British Columbia Neonatal Transfer Record

1. Surname Given Name	Date/Time of Birth	Gestational Age at Birth weeks/days	Post Menstrual Age weeks/days	Birth Weight /grams
	Sex ☐ M ☐ F ☐ Unk.	Neonatal Daily Classification		
Sending Facility	Attending MD/RM	Discharge Diagnosis		Today's Weight /grams
Receiving Facility	Receiving Physician	Maternal / Birth History		
G T P A L	APGAR Scores			

Surname Given Name

Address

Phone number

Personal Health Number Physician/Midwife Name

2. Parent or Guardian Name(s)

Newborn Exposure to (check if positive)
☐ HIV ☐ Hep B ☐ Hep C ☐ Substance
☐ GBS ☐ ARO ☐ HPV ☐ Other (specify)

Current Isolation Status

Hometown of Baby | Contact Number | Language Preferred

☐ Photos of Baby to Mother
☐ Mom Expressing Breast Milk

3. Vital Signs Time:	HR	RR	SpO_2	BP / M	T

4. Assessments

Respiratory: Airway: ☐ ETT # _____ @ _____ cm Date/Time: _____ Extubated Date/Time: _____ ☐ LMA # _____

Current Ventilator Settings: Mode: _____ FiO_2: _____ Rate: _____ Pressure: _____ I:T _____ VT: _____

Non-Invasive Respiratory Support: ☐ CPAP ☐ LFNP ☐ HFNP ☐ Other (specify) _____ Setting: _____ FiO_2: _____ Date Initiated: _____

Surfactant ☐ Date: _____ # of Doses _____ ☐ Caffeine Discontinued Date: _____

Date and Time of last ☐ ABG ☐ CBG: _____ Results: pH _____ pCO_2 _____ pO_2 _____ HCO_3 _____ BD or BE _____

Cardiovascular

Neurology

GI/GU/Other

5. Intake

☐ PVAD (PIV) ☐ PICC Type: _____ at _____ cm ☐ CVAD (CVC) Type: _____

☐ UAC at _____ cm ☐ UVC at _____ cm # of lumens: ☐ 1 ☐ 2 ☐ 3 Other: _____

Total Fluids Order (including feeds) mL/kg/day	Site/Route	Rate
Infusion #1 Solution/Dose		
Infusion #2 Solution/Dose		
Infusion #3 Solution/Dose		
Infusion #4 Solution/Dose		
Infusion #5 Solution/Dose		

Feeding: Type ☐ EBM ☐ Donor Human Milk
☐ Human Milk Substitute (specify)

Additives

Method: ☐ BR ☐ B ☐ OG ☐ NG ☐ NJ ☐ G-tube ☐ GJ-tube

Date Inserted and Location of Tube /cm depth

Amount	Frequency	Syringe pump over _____ minutes
Last Fed	☐ Feeding Concerns (specify) _____ ☐ Infant Feeding Assessment Tool Attached	

6. Output Last Void: | Last Stool: | Additional Losses (e.g., blood from lab tests)

7. Medications: Name / Dose / Route / Frequency ☐ Medication record attached

	Last Given	Next Due		Last Given	Next Due
1.			4.		
2.			5.		
3.			6.		

8. Treatments +/or Investigations ☐ Abnormal Lab Values +/or Blood Culture Results attached

9. Screening

☐ CCHD Screen Done Date: _____ ☐ Passed

Follow-up:

☐ Eye Exam Done Date of Last Exam: _____ Due: _____

Results:

☐ Hearing Screen Done Date: _____ ☐ Passed

Follow-up:

☐ Phototherapy Date Discontinued: _____

☐ Newborn Screen Done (blood spot card) Date: _____

☐ Repeat Newborn Screen Needed Date: _____

Immunizations: ☐ Provincial Immunization Record Attached

RSV Prophylaxis Candidate: ☐ Yes ☐ No

RSV Prophylaxis Date Given: _____ ☐ Not Given

10. Consultants ☐ Social Work, Name: _____ Contact: _____ ☐ SLP ☐ OT ☐ PT

☐ MCFD, Name: _____ Contact: _____ ☐ Dietitian ☐ LC ☐ Other:

11. Complex Care / Teaching

Parent Teaching: Basic Care for Baby: ☐ Bath ☐ Diaper Change ☐ Temperature ☐ Cuddle ☐ Skin-to-Skin ☐ Feeding ☐ Safe Sleep Positions / Environment

☐ Complex Care Involvement / Teaching (specify): ☐ RSV Screening / Teaching ☐ Purple Crying ☐ Biliary Atresia ☐ Maintenance of Milk Supply ☐ Safe Storage and Handling of Human Milk

Other: _____

12. Additional Information (including socioeconomic issues / needs)

13. Transfer Checklist (if applicable * indicates mandatory)

☐ Physician Discharge Order

☐ Copy of Chart (refer to Guide for Completion)*

☐ Copy of MAR*

☐ Signed Transfusion Consent

☐ Discharge Summary from Sending Facility*
☐ Mother ☐ Baby

☐ 2 ID Bands on Baby*

☐ ID Bands Checked with RN / Transport Team*

☐ Parents Notified of Transfer*

☐ Parents to Accompany
☐ Mother ☐ Partner

☐ Pumping Initiated _____ *(date)*

☐ Report Given to Receiving Facility

Acute Transfer

☐ Maternal Blood

☐ Cord Blood

☐ Placenta

☐ Baby's Blood Culture

☐ Other Lab Work

☐ Vitamin K administered

☐ Erythromycin administered

Repatriation Transfer

☐ EBM double checked and in cooler

☐ Personal Belongings

☐ Medications

Environment for Transfer

☐ Incubator ☐ Car Seat ☐ Other (specify)

Incubator Temperature and Humidity

☐ Dressed

☐ Covered

☐ **Care Transferred to Infant Transport Team** ☐ **Care Transferred to HART** ☐ **Ambulance Transfer with** ○ MD ○ RN

14. Nurse(s) Completing Form

Printed Name	Signature	Date	Time

Baby Left Sending Hospital: _____ Date _____ Time