Northern Neonatal Transport Service

# ACUTE REFERRAL

*CAN A BABY BE MOVED TO A LOCAL NICU TO REDUCE IUT DISTANCE?
(CHECK WITH NNeTS TL / CONS IF UNSURE)

| REFERRAL DETAILS | | | DATE REVIEWED | |
|---|---|---|---|---|
| REFERRAL TAKEN BY: | | | DATE: | TIME: |
| REFERRING CENTRE & TEL NO. | | REFERRER & GRADE: | | |
| REFERRING CONSULTANT & TEL NO. | | | | |
| RECEIVING UNIT & TEL NO. | | | | |
| RECEIVING CONSULTANT & TEL NO. | | | | |
| NNeTS CONSULTANT ON DUTY (OR RED CONSULTANT IF OUT OF HOURS)<br>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: | | | |
| REASON FOR REFERRAL: MEDICAL / SURGICAL / CARDIAC / ECMO / PICU / ADVICE | | | CAPACITY: YES / NO | |

| CURRENT STATUS / SITUATION |
|---|
| (DO YOU NEED TO CONFERENCE CONS IN) |

| DELIVERY DETAILS (IF RELEVANT) | | | |
|---|---|---|---|
| ANTENATAL HISTORY: | | ANTENATAL STEROIDS: YES / NO | |
| REASON FOR DELIVERY: | | | |
| DELIVERY TYPE: NVD / INSTRUMENTAL / BREECH / ELECTIVE CS / EMERGENCY CS | | | |
| RESUSCITATION: 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<br>ETT SIZE & LENGTH: | | MODE: | PIP/PEEP: | RATE: | Ti: | NITRIC: | $FIO_2$: | SATS: |
| C | HR: | BP: mmhg | | CRT: | ACCESS<br>UVC / UAC / PICC / PERIPHERAL X1 , X2 | | | | |
| | BLOOD GAS DATE & TIME | 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 ML / 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<br>IF YES, HAVE REFERRING UNIT D/W RECEIVING UNIT YES/NO (IF NOT ADVISE TO DO THIS) | | | | | | | | | |

| 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 / N0 |
| DELAYS OR ISSUES WITH AMBULANCE: | | | |

**ADDITIONAL ADVICE / CONTINUATION SHEET**

**(DATE, TIME & SIGN ENTRY)**