NNeTS ACUTE/ADVICE Referrals

Northern Neonatal Transport Service

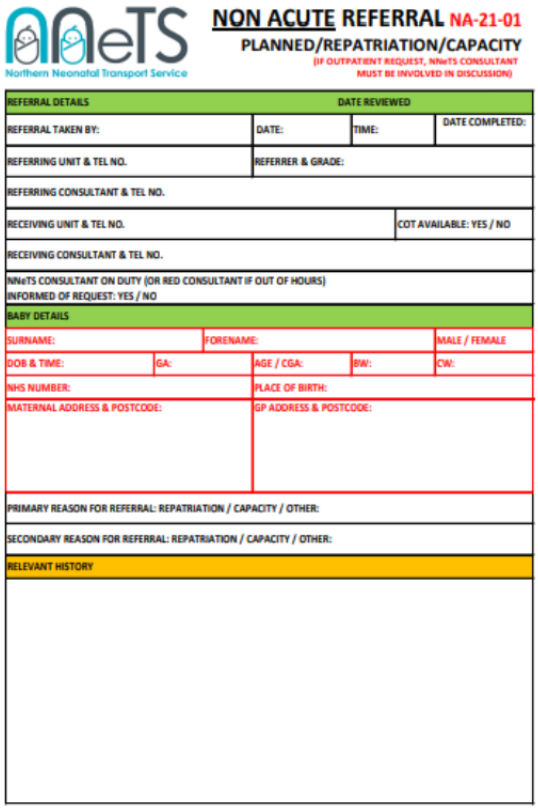
ACUTE/ADVICE REFERRAL

AA-36-01

REFERRAL DETAILS			DATE REVIEWED
REFERRAL TAKEN BY:		DATE:	TIME:
REFERRING CENTRE & TEL NO.		REFERRER & GRADE:	
REFERRING CONSULTANT & TEL NO.		LOCATION: UNIT / EN ROUTE / HOME	
RECEIVING UNIT & TEL NO.			
RECEIVING CONSULTANT & TEL NO.			
NNeTS CONSULTANT ON DUTY (OR RED CONSULTANT IF OUT OF HOURS) INFORMED OF REQUEST: YES / NO			
BABY DETAILS			
SURNAME:	FORENAME:		MALE / FEMALE
DOB & TIME:	GA:	AGE/CGA:	BW: CW:
NHS NUMBER:	MRN		PLACE OF BIRTH:
MATERNAL ADDRESS & POSTCODE:	GP ADDRESS & POSTCODE:		
REASON FOR REFERRAL: MEDICAL / SURGICAL / CARDIAC / ECMO / PICU / ADVICE			CAPACITY: YES / NO
CURRENT STATUS / SITUATION			
DAY TIME & OUT OF HOURS TC/ID REFERRALS CONFERENCE CONS: YES / NO & REFERRING CONS. LOCATION GIVEN: YES / NO			
DELIVERY DETAILS (IF RELEVANT)			
ANTENATAL HISTORY:			
REASON FOR DELIVERY:			ANTENATAL STEROIDS: YES / NO
DELIVERY TYPE: NVD / INSTRUMENTAL / BREECH / ELECTIVE CS / EMERGENCY CS			
RESUSCITATION: NONE / INFLATION BREATHS / IPPV VIA MASK / PEEP / INTUBATED & VENTILATED			
SURFACTANT: YES / NO DOSE:	CPR	DRUGS:	FLUIDS:
SPONTANEOUS BREATHS AT:		TIME TO 1ST GASP:	HR >100 AT:

CURRENT CLINICAL STATUS										
A	NO SUPPORT	LOW FLOW: LPM	HFNC: LPM	CPAP: cmH_2O						
B	VENTILATED ETT SIZE: LENGTH:	MODE:	PIP/PEEP:	RATE:	TI:	NITRIC:	FIO_2:	SATS:		
C	HR:	BP:	CRT:	ACCESS: UVC / UAC / PICC / PERIPHERAL X1 , X2						
	BLOOD GAS: DATE & TIME	VENT MODE	SITE	PH	PCO_2	PO_2	$HCO3^-$	BE	LAC	GLU
			A / V / C							
			A / V / C							
	OTHER RELEVANT BLOOD RESULTS:									
D	NEUROLOGICAL CONCERNS: YES / NO									
	PRETERM	SEIZURES: YES / NO	DESCRIPTION:							
		IVH: YES / NO								
	TERM or HIE	SEIZURES: YES / NO	DESCRIPTION:							
		SUSPECTED HIE: YES / NO	ENCEPHALOPATHY SCORE: MILD / MODERATE / SEVERE							
		COOLING: YES / NO	PASSIVE / ACTIVE	TIME COOLING STARTED:						
E	OTHER EXAMINATION FINDINGS:							TEMP:		
MEDICATION										
INOTROPES:	OTHER MEDICATIONS:									
FLUIDS / FEEDS	TOTAL MLS / KG	10% Dex / 10% DexSal / TPN / OTHER (STATE):								
	METHOD /FREQUENCY:	FEED TYPE:								
IMAGING										
X-RAY: CXR / AXR	X-RAY FINDINGS:	XRAY SENT: YES / NO								
Cr USS FINDINGS:										
INFECTION CONTROL ISSUES										
YES / NO	DETAILS:									
SAFEGUARDING										
CURRENT SAFEGUARDING CONCERNS: YES / NO IF YES, HAVE REFERRING UNIT D/W RECEIVING UNIT YES / NO (IF NOT ADVISE TO DO THIS)										

NON ACUTE Referral



NON ACUTE REFERRAL NA-21-01

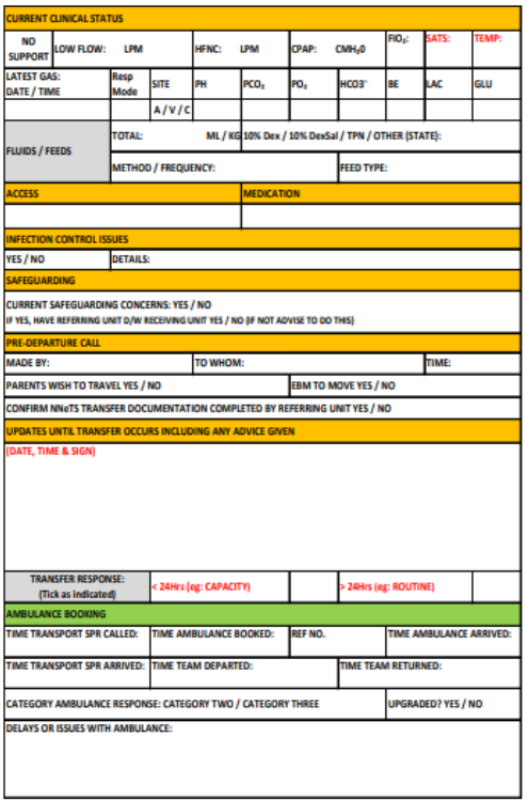
PLANNED/REPATRIATION/CAPACITY

(IF OUTPATIENT REQUEST, NNeTS CONSULTANT MUST BE INVOLVED IN DISCUSSION)

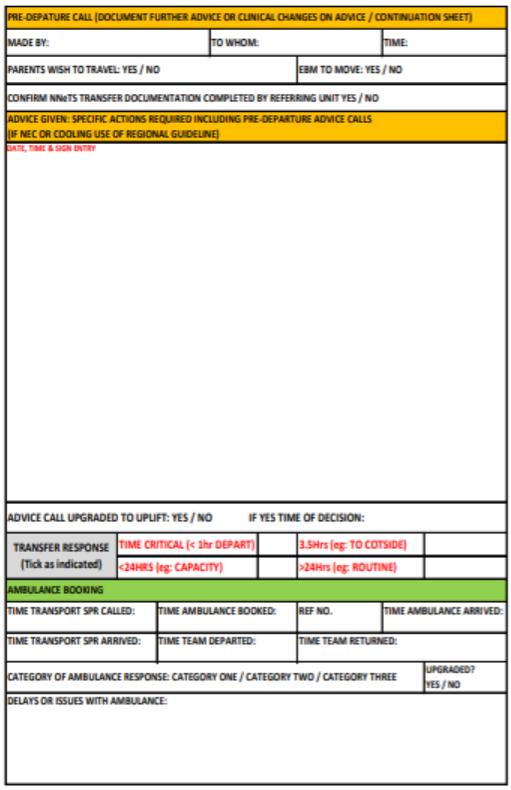
Northern Neonatal Transport Service

REFERRAL DETAILS			DATE REVIEWED
REFERRAL TAKEN BY:	DATE:	TIME:	DATE COMPLETED:
REFERRING UNIT & TEL NO.	REFERRER & GRADE:		
REFERRING CONSULTANT & TEL NO.			
RECEIVING UNIT & TEL NO.		COT AVAILABLE: YES / NO	
RECEIVING CONSULTANT & TEL NO.			
NNeTS CONSULTANT ON DUTY (OR RED CONSULTANT IF OUT OF HOURS) INFORMED OF REQUEST: YES / NO			

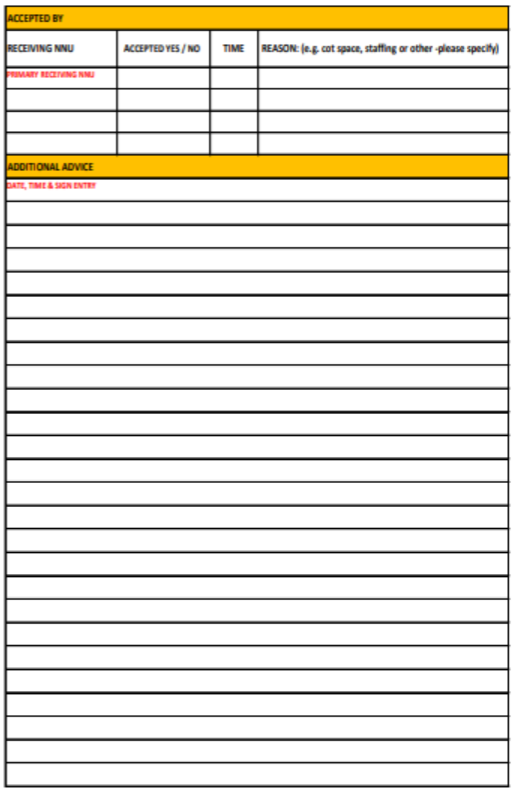
BABY DETAILS				
SURNAME:	FORENAME:			MALE / FEMALE
DOB & TIME:	GA:	AGE / CGA:	BW:	CW:
NHS NUMBER:	PLACE OF BIRTH:			
MATERNAL ADDRESS & POSTCODE:	GP ADDRESS & POSTCODE:			
PRIMARY REASON FOR REFERRAL: REPATRIATION / CAPACITY / OTHER:				
SECONDARY REASON FOR REFERRAL: REPATRIATION / CAPACITY / OTHER:				
RELEVANT HISTORY				



CURRENT CLINICAL STATUS									
NO SUPPORT	LOW FLOW: LPM		HFNC: LPM		CPAP: CMH_2O		FIO_2:	SATS:	TEMP:
LATEST GAS: DATE / TIME	Resp Mode	SITE	PH	PCO_2	PO_2	$HCO3^-$	BE	LAC	GLU
		A / V / C							
FLUIDS / FEEDS	TOTAL: ML / KG		10% Dex / 10% DexSal / TPN / OTHER (STATE):						
	METHOD / FREQUENCY:				FEED TYPE:				
ACCESS			MEDICATION						
INFECTION CONTROL ISSUES									
YES / NO	DETAILS:								
SAFEGUARDING									
CURRENT SAFEGUARDING CONCERNS: YES / NO IF YES, HAVE REFERRING UNIT D/W RECEIVING UNIT YES / NO (IF NOT ADVISE TO DO THIS)									
PRE-DEPARTURE CALL									
MADE BY:	TO WHOM:						TIME:		
PARENTS WISH TO TRAVEL YES / NO	EBM TO MOVE YES / NO								
CONFIRM NNeTS TRANSFER DOCUMENTATION COMPLETED BY REFERRING UNIT YES / NO									
UPDATES UNTIL TRANSFER OCCURS INCLUDING ANY ADVICE GIVEN									
(DATE, TIME & SIGN)									
TRANSFER RESPONSE: (Tick as indicated)	< 24Hrs (eg: CAPACITY)			> 24Hrs (eg: ROUTINE)					
AMBULANCE BOOKING									
TIME TRANSPORT SPR CALLED:	TIME AMBULANCE BOOKED:		REF NO.		TIME AMBULANCE ARRIVED:				
TIME TRANSPORT SPR ARRIVED:	TIME TEAM DEPARTED:		TIME TEAM RETURNED:						
CATEGORY AMBULANCE RESPONSE: CATEGORY TWO / CATEGORY THREE					UPGRADED? YES / NO				
DELAYS OR ISSUES WITH AMBULANCE:									



PRE-DEPATURE CALL (DOCUMENT FURTHER ADVICE OR CLINICAL CHANGES ON ADVICE / CONTINUATION SHEET)					
MADE BY:	TO WHOM:		TIME:		
PARENTS WISH TO TRAVEL: YES / NO	EBM TO MOVE: YES / NO				
CONFIRM NNeTS TRANSFER DOCUMENTATION COMPLETED BY REFERRING UNIT YES / NO					
ADVICE GIVEN: SPECIFIC ACTIONS REQUIRED INCLUDING PRE-DEPARTURE ADVICE CALLS (IF NEC OR COOLING USE OF REGIONAL GUIDELINE)					
DATE, TIME & SIGN ENTRY					
ADVICE CALL UPGRADED TO UPLIFT: YES / NO	IF YES TIME OF DECISION:				
TRANSFER RESPONSE (Tick as indicated)	TIME CRITICAL (< 1hr DEPART)		3.5Hrs (eg: TO COTSIDE)		
	<24HRS (eg: CAPACITY)		>24Hrs (eg: ROUTINE)		
AMBULANCE BOOKING					
TIME TRANSPORT SPR CALLED:	TIME AMBULANCE BOOKED:	REF NO.	TIME AMBULANCE ARRIVED:		
TIME TRANSPORT SPR ARRIVED:	TIME TEAM DEPARTED:	TIME TEAM RETURNED:			
CATEGORY OF AMBULANCE RESPONSE: CATEGORY ONE / CATEGORY TWO / CATEGORY THREE			UPGRADED? YES / NO		
DELAYS OR ISSUES WITH AMBULANCE:					



ACCEPTED BY			
RECEIVING NNU	ACCEPTED YES / NO	TIME	REASON: (e.g. cot space, staffing or other -please specify)
PRIMARY RECEIVING NNU			
ADDITIONAL ADVICE			
DATE, TIME & SIGN ENTRY			