Northern Neonatal Transport Service

NON ACUTE REFERRAL

PLANNED/REPATRIATION/CAPACITY

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

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:				
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_20	FIO_2: %
FLUIDS / FEEDS	TOTAL: ML / KG	10% Dex / 10% DexSal / TPN / OTHER (STATE):		
	METHOD / FREQUENCY:	FEED TYPE:		
ACCESS	MEDICATION			
PERIPHERAL / OTHER:				
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:				