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:
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		

Receiving Hospital:	
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 □ Tracheostomy type: Size	
Settings:	Flow/ PEEP: FiO2: Apnoeas & Bradys:
IV / Central lines: **NG / OG / Other:**	**Cardiovascular:** **Surgical/xrays:**

Clinical observations:							
Heart rate:	/bpm	Temperature:	^oC	Resp rate:	/bpm	BP (mean):	

Blood gases:											
Date	Time	Site	Type	pH	pCO_2	pO_2	HCO_3	BE	Lac	Glucose	Hb

Medications: **Allergies:**	Total Fluids (mls/kg/day)		
	Fluid/feed type:		
	Feed frequency:	Last fed:	NG Aspirate:

Screening: Guthrie Imms: ROP Screening: Hearing:	**Parents:** Aware of transfer Y / N Maternal transfer required? Y/N Parent wishes to travel? Y/N Parent accommodation needed? Y/N	**Safeguarding:**

Clinical Advice given: Date/ Time:	**Reminders:** Referral unit pre transfer checklist □ Maternal blood sample □

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

OBSERVATION CHART:

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

Time												
A S T R												
Heart Rate	200											
	180											
	160											
	140											
	120											
	100											
	80											
Respiratory rate												
	60											
	40											
BP												
BP (Mean)												
SpO_2 (pre/post)												
Temp	Axilla											
	Surface											
Inc set	Inc temp											
Transwarmer (T) Bubble wrap (B)												
Respiratory Support	Mode											
	Flow											
	PEEP											
	Fio2											
Humidifier temp ^oC												
Blood Gas	Time											
	Site											
	pH											
	PCO_2											
	PO_2											
	HCO_3											
	BE											
	Lactate											
	Glucose											
	Hb											
Suction												
Phototherapy												
Comments												

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

Assessment/examination:

Airway/breathing:	**Cardiovascular:**
Neuro/pain:	**Gastro/surgical:**

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

Infusions:

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

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		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 checked. Transwarmer?	
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	

Transfer summary:

Uneventful transfer ☐ Parents updated ☐

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 .....

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: