

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

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

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

<b>Reason for Transfer:</b>
Planned <input type="checkbox"/> Unplanned <input type="checkbox"/>

**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		

<b>Receiving Hospital/Hospice:</b>	
Ward:	Accepting Consultant:
Contact details:	
Bed available when referred? Yes/No Updates:	
Bed available (date):	Bed confirmed prior to departure <input type="checkbox"/>

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

<b>Main clinical problems:</b>

<b>Respiratory Support:</b> None <input type="checkbox"/> Low flow <input type="checkbox"/> High flow / Vapotherm <input type="checkbox"/> CPAP <input type="checkbox"/> Ventilation <input type="checkbox"/>	
Tracheostomy type:                      Size	
Settings:	<b>Cardiovascular:</b>
FiO2:	
<b>IV / Central lines:</b>	<b>Resuscitation status:</b>
<b>NG / OG / Other:</b>	<b>Advanced care plan</b> <input type="checkbox"/>

<b>Clinical observations: (if appropriate)</b>									
Heart rate:	/bpm	Temperature:	°C	Resp rate:	/bpm	BP (mean):		Sats:	%

<b>Medications:</b>	Total Fluids (mls/kg/day):	
	Fluid/feed type and route:	
	Feed frequency:	Last fed:
	<b>Allergies:</b>	NG Aspirate:

<b>Parents:</b> Aware of transfer Y / N Maternal transfer required? Y/N Parent wishes to travel? Y/N Parent accommodation needed? Y/N	<b>Specific parental wishes:</b>	<b>Safeguarding:</b>
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<b>Plan at receiving unit:</b>	Compassionate extubation: Yes / No





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**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		<b>Transfer after death</b>	
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	

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Children's hospices in Wessex ( [www.togetherforshortlives.org.uk](http://www.togetherforshortlives.org.uk) )

**Naomi House and Jack's Place**  
Stockbridge Road  
Sutton Scotney, Winchester  
SO21 3JE 01962 760555  
[www.naomihouse.org.uk](http://www.naomihouse.org.uk)

**Julia's House Hospice.**  
135. Corfe Mullen Road.  
Wimbourne  
Dorset  
01202389837  
[www.juliashouse.org](http://www.juliashouse.org)

**Chestnut Tree House.**  
Dover Lane.  
Arundel  
West Sussex.BN18 9PX  
01903 871800  
[www.chestnut-tree-house.org.uk](http://www.chestnut-tree-house.org.uk)

Additional Information/Notes:

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**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 Equipment Clinical	Communication Delays Training	Vehicle Other

**CASE REVIEW**

<b>Present:</b>
<b>Good points:</b>
<b>Learning points:</b>