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 □ Unplanned □

□ Ventilated Tracheo-oesophageal Fistula +/- atresia □ Gastroschisis

□ Suspected Cardiac Lesion **not responding to prostin** □ Intestinal Perforation

□ 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

These moves are deemed TIME CRITICAL – Please initiate team ASAP

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:	

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

REFERRAL

Antenatal History and current problems			
Resus: Apgars:	**Cord Gases**		Antenatal steroids? Full □ Incomplete □ MgSO4: Yes □ No □
	Arterial: pH BE	Venous: pH BE	Vit K: Yes □ No □

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

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:

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

CVS & Access: ECG □ ECHO □
Peripheral IV x □ UAC □ UVC single lumen □ UVC Double lumen □ Long line □ Peripheral art line □
Other tubes: NGT □ Size: OGT □ Size: Urinary catheter: □ Replogle tube: □ Size: Chest drain: □ Details:

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

Neurology:
Cooling: Active □ Passive □ Date/time started: Age (in hrs) at 33-34°C (May be before referral) Seizures □ CRUSS □ Anticonvulsants □ 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:**

Clinical Advice given: Date/ Time: Additional notes (Page 11)	**Reminders:** Referral unit pre transfer checklist and print drug chart (SONeT website) □ Maternal blood sample □ Preterm birth – request placental swab □ Chest compressions and adrenaline required at delivery – request placental histology □ Low Hb at birth – consider maternal Kleihauer test □

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

EXAMINATION & CLINICAL CHANGES: **INTERVENTIONS**

Airway and Breathing:	Intubation	RH □ SONeT □
	Surfactant	RH □ SONeT □
	ETT reposition	RH □ SONeT □
	ETT securing	RH □ SONeT □
	Ventilation	RH □ SONeT □
	HFOV	RH □ SONeT □
	iNO	RH □ SONeT □
	Thoracentesis	RH □ SONeT □
	Chest drain	RH □ SONeT □
	CXR	RH □ SONeT □

Cardiovascular & Vitals:	CPR	RH □ SONeT □
	ECG	RH □ SONeT □
	ECHO	RH □ SONeT □
	Inotropes	RH □ SONeT □
	Defib	RH □ SONeT □
	Prostin	RH □ SONeT □

Neuro/Pain/Sedation:	CrUss	RH □ SONeT □
	Cooling (passive)	RH □ SONeT □
	Cooling (active)	RH □ SONeT □
	CFM	RH □ SONeT □
	Sedation	RH □ SONeT □
	Paralysis	RH □ SONeT □
	Anticonvulsant	RH □ SONeT □

Gastro/Surgical:	NGT/OGT	RH □ SONeT □
	Urine Catheter	RH □ SONeT □
	AXR	RH □ SONeT □
	Replogle	RH □ SONeT □

Lines/Fluids:	IV periph access	RH □ SONeT □
	UVC	RH □ SONeT □
	UAC	RH □ SONeT □
	Periph art line	RH □ SONeT □
	Long line	RH □ SONeT □
	Blood products	RH □ SONeT □

Medication/Infection:	**Parents:** Updated □ Travelling with baby? Y / N Details:	**Safeguarding:**

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

Lines / Imaging:				**Imaging:**
Line / Tube	Type / Size	Length	Site / Tip	

NOTES/EXAMINATION

Additional notes (Page 11)

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

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 Ml/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

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

TOTAL FLUIDS = ...mls/kg/day = ...mls/hr WEIGHT.....

	INFUSION 1				INFUSION 2				INFUSION 3				INFUSION 4				Gastric aspirate
FLUID TYPE																	
ROUTE																	
PUMP NO.																	
TIME	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP	

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

	INFUSION 5				INFUSION 6				INFUSION 7				INFUSION 8			
FLUID TYPE																
ROUTE																
PUMP NO.																
TIME	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP	Sign changes	Rate	Total	Pressure / VIP

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

ETT size: ETT @ lips: cm A = Arrival at referring unit S= Stabilisation T = Transport R = Receiving unit

Time (24 hr)													
A S T R													
Heart Rate	200												
	180												
	160												
	140												
	120												
	100												
	80												
Respiratory rate													
	60												
	40												
BP (invasive/cuff)	BP												
	Mean												
SpO_2 (pre/post)													
Temp	Axilla												
	Surface												
	Rectal												
Criticool	Set Temp												
	Rectal												
	Skin												
Cooling Active (A) Passive (P)													
Inc set	Inc temp												
Transwarmer (T) Bubble wrap (B)													
Respiratory Support	Mode												
	Ppeak/ΔP												
	Pinsp												
	PEEP												
	RATE/Hz												
	MAP												
	I Time												
	TV												
	O_2												
	Flow												
	NO/NO_2												
	Mode												
Humidifier	Temp												
Transcutaneous CO_2 / ET CO_2													
Blood Gas	Time												
	SITE												
	pH												
	PCO_2												
	PO_2												
	HCO_3												
	BE												
	Lactate												
	Glucose												
	Hb												
Suction (oral / ETT)													
Comments													

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

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	

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

ADDITIONAL INFORMATION/EXAMINATION

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

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: