

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 <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		

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

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Main clinical problems:

Respiratory Support: None <input type="checkbox"/> Low flow <input type="checkbox"/> High flow / Vapotherm <input type="checkbox"/> CPAP <input type="checkbox"/>	
Tracheostomy type: Size	
Settings: Flow/ PEEP: FiO2: Apnoeas & Bradys:	Cardiovascular:
IV / Central lines:	Surgical/xrays:
NG / OG / Other:	

Clinical observations:										
Heart rate:		/bpm	Temperature:		°C	Resp rate:		/bpm	BP (mean):	

Blood gases:											
Date	Time	Site	Type	pH	pCO ₂	pO ₂	HCO ₃	BE	Lac	Glucose	Hb

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

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:
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Clinical Advice given: Date/ Time:	Reminders: Referral unit pre transfer checklist <input type="checkbox"/> Maternal blood sample <input type="checkbox"/>
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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		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	

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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

Present:
Good points:
Learning points: