

Date of transfer:

REFERRING UNIT NURSING TRANSFER LETTER

<p>Name of infant:</p> <p>Sex: M/F</p> <p>Date/time of birth: <i>Affix</i></p> <p>NHS number: <i>Addressograph</i></p> <p>Hospital number: <i>Label</i></p> <p>Address:</p> <p>Ethnicity:</p> <p>Social concerns: Y/N</p>	<p>Mothers name:</p> <p>Mothers NHS number:</p> <p>Contact number:</p> <p>Support person:</p> <p>GP name:</p> <p>GP address:</p>
<p>Delivery Details</p> <p>Type/Reason:</p> <p>Gestation: Corrected gestation:</p> <p>Age in days:</p> <p>Birth weight: g Current weight: g</p>	<p>Nutritional Care</p> <p>IV Fluids: Y/N <i>(If Y see reverse for infusions)</i></p> <p>IV: mls/kg/day</p> <p>Milk feeds: Y/N Milk type:</p> <p>Milk: mls/kg/day</p> <p>Route: NG <input type="checkbox"/> OG <input type="checkbox"/> Oral <input type="checkbox"/></p> <p>Amount: Freq: Last fed@</p> <p>Date gastric tube inserted:</p> <p>Gastric tube size/length:</p> <p>EBM to transfer: Y/N</p>
<p>Respiratory Care</p> <p>Ongoing respiratory support Y/N</p> <p>VENT <input type="checkbox"/> Mode: ETT size/length:</p> <p>Setting: PIP: PEEP: RATE:</p> <p>Ti: FiO₂: % Nitric: ppm</p> <p>Surfactant <input type="checkbox"/>: Dose mg @ Date/time:</p> <p>NIV: BIPAP <input type="checkbox"/> CPAP <input type="checkbox"/> HIGH FLOW <input type="checkbox"/></p> <p>LOW FLOW <input type="checkbox"/></p> <p>PEEP cmH₂O Flow settings: litres/min</p> <p>Date respiratory support stopped:</p> <p>Recent Blood Gas: CAP <input type="checkbox"/> ART <input type="checkbox"/> VEN <input type="checkbox"/></p> <p>pH: CO₂: O₂:</p> <p>BE: Gluc: Lact:</p>	<p>Elimination</p> <p>Date last passed urine:</p> <p>Urine output: ml/kg/hr</p> <p>Date last opened bowels:</p> <p>Stoma: Y/N</p>
	<p>Thermoregulation</p> <p>Incubator <input type="checkbox"/> Cot <input type="checkbox"/></p> <p>Incubator/mattress temperature:</p> <p>Incubator humidity: %</p> <p>Last axilla temperature:</p>

Neurological Cooled: Y/N

Details:

Medications and Infusions:

Vit K: Y/N IM Oral Date:

IV access: Peripheral UVC UAV Long Line Other

Infusions:

Drug: Dose: Rate: Site:

Drug: Dose: Rate: Site:

Drug: Dose: Rate: Site:

Drug: Dose: Rate: Site:

Medications:

Drug: Route: Dose: Freq: Last given:

Drug: Route: Dose: Freq: Last given:

Drug: Route: Dose: Freq: Last given:

Drug: Route: Dose: Freq: Last given:

Drug: Route: Dose: Freq: Last given:

Drug: Route: Dose: Freq: Last given:

Screening/Investigations

One spot: Y/N Date:

Newborn blood spot: Y/N Date:

<32/40 repeat blood spot: Y/N Date:

Post transfusion blood spot: Y/N Date:

Cranial ultrasound scan: N/A

Due Done Week 1 date:

Due Done Week 6 date:

ROP Check: N/A Required Discharged

Date of next check (if req^d):

Further investigations:

Infection Control

Infection: Y/N

Details:

Maternal infections: Y/N

Details:

Tissue Viability Concerns: Y/N

Details:

Enrolled research studies (details/transfer packs)