Provincial Neonatal Retro-transfer Record

Provincial Council for Maternal and Child Health
building a brighter future

PATIENT LABEL

FAMILY INFORMATION — INITIAL:

Date of Birth: ..... / ..... / ..... **Time:** ..... hours

Date of transfer: ..... / ..... / ..... **Time:** ..... hours

Patient name: ☐ M ☐ F

Singleton, Twin, other:

Mother:

Maternal ID#:

Address:

Home phone:

Cell phone:

Contacted/informed about transfer ☐ No ☐ Yes

Parent(s):

Home phone:

Cell phone:

Referring hospital:

Referring unit:

Referring resident/fellow/NP:

Staff MD:

Phone:

Destination hospital:

Accepting MD:

Phone:

MD contacted/informed of transfer: Date ..... / ..... / ..... Time ..... hours

Comments:

MT #

Health card#

Parent(s)/family involved in care: ☐ Mother ☐ Father ☐ Other:

Care by parent(s): ☐ Bath ☐ Holding ☐ Changing ☐ Kangaroo Other:

Visiting patterns: Restrictions:

Relevant Maternal Information:

BASELINE INFORMATION — INITIAL:

Birth weight:	Current weight:	Gest age @ birth:	Corrected age:	☐ Incubator ☐ Bassinet	Last void:	Last stool:

FEEDING PLAN — INITIAL:

☐ Breast ☐ Expressed breast milk Donor breast milk: ☐ No ☐ Yes Number of days received: .....

☐ Breast milk substitute ☐ Other:

Feeding type: TFI **Frequency** **Last fed at:** ☐ NG ☐ OG ☐ G-Tube

Feeding mode: ☐ Breast ☐ Bottle ☐ Pump ☐ Gravity Other: Insertion date:

Size: .....Fr ..... cm

CURRENT THERAPIES/TEST RESULTS — INITIAL:

Vitamin K given: ☐ No ☐ Yes **Eye ung given**: ☐ No ☐ Yes **Hearing Screen** ☐ Not completed ☐ Pass ☐ Referred

Newborn Screening: ☐ No ☐ Yes Date: ..... /..... / ..... 3 week repeat (if candidate): ☐ Done ☐ Due: ..... /..... / .....

Retinopathy of Prematurity: Last exam date: ..... / ..... / ..... Results: Follow-up:

Latest test results:

Last Bilirubin: Date:

Last Hgb: Date:

Results to follow:

Transfused: ☐ No ☐ Yes Date:

Direct Donor: ☐ No ☐ Yes ☐ Donor blood sent

IV Therapy:	Rate:	Site:	Inserted:
1:			
2:			
3:			

Date started	Medications	Dose	Times	Last given

IMMUNIZATIONS, INFORMATION, REFERRALS & TEST RESULTS — INITIAL:

RSV Candidate: ☐ No ☐ Yes Prophylaxis given: ☐ No ☐ Yes Reference # Date last given: ..... / ..... / .....

Information package sent with baby related to: ☐ Yes ☐ No ☐ Given to parents

Immunization given:	Date	Immunization given:	Date

Hepatitis B Vaccine given: ☐ No ☐ Yes
Next due:

Hepatitis B Immunoglobulin given: ☐ No ☐ Yes
Date: ..... / ..... / .....

Special precautions: ☐ Isolation ☐ Antibiotic resistant organisms ☐ Precautions:

Neonatal Follow Up Clinic referral(s): ☐ N/A ☐ Yes Location:

Referral requested: ☐ No ☐ Yes Appointment Date: ..... / ..... / ..... Time: .....hours

Social Worker: ☐ No ☐ Yes **Name** **Phone #**

CAS involved: ☐ No ☐ Yes ☐ To be referred **Contact name:** **Phone:**

Copy of apprehension letter attached: ☐ Yes ☐ N/A

Occupational therapy: ☐ No ☐ Yes **Physiotherapy**: ☐ No ☐ Yes

***Pre-transport Equipment check*:** ☐ O_2/Air tanks ☐ Suction ☐ Bag/mask ☐ Supplies **INITIAL:**

CARE DURING TRANSIT (Chart q15 minutes) — INITIAL:

Time	Incubator Temp	HR	RR	O_2 sat	FiO_2	Mode	A/B/ Desat	Intervention/Comments
Departure								
Arrival								

TRANSFER OF ACCOUNTABILITY INFORMATION

Date & Time:	Patient ID intact & checked & report received by:	IV Site/Solution checked by:
	_____/_____ sign print	_____/_____ sign print

Referring Hospital:

_____ / _____
Sign Print

Documents sent with patient:
☐ Immunization card
☐ RSV package
☐ Medical Discharge Summary
☐ PICC Line Package Sent: ☐ Yes ☐ N/A
☐ Other: (Images CD, etc.,)

Patient possessions: ☐ Clothing/toys
☐ EBM ☐ Donor Milk
Other:

SECTION V: SIGNATURES

PRINT NAME	SIGNATURE	INITIAL	DATE	TIME