

A Guide for Completion of the British Columbia Neonatal Transfer Record (PSBC 1600)

January 2017

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While every attempt has been made to ensure that the information contained herein is clinically accurate and current, Perinatal Services BC acknowledges that many issues remain controversial, and therefore may be subject to practice interpretation.

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Introduction

The safe transfer of care is a vital component of the quality of care and safe practice. When the process of transfer of care is inadequately undertaken, risks to the patient are increased and may subsequently lead to harm (Accreditation Canada, 2013). The transfer of essential information and the responsibility for care of the baby from one nurse to another is an integral component of communication in neonatal care. The literature highlights the adverse effects of ineffective transfer of information and suggests standardizing reporting to ensure accurate and efficient transfer of patient information (Accreditation Canada, 2013; Friesen, White & Byers, 2008). Improving transfer of information at transition points is also a required organizational practice from Accreditation Canada.

Effective communication has been identified as a critical element in improving patient safety, particularly with regard to transition points such as shift changes, end of service, and patient transfer to other health services or community-based providers. Safe and valuable communication includes transfer of information with the family, within the organization, between staff and service providers, and to other services outside the organization, such as primary care providers. Examples of mechanisms to ensure accurate transfer of information may include transfer forms and checklists.

The British Columbia Neonatal Transfer Record (PSBC 1600) is a tool developed to standardize the communication and continuity of care between facilities. A provincial working group was established in 2011/2012 in response to several requests to Perinatal Services BC (PSBC) to standardize communication from nurse to nurse as newborns are transported throughout British Columbia. This tool will therefore facilitate documentation of pertinent information of newborns transferred from one hospital to the next in a structured, logical and standardized manner. It is a form developed and designed to facilitate consistent and complete documentation, communication, and continuity of nursing care.

The BC Neonatal Transfer Record was developed for use for inter hospital transfers. This form is to be completed by the nurse caring for the newborn, given to the transfer team who will then hand this form to the receiving hospital's nurse to facilitate communication and continuity of nursing care. To ensure optimal effective communication, the nurse must copy this record (original to stay on the chart). Scanning or faxing this form is also an option and would eliminate the need for copying. This form does not replace the telephone report, which is an essential component of the nurse to nurse handover.

Several key principles guided the development and design:

- Be applicable for all hospitals providing newborn care.
- Incorporate relevant information from the hospital stay.
- Minimize double charting or need for several narrative notes on several forms.
- Utilize standardized terminology and abbreviations.
- Facilitate early recognition, timely communication and intervention for changes in newborn conditions.
- Provide a standardized form that provincial stakeholders recognize.
- Facilitate complete documentation and communication from one facility to another.

Abbreviations

ABG	Arterial Blood gas	kg	Kilogram
ARO	Antibiotic Resistant Organisms	LC	Lactation Consultant
BD	Base Deficit	LFNP	Low Flow Nasal Prongs
BE	Base Excess	LMA	Laryngeal Mask Airway
BP	Blood Pressure	M	male
BR	Breast	MAR	Medication Administration Record
CBG	Capillary Blood Gas	MCFD	Ministry of Child and Family Development
CCHD	Critical Congenital Heart Disease	MD	Physician
cm	Centimeter	mL	milliliter
CPAP	Continuous Positive Airway Pressure	NG	Nasogastric Tube
CVAD (CVC)	Central Venous Access Device (Central Venous Catheter)	NJ	Nasojejeunal Tube
EBM	Expressed Breast Milk	NRP	Neonatal Resuscitation Program
ETT	Endotracheal Tube	OG	Orogastric
F	female	OT	Occupational Therapist
FiO₂	Fractional concentration of inspired oxygen	PICC	Peripherally Inserted Central Venous Catheter
GBS	Group B Streptococcal	PMA	Post menstrual age.
GI/GU	Gastrointestinal/Genitourinary	PT	Physiotherapist
G-tube	Gastrostomy Tube	PSBC	Perinatal Services of British Columbia
GJ-tube	Gastrojeostomy Tube	PVAD (PIV)	Peripheral Vascular Access Device (Peripheral Intravenous)
GTPAL	gravida term preterm abortion living	RM	Registered Midwife
HART	High Acuity Response Team	RN	Registered Nurse
Hep B	Hepatitis B	RR	Respiratory Rate
Hep C	Hepatitis C	RSV	Respiratory Syncytial Virus
HIV	Human immunodeficiency virus	SLP	Speech Language Pathologist
HFNP	High Flow Nasal Prongs	SpO₂	Saturation of oxygen with pulse oximetry
HPV	Human papilloma virus	T	Temperature
HR	Heart Rate	UAC	Umbilical Arterial Catheter
ID	Identification	Unk.	Unknown
I:T	Inspiratory Time	UVC	Umbilical Venous Catheter
ITT	Infant Transport Team	VT	Tidal volume

Completion of the Form

The patient's label or the addressograph stamp should be placed in the upper right hand corner of the form.

Section 1

- Surname and Given Name – Record the baby's last and first name
- Date/Time of Birth – Record the baby's date and time of birth
- Gestational Age at Birth (weeks and days) – Use the dating ultrasound or by exam
- Post Menstrual Age (weeks and days) – The PMA takes into account the baby's gestational age at birth plus the postnatal age (days of life). Age is always in completed weeks.
- Birth Weight – Record the baby's birth weight in grams
- Sex – check whether Male (M) or Female (F) or Unknown
- Neonatal Daily Classification – Record the level on day of transfer
- Sending Facility – Record the name of the sending facility
- Attending MD/RM – Record the name of the attending Physician or Midwife from sending facility
- Discharge Diagnosis – Record the most applicable discharge diagnosis
- Today's Weight – Record the baby's weight on day of transfer in grams
- Receiving Facility – Record the name of the receiving facility
- Receiving Physician – Record the name of the admitting physician at receiving facility
- Maternal/Birth History – Record any pertinent maternal/birth history
- GTPAL – Record maternal GTPAL status
- APGAR Scores – Record the baby's APGAR Scores at 1, 5 and 10 minutes and, if available, 15 and 20 minutes

Section 2

- Parent or Guardian Name(s)
- Newborn Exposure to ("tick" if positive) HIV, Hep B, Hep C, Substance (refers to perinatal substance exposure), GBS, ARO, HPV, Other (specify)
- Current Isolation Status – Record N/A if not applicable
- Hometown of Baby
- Contact Number – Contact phone number for parents/guardians.
- Language Preferred by parents/guardians
- Photos taken of Baby for Mother (family)
- Mom Expressing Breast Milk

Sections 3 to 14

The purpose of the following sections is to capture the baby's status as close to transfer as possible. This ensures the record reflects the baby's current status as much as possible. Please include the time you recorded this information in the space provided next to your signature on the bottom of page 2.

Item	Description
3. Vital Signs	
<ul style="list-style-type: none"> • Time • HR • RR • SpO₂ • BP and MAP • T 	<ul style="list-style-type: none"> • Record the time this set of vital signs was taken • Record the baby's heart rate • Record the baby's respiratory rate • Record the baby's pulse oximeter oxygen saturation • Record the baby's blood pressure, including mean blood pressure • Record the baby's temperature
4. Assessments	
<p>Respiratory</p> <ul style="list-style-type: none"> • Airway: <ul style="list-style-type: none"> • ETT • Intubated Date • Extubated Date • LMA • Current Ventilator Settings: <ul style="list-style-type: none"> • Mode • FiO₂ • Rate • Pressure • I:T • VT • Non-Invasive Respiratory Support: <ul style="list-style-type: none"> • CPAP • LFNP • HFNP • Other (specify) • Setting • FiO₂ • Date Initiated • Surfactant • Caffeine Discontinued Date 	<ul style="list-style-type: none"> • “Tick” the box if the baby has an endotracheal tube. Record the size and centimeters at the lips • Record the intubation date and time • Record the extubation date and time • “Tick” the box if the baby has a laryngeal mask airway. Record the size. • Record the ventilator mode • Record fractional concentration of inspired oxygen set on blender • Record set ventilator rate • Record set peek inspiratory pressure (PIP) and positive end expiratory pressure (PEEP) • Record set inspiratory time • Record set tidal volume • “Tick” the appropriate box(s) and indicate which type of respiratory support the baby is receiving <ul style="list-style-type: none"> • Continuous Positive Airway Pressure • Low Flow Nasal Prongs • High Flow Nasal Prongs • “Tick” and specify if the baby is receiving an ‘other’ type of non-invasive respiratory support • Record the CPAP level (eg 5 cm H₂O) or flow rate (eg 500 cc for LFNP) as pertains to the mode of non-invasive respiratory support • Record set fractional concentration of inspired oxygen • Record date non-invasive respiratory support was last initiated • Record date last dose was administered and number of doses administered in total • Record the date the last dose of caffeine was administered

Item	Description
<ul style="list-style-type: none"> • Date and Time of last ABG or CBG <ul style="list-style-type: none"> • pH • pCO₂ • pO₂ • HCO₃ • BD or BE 	<ul style="list-style-type: none"> • “Tick” whether blood gas result is from an arterial or capillary blood sample <ul style="list-style-type: none"> • Record pH result • Record partial pressure of carbon dioxide result • Record partial pressure of oxygen result • Record the bicarbonate result • Circle if result is a base deficit or base excess and record result
Cardiovascular	<ul style="list-style-type: none"> • Document results of cardiovascular investigations (ECHO, ECG), cardiac surgeries, specific cardiac monitoring • Complete documentation under “Additional Information” section on page 2 if additional space needed
Neurology	<ul style="list-style-type: none"> • Document results of neurological investigations (head ultrasound, electroencephalogram, magnetic resonance imaging), cooling date and time for hypoxic ischemic encephalopathy, further testing needed • Complete documentation under “Additional Information” section on page 2 if additional space needed
GI/GU/Other	<ul style="list-style-type: none"> • Document date and physiological location of surgical procedures, GI/GU anomalies at birth, further testing needed • Complete documentation under “Additional Information” section on page 2 if additional space needed
5. Intake	
Vascular Access <ul style="list-style-type: none"> • PVAD (PIV) • PICC • CVAD (CVC) • UAC • UVC • Other (Specify) 	<p>“Tick” the appropriate box(s) and indicate which type of vascular access the baby has and in what location</p> <ul style="list-style-type: none"> • Peripheral Vascular Access Device (Peripheral Intravenous) • Peripherally Inserted Central Venous Catheter: record type, size and insertion depth • Central Vascular Access Device (Central Venous Catheter): record type • Umbilical Arterial Catheter and insertion depth • Umbilical Venous Catheter and insertion depth. “Tick” number of lumens • Indicated when “Other” vascular device is insitu. This may refer to an intraosseous device. Please indicate what this device is and its location
Total Fluids Order (including feeds) <ul style="list-style-type: none"> • Infusion List <ul style="list-style-type: none"> • Site/Route • Rate 	<ul style="list-style-type: none"> • Record the total fluids order from the Doctor’s Order Sheet as mL/kg/day • Record the fluid and dose infusing (e.g. D10W, 0.9% NaCl with xx mcg Morphine/100 mL) <ul style="list-style-type: none"> • Record the location the solution is infusing by referring to the vascular access list (PVAD, CVAD, UAC, UVC). If the access has more than one lumen, please indicate which lumen the fluid is infusing in • Record the rate the fluid is infusing/per hour

Item	Description
<p>Feeding</p> <ul style="list-style-type: none"> • Type <ul style="list-style-type: none"> • EBM • Donor Human Milk • Human Milk Substitute (specify) • Additives • Method <ul style="list-style-type: none"> • BR • B • OG • NG • NJ • G-tube • GJ-tube <ul style="list-style-type: none"> • Date Inserted and Location of Tube • Amount • Frequency • Syringe pump over _____ minutes • Last Fed • Feeding Concerns (Specify) • Infant Feeding Assessment Tool Attached 	<ul style="list-style-type: none"> • “Tick” the type of enteral nutrition the baby is receiving <ul style="list-style-type: none"> • Mother’s own expressed breast milk • Donor Human Milk from a certified milk bank • Record the breast milk alternative and calorie • Record feeding additive(s) the baby is currently receiving • “Tick” how the baby is receiving the enteral feed <ul style="list-style-type: none"> • Breast • Bottle • Orogastic • Nasogastric • Nasojejunal • Gastrostomy tube • Gastrojejunostomy tube <ul style="list-style-type: none"> • Document the tube insertion date and insertion depth in cm • Record the volume of feed the baby receives at a feeding • Record the frequency of feedings • When a syringe pump is used, document the amount of time the feed is programmed to infuse over • Indicate the time of the last feed • “Tick” if there are feeding concerns • Specify concerns. If need additional space, record under “Additional Information” header on page 2 • “Tick” if an infant feeding assessment tool is attached
6. Output	
<ul style="list-style-type: none"> • Last Void • Last Stool • Additional Losses 	<ul style="list-style-type: none"> • Record the time of last urine output • Record the time of last stool • Record additional output. This may include blood taken for lab tests, ostomy or surgical site output

Item	Description
7. Medications	
<ul style="list-style-type: none"> • Medication record attached • Last Given • Next Due 	<p>List the name, dose, route and frequency of the current medication(s) as you would see on the doctor's order sheet</p> <ul style="list-style-type: none"> • "Tick" to ensure most recent Medication Record is attached to this record • Document the date and time the last dose was administered to the baby • Document the date and time the next dose is due
8. Treatment +/- or Investigations	
<ul style="list-style-type: none"> • Abnormal Lab Values +/- or Blood Culture Results attached 	<p>Indicate any other treatments or investigations omitted in the Assessment Section</p> <ul style="list-style-type: none"> • "Tick" if a copy of the lab tests is attached to this record • Complete documentation under "Additional Information" section on page 2 if additional space needed
9. Screening	
<ul style="list-style-type: none"> • CCHD Screen Done <ul style="list-style-type: none"> • Date • Passed • Follow-up • Eye Exam Done <ul style="list-style-type: none"> • Date of Last Exam • Due • Results • Hearing Screen Done <ul style="list-style-type: none"> • Date • Passed • Follow-up • Phototherapy <ul style="list-style-type: none"> • Date Discontinued • Newborn Screen Done • Newborn Screen Needed 	<ul style="list-style-type: none"> • "Tick" if the Critical Congenital Heart Disease screen was completed <ul style="list-style-type: none"> • Record the date • "Tick" if the baby passed the CCHD screen • Record follow-up plans if failed the CCHD Screen • "Tick" if an eye exam has been completed <ul style="list-style-type: none"> • Document the date of the last eye exam • Record the date for the next eye exam • Record results of the eye exam • "Tick" if the hearing screen has been completed <ul style="list-style-type: none"> • Document the date of the last hearing exam • "Tick" if the baby passed the hearing screen • Record follow-up appointment date if failed the hearing screen • "Tick" if the baby is currently receiving phototherapy <ul style="list-style-type: none"> • Document the last date phototherapy was discontinued • "Tick" if the newborn screening has been done • "Tick" if repeat newborn screening is needed and record date

Item	Description
<ul style="list-style-type: none"> • Immunizations <ul style="list-style-type: none"> • Provincial Immunization Record Attached • RSV Prophylaxis Candidate • RSV Prophylaxis Given 	<ul style="list-style-type: none"> • “Tick” if the Provincial Immunization form is attached • “Tick” Yes or No to indicate if the baby is a candidate for Respiratory Syncytial Virus prophylaxis • Document the date Respiratory Syncytial Virus prophylaxis was administered
10. Consultants	
<ul style="list-style-type: none"> • Social Work • MCFD • SLP • Dietitian • LC • OT • PT • Other 	<p>“Tick” if the following consultants are involved in the care of the baby at the time of transfer</p> <ul style="list-style-type: none"> • Complete the name and contact information if Social Work is involved. Include Social Work notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Complete the name and contact information if the Ministry of Child and Family Development is involved. Include MCFD documentation with copy of chart. Indicate briefly in “Additional Information” section reason for involvement, and if MCFD aware of transfer • Include Speech Language Pathologist notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Include Dietitian notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Include Lactation Consultant notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Include Occupational Therapist notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Include Physiotherapist notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement • Indicate involvement of any other specialty or allied health. Include notes with copy of chart. Indicate briefly in “Additional Information” section reason for involvement

Item	Description
11. Complex Care/Teaching	
<p>Parent Teaching</p> <ul style="list-style-type: none"> • Basic Care for Baby <ul style="list-style-type: none"> • Bath • Diaper Change • Temperature • Cuddle • Skin-to-Skin • Feeding • Safe Sleep • Complex Care Involvement/Teaching (specify) <ul style="list-style-type: none"> • RSV Screening/Teaching • Purple Crying • Biliary Atresia • Maintenance of Milk Supply • Safe Storage and Handling of Human Milk • Other 	<p>“Tick” the appropriate box(s) to indicate parent teaching completed. When indicating “Other,” specify what parent teaching has been completed.</p> <ul style="list-style-type: none"> • Attach a copy of the current Nursing Care Plan and appropriate information required for continuing care • Safe Sleep: Ensure positioning as well as environment are discussed. See PSBC Guideline at: www.perinatalervicesbc.ca/Documents/Guidelines-Standards/HealthPromotion/SafeSleepGuideline.pdf
12. Additional Information	
	<p>Continue documentation here if additional space needed to record concerns identified in any of the previous sections. Include any socioeconomic issues or needs.</p>
13. Transfer Checklist	
<ul style="list-style-type: none"> • Physician Discharge Order 	<p>This section is a list of activities involved in preparing a baby for transport. The asterisk (*) indicates mandatory activities.</p> <ul style="list-style-type: none"> • Check chart for physician’s order for the baby’s transfer

Item	Description
<ul style="list-style-type: none"> • *Copy of chart • Copy of Medication Record • Signed transfusion consent • *Discharge summary from sending facility <ul style="list-style-type: none"> • Mother • Baby • *2 ID bands on baby • *2 ID bands checked with RN/ Transport Team • *Parents notified of transfer • Parents to accompany <ul style="list-style-type: none"> • Mother • Partner 	<ul style="list-style-type: none"> • Relevant sections of the chart to be photocopied and sent with the baby include: <ul style="list-style-type: none"> • Newborn birth record 1 and 2 • Prenatal, labour and delivery records • Mother's chart with all relevant neonatal history • Nursing notes/daily flow sheets (variable in how many days are photocopies) • Dr's orders (all) • Progress notes (all) • Sub-specialty consultation reports • Social Worker's notes • Allied health notes (Dietitian, PT/OT/SLP) • Eye exam reports • Summary of blood work • Diagnostic test reports • Discharge summary • Nursing discharge sheet • Photocopy current Medication Record and recent medication changes • Check if there is a signed consent form for the transfusion of blood products if appropriate • Check chart for medical discharge physical exam and summary notes, for both mother and baby • Ensure there are 2 identification bands attached to the baby • Identify the baby with a member of the transfer team and sign record • Ensure family is aware of pending transfer • Provide the parents with the receiving facility's contact phone number and address • Check with the parents to ensure that their contact numbers are correct • If the parents are not present on the Neonatal Unit, telephone them to inform them that their baby is in transit • Indicate if mother or partner wished to accompany if there is available space

Item	Description
<ul style="list-style-type: none"> • Hand expressing / pumping initiated • Report given to receiving facility 	<ul style="list-style-type: none"> • “Tick” if mother has begun expressing breast milk. Include date when hand expression or pumping first initiated • Ensure the receiving agency is aware and prepared for patient care requirements • Provide receiving agency with written and/or verbal report of patient, special nursing, nutritional, or lactation support needs, as well as any socioeconomic or psychosocial concerns
<p>Acute Transfer</p> <ul style="list-style-type: none"> • Maternal blood • Cord blood • Placenta • Baby’s Blood Culture • Other Lab Work • Vitamin K administered • Erythromycin administered 	<p>“Tick” the items sent with the baby</p> <ul style="list-style-type: none"> • Ensure any requested specimens are clearly labeled, for example: <ul style="list-style-type: none"> • Baby’s blood cultures (aerobic ± anaerobic) • Maternal blood sample • Cord blood sample from the placenta. Useful mainly for a direct antibody (Coombs’) test • Placenta, wrapped in a sealed plastic bag or placed in a bucket with a lid (no additives or preservatives) • “Tick” if vitamin K and erythromycin were administered.
<p>Repatriation Transfer</p> <ul style="list-style-type: none"> • EBM double checked and in cooler • Personal belongings • Medications 	<p>“Tick” the items sent with the baby</p> <ul style="list-style-type: none"> • Double check all expressed breast milk being sent with the baby prior to placing it in the cooler • Place any labelled expressed breast milk in cool bag with gel packs and send with the baby if appropriate • Ensure the baby’s belongings are sent with patient
<p>Environment for Transfer</p> <ul style="list-style-type: none"> • Incubator • Cot • Car seat <ul style="list-style-type: none"> • Incubator Temperature and Humidity • Dressed • Covered 	<p>“Tick” which environment the baby is being transferred in</p> <ul style="list-style-type: none"> • Record the incubator temperature and humidity settings, if being transferred in an incubator • Ensure baby is safely secured in a CSA-approved car seat, if being transferred in car seat. See https://www.tc.gc.ca/eng/motorvehiclesafety/safedrivers-childsafety-programs-regulations-regulations-884.htm • “Tick” if the baby is dressed or covered with a blanket

Item	Description
<ul style="list-style-type: none"> Care transferred to Infant Transport Team Care Transferred to HART Ambulance transfer with MD or RN 	<p>“Tick” who the baby was discharged to</p> <ul style="list-style-type: none"> HART (High Acuity Response Team) is an Interior Health transport program
14. Nurse(s) Completing Form	
<ul style="list-style-type: none"> Baby left sending hospital 	<ul style="list-style-type: none"> Complete nursing transfer form on the day of transfer. There are times when the transfer is delayed or occurs past shift change, thus there may be more than one nurse completing the transfer record. Both nurses must sign the form. The second nurse signing needs to read and agree with the previous documentation before signing. Record the date and time the baby left the sending hospital in the care of the transport team identified above.

Members of the Neonatal Transfer Form Working Group

Tara Loutit	(Chair) Faculty, Neonatal Nursing Specialty Program – BCIT
Brianne Bourdon	Interim Perinatal Program Planning Lead – Fraser Health Authority
Gillian Kozinka	Neonatal Educator – NICU, Victoria General Hospital
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Debra O’Flaherty	Coordinator, Neonatal Outreach – Perinatal Services BC
Lynn Popien	Perinatal Education Coordinator – Interior Health Authority
Sarah Rourke	CNS, NICUs – Fraser Health Authority
Dallyce Varty	NICU Patient Care Coordinator – Burnaby General Hospital

Obtaining Copies of the BC Neonatal Transfer Record

- For sites wishing to order forms or to obtain ordering information, refer to the PSBC website www.perinataleservicesbc.ca/Documents/Form/RRDonnelleyOrderForm.pdf
- Contact Perinatal Services BC (PSBC) at 604-877-2121 regarding any feedback or questions about any of the perinatal forms.

References

- Accreditation Canada. (2013). Safety in Canadian health care organizations: A focus on transitions in care and Required Organizational Practices. Ottawa, ON: Accreditation Canada.
- British Medical Association (2004). Safe handover: safe patients. Guidance for clinical handover for clinicians and managers. BMA. London.
- Friesen, M., White, S.V., & Byers, J.F. (2008). Handoffs: Implications for nurses. In Hughs, R.G. (Ed.), Patient safety and quality: An evidence-based handbook for nurses (pp. 2-285-2-332). Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK2649/>

Appendix A:

Neonatal Transfer Record

British Columbia Neonatal Transfer Record

1. Surname Given Name	Date/Time of Birth	Gestational Age at Birth	Post Menstrual Age	Birth Weight	Surname	Given Name
	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk.	Neonatal Daily Classification	weeks/days	weeks/days	/grams	Address
Sending Facility	Attending MD/RM	Discharge Diagnosis	Today's Weight		Phone number	
Receiving Facility	Receiving Physician	Maternal / Birth History		Personal Health Number		
G T P A L	APGAR Scores			Physician/Midwife Name		

2. Parent or Guardian Name(s)		Newborn Exposure to (check if positive)		Current Isolation Status
		<input type="checkbox"/> HIV <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> Substance <input type="checkbox"/> GBS <input type="checkbox"/> ARO <input type="checkbox"/> HPV <input type="checkbox"/> Other (specify)		
Hometown of Baby	Contact Number	Language Preferred		<input type="checkbox"/> Photos of Baby to Mother <input type="checkbox"/> Mom Expressing Breast Milk

3. Vital Signs	HR	RR	SpO ₂	BP	T
Time:				M	

4. Assessments

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

Current Ventilator Settings: Mode: _____ FiO₂: _____ Rate: _____ Pressure: _____ I:T _____ VT: _____

Non-Invasive Respiratory Support: CPAP LFNP HFNP Other (specify) _____ Setting: _____ FiO₂: _____ Date Initiated: _____

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

Date and Time of last ABG CBG: _____ Results: pH _____ pCO₂ _____ pO₂ _____ HCO₃ _____ BD or BE _____

Cardiovascular _____ Neurology _____

GI/GU/Other _____

5. Intake		Feeding: Type <input type="checkbox"/> EBM <input type="checkbox"/> Donor Human Milk	
<input type="checkbox"/> PVAD (PIV) <input type="checkbox"/> PICC Type: _____ at _____ cm <input type="checkbox"/> CVAD (CVC) Type: _____ <input type="checkbox"/> UAC at _____ cm <input type="checkbox"/> UVC at _____ cm # of lumens: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Other: _____		<input type="checkbox"/> Human Milk Substitute (specify) _____	
Total Fluids Order (including feeds)		Additives	
	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		
		Method: <input type="checkbox"/> BR <input type="checkbox"/> B <input type="checkbox"/> OG <input type="checkbox"/> NG	Date Inserted and Location of Tube
		<input type="checkbox"/> NJ <input type="checkbox"/> G-tube <input type="checkbox"/> GJ-tube	/cm depth
		Amount	Frequency
			Syringe pump over _____ minutes
		Last Fed	<input type="checkbox"/> Feeding Concerns (specify) _____ <input type="checkbox"/> 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 <input type="checkbox"/> Medication record attached					
1.	Last Given	Next Due	4.	Last Given	Next Due
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

2 ID Bands on Baby*

Acute Transfer

Repatriation Transfer

Copy of Chart (refer to Guide for Completion)*

ID Bands Checked with RN/Transport Team*

Maternal Blood

EBM double checked and in cooler

Copy of MAR*

Parents Notified of Transfer*

Cord Blood

Personal Belongings

Signed Transfusion Consent

Parents to Accompany
 Mother Partner

Placenta

Medications

Discharge Summary from Sending Facility*
 Mother Baby

Pumping Initiated _____ (date)
 Report Given to Receiving Facility

Baby's Blood Culture

Other Lab Work

Vitamin K administered

Erythromycin administered

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

Printed Name Signature Date Time

Printed Name Signature Date Time

Baby Left Sending Hospital: _____
Date Time

Perinatal Services BC

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Perinatal Services BC

An agency of the Provincial Health Services Authority

While every attempt has been made to ensure that the information contained herein is clinically accurate and current, Perinatal Services BC acknowledges that many issues remain controversial, and therefore may be subject to practice interpretation.

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