel West Sussex.BN18 9PX 01903 871800 **www.chestnut-tree-house.org.uk**

Additional Information/Notes:

Job Number ..... Name..... Date .....

Additional Information/Notes:

Job Number ..... Name..... Date .....

TRANSFER TIMES: (Clinical team to fill in)

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: