



BC Neonatal Transfer Record (PSBC 1995)

Guide for Completion

June 2020



**Perinatal
Services BC**

Provincial Health Services Authority

Summary of Changes

WHAT'S NEW?

The updated record was developed to reflect the recommendations of the BC Coroners report, the Provincial Patient Transfer Advisory Committee, accreditation requirements, and the British Columbia College of Nursing Professionals Practice Standards. Additional changes were also made by the 2019 provincial working group to streamline the documentation and handover process.

The updated Neonatal Transfer Record (PSBC 1995) replaces the 2017 version (PSBC 1600).

Section 1:

- Maternal / Birth History: Free text box replaced with pertinent questions such as antenatal steroids, prophylactic antibiotics, and delivery type.

Section 2:

- Newborn Exposure: Checkbox added to indicate if exposure is unknown.

BC Neonatal Transfer Record (PSBC 1995)

Section 4:

- Biphasic non-invasive respiratory support added.

Section 5:

- Specific feeding additives listed.

Section 7:

- Space to record specific medication information removed, to comply with accreditation standards only a copy of the patient medication record will be attached.

Section 8:

- Reminder to attach imaging results added.

Section 9:

- Head Ultrasound added.
- Immunizations: Provincial Immunization Record removed, checkboxes added to indicate when immunization was given.

Section 11:

- Basic and complex care teaching separated.

Section 12:

- In previous version socioeconomic issues/needs were in section 12 with Other. Socioeconomic issues/needs are now in Section 12.

Section 13:

- New section to document Other.

Section 14:

- This was section 13 in PSBC 1600.
- Transfer checklist reorganized with mandatory items at the beginning of the list.
- Car Bed added as an option in Environment for transfer.
- Care transferred to HART removed.

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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.¹ 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.^{1,2} Improving transfer of information at transition points is also a required organizational practice from Accreditation Canada.¹

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 within the organization, between staff and service providers, and to other services outside the organization, such as primary care providers.^{3,4} Examples of mechanisms to ensure accurate transfer of information may include transfer forms and checklists.

The British Columbia Neonatal Transfer Record (PSBC 1995) is a tool developed to standardize the communication and continuity of care

4 W'S OF NEONATAL TRANSFER DOCUMENTATION

- > **WHEN?** Inter hospital transfer of a neonate
- > **WHO?** Completed by RN at sending hospital
- > **WHAT?** Document using standardized provincial Neonatal Transfer Record (PSBC 1995)
- > **WHY?** Documentation of pertinent patient information ensure patient safety 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. In 2017 the Neonatal Transfer Record was updated to reflect recommendations made in the 2016 Coroner's report on infant deaths in BC. In 2018 the Provincial Patient Transfer Services Advisory Committee emphasized the importance of using a provincial standardized nursing handover document during inter-facility patient transfers. Implementation of this document reinforces the College of Registered Nurses of BC Standards of Practice concerning nursing handover report.⁵

In 2019 another provincial working group revised and updated the BC Neonatal Transfer Record and Guide for Completion. This tool facilitates 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.

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.

Key Principles

The Neonatal Transfer Record:

- > Incorporates relevant information from the hospital stay.
- > Minimizes double charting or need for narrative notes on several forms.
- > Utilizes standardized terminology and abbreviations.
- > Facilitates early recognition, timely communication and intervention related to changes in newborn conditions.
- > Provides a standardized form that provincial stakeholders recognize.
- > Facilitates complete documentation and communication from one facility to another.

PRACTICE POINT

Electronic health records do not replace the Neonatal Transfer Record. To ensure consistency in handover of pertinent patient information the BC Neonatal Transfer Record is the recognized and accepted transfer document for all neonatal transfers in BC.

This form does not replace the telephone report, which is an essential component of the nurse to nurse handover.



Abbreviations

ABG	Arterial Blood Gas
ARO	Antibiotic Resistant Organisms
B	Bottle
BD	Base Deficit
BE	Base Excess
BP	Blood Pressure
BR	Breast
CBG	Capillary Blood Gas
CCHD	Critical Congenital Heart Disease
CPAP	Continuous Positive Airway Pressure
CVAD (CVC)	Central Venous Access Device (Central Venous Catheter)
EBM	Expressed Breast Milk
ETT	Endotracheal Tube
F	female
FiO₂	Fractional concentration of inspired oxygen
GBS	Group B Streptococcal
GI/GU	Gastrointestinal/Genitourinary
G-tube	Gastrostomy Tube
GJ-tube	Gastrojeostomy Tube

Abbreviations

GTPAL	gravida term preterm abortion living
Hep B	Hepatitis B
Hep C	Hepatitis C
HIV	Human immunodeficiency virus
HFNP	High Flow Nasal Prongs
HPV	Human papilloma virus
HR	Heart Rate
ID	Identification
I:T	Inspiratory Time
LC	Lactation Consultant
LFNP	Low Flow Nasal Prongs
LMA	Laryngeal Mask Airway
M	male
MAP	Mean Arterial Pressure
MCFD	Ministry of Child and Family Development
MD	Physician
mL	milliliter
NG	Nasogastric Tube
NJ	Nasojejeunal Tube
NRP	Neonatal Resuscitation Program

Abbreviations

OG	Orogastric
OT	Occupational Therapist
PICC	Peripherally Inserted Central Venous Catheter
PT	Physiotherapist
PSBC	Perinatal Services of British Columbia
PVAD (PIV)	Peripheral Vascular Access Device (Peripheral Intravenous)
RM	Registered Midwife
RN	Registered Nurse
RR	Respiratory Rate
RSV	Respiratory Syncytial Virus
SLP	Speech Language Pathologist
SpO₂	Saturation of oxygen with pulse oximetry
T	Temperature
UAC	Umbilical Arterial Catheter
Unk.	Unknown
UVC	Umbilical Venous Catheter
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

Item	Description
Surname / Given Name	Record the baby's last and first name.
Date / Time of Birth	Record the baby's date in dd/mm/yyyy format and time of birth in hh:mm format.
Gestational Age at Birth (weeks / days)	Use the dating ultrasound or by exam. Document in weeks/days format.
Post Menstrual Age (weeks / days)	The Post Menstrual Age takes into account the baby's gestational age at birth plus the postnatal age (days of life). Document in weeks/days format.
Birth Weight (grams)	Record the baby's birth weight in grams.
Sex	Check whether Male (M) or Female (F) or Unknown.
Neonatal Daily Classification	Record the level of care as documented on the Neonatal Daily Classification Record on the 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 (grams)	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.
G T P A L	Record maternal G T P A L status.
APGAR Scores	Record the baby's APGAR Scores at 1, 5 and 10 minutes and, if available, 15 and 20 minutes.
Maternal / Birth History	<ul style="list-style-type: none"> > Antenatal Steroids: Indicate Yes, No, or Not Applicable. > Prophylactic antibiotics: Indicate Yes, No, or Not Applicable. > Delivery Type: Document delivery type. > Other: Record any other pertinent maternal / birth history.

Completion of the Form

Section 2

Item	Description
Parent or Guardian Name(s)	Document parent(s) or guardian name(s).
Newborn Exposure (check if positive)	Complete checkboxes to indicate if newborn was exposed to HIV, Hep B, Hep C, Substance (refers to perinatal substance exposure), GBS, ARO, HPV, Other (specify). If exposure is unknown complete Unk checkbox.
Current Isolation Status	Document isolation precaution if applicable. Record N/A if not applicable.
Hometown of Baby	Record home town of parents/guardians.
Contact Number	Contact phone number for parents/guardians.
Language Preferred	Record language preferred by parents/guardians.
Photos of Baby to Mother	Complete checkbox if photos were taken of baby for mother (family).
Mom Expressing Breast Milk	Complete checkbox if mom is 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	
Time	Record the time this set of vital signs was taken.
HR	Record the baby's heart rate.
RR	Record the baby's respiratory rate.
SpO₂	Record the baby's pulse oximeter oxygen saturation.
BP and MAP	Record the baby's blood pressure, including mean blood pressure.
T	Record the baby's temperature.

Completion of the Form

Item	Description
4. Assessments	
Respiratory	
Airway:	
ETT	Complete the checkbox if the baby has an endotracheal tube. Indicate if the insertion is oral or nasal. Record the size and cm at the lips or nose.
Intubation Date /Time	Record the intubation date in dd/mm/yyyy format and time in hh:mm format.
Extubation Date /Time	Record the extubation date in dd/mm/yyyy format and time in hh:mm format.
LMA	Complete the checkbox if the baby has a laryngeal mask airway. Record the size.
Current Ventilator Settings:	
Mode	Record the ventilator mode
FiO₂	Record fractional concentration of inspired oxygen set on blender
Rate	Record set ventilator rate
Pressure	Record set peak inspiratory pressure (PIP) and positive end expiratory pressure (PEEP)
I:T	Record set inspiratory time
VT	Record set tidal volume
Non-Invasive Respiratory Support:	
Biphasic	Complete the appropriate checkbox(es) and indicate which type of respiratory support the baby is receiving.
CPAP	Continuous Positive Airway Pressure
LFNP	Low Flow Nasal Prongs
HFNP	High Flow Nasal Prongs
Setting	Record the CPAP level (e.g. 5 cm H ₂ O) or flow rate (e.g. 20 mL / min for LFNP) as pertains to the mode of non-invasive respiratory support.
FiO₂	Record set fractional concentration of inspired oxygen.
Date Initiated	Record date non-invasive respiratory support was most recently initiated in dd/mm/yyyy format.
Surfactant	Record date in dd/mm/yyyy format and time in hh:mm format last dose was administered and number of doses administered in total.
Caffeine Discontinued Date /Time	Record date in dd/mm/yyyy format and time in hh:mm format the last dose of caffeine was administered.
Date and Time of last ABG or CBG	Complete the appropriate checkbox to indicate whether blood gas result is from an arterial (ABG) or capillary (CBG) sample. Record date in dd/mm/yyyy format and time in hh:mm format of sample.

Completion of the Form

Item	Description
Results:	
pH	Record pH result.
pCO₂	Record partial pressure of carbon dioxide result.
pO₂	Record partial pressure of oxygen result.
HCO₃	Record the bicarbonate result.
BD or BE	Circle if result is a base deficit or base excess and record result.
Cardiovascular	Document results of cardiovascular investigations (ECHO, ECG), cardiac surgeries, specific cardiac monitoring. Complete documentation under "Additional Information" section 13 on page 2 if additional space needed.
Neurology	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 13 on page 2 if additional space needed.
GI / GU / Other	Document date and anatomical location of surgical procedures, GI / GU anomalies at birth, further testing needed. Complete documentation under "Additional Information" section 13 on page 2 if additional space needed.
5. Intake	
[Vascular Access]	Complete the appropriate checkbox(es) and indicate which type of vascular access the baby has and in what location.
PVAD (PIV)	Peripheral Vascular Access Device (Peripheral Intravenous)
PICC	Peripherally Inserted Central Venous Catheter: record type, size, and insertion depth
CVAD (CVC)	Central Vascular Access Device (Central Venous Catheter): record type.
UAC	Umbilical Arterial Catheter and insertion depth.
UVC	Umbilical Venous Catheter and insertion depth. Indicate number of lumens.
Other	Indicate when "Other" vascular device is insitu. This may refer to an intraosseous device. Indicate what this device is and its location.
Total Fluids Order (including feeds)	Record the total fluids order (including feeds) from the Doctor's Order Sheet as mL/kg/day.
Solution / Dose	Record the fluid and dose infusing (e.g. D10W, 0.9% NaCl with xx mcg Morphine / 100 mL).
Site / Route	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.
Rate	Record the rate the fluid is infusing / per hour.
Feeding	
Type	Complete the appropriate checkbox(es) to indicate the type of enteral nutrition the baby is receiving.
EBM	Mother's own expressed breast milk.

Completion of the Form

Item	Description
Donor Human Milk	Donor Human Milk from a certified milk bank.
Human Milk Substitute (specify)	Record the breast milk alternative.
Additives	Complete the appropriate checkbox(es) to indicate the feeding additive(s) the baby is currently receiving.
Method	Complete the appropriate checkbox(es) to indicate how the baby is receiving the enteral feed.
BR	Breast
B	Bottle
OG	Orogastric
NG	Nasogastric
NJ	Nasojejunal
G-tube	Gastrostomy tube
GJ-tube	Gastrojejunostomy tube
Date Inserted and Location of Gastric Tube	Document the insertion date in dd/mm/yyyy format and insertion depth in cm of the gastric tube.
Amount	Record the volume of feed the baby receives at a feeding.
Frequency	Record the frequency of feedings.
Syringe pump over _____ minutes	When a syringe pump is used, document the amount of time the feed is programmed to infuse over.
Last Fed	Indicate the date (dd/mm/yyyy) and time (hh:mm) of the last feed.
Feeding Concerns (specify)	Complete checkbox if there are feeding concerns. Specify concerns. If need additional space, record in Section 13 on page 2.
Infant Feeding Assessment Tool Attached	Complete checkbox if an infant feeding assessment tool is attached.
6. Output	
Last Void	Record the time (hh:mm) of last urine output.
Last Stool	Record the date (dd/mm/yyyy) and time (hh:mm) of last stool.
Additional Losses	Record additional output. This may include blood taken for lab tests, ostomy or surgical site output.

Completion of the Form

Item	Description
7. Medications	
Medication Record	Complete checkbox to indicate if most current medication record is attached, indicating all the medications baby is currently receiving including dose, route, and frequency. Record must indicate when last dose/s were given and when next dose/s are due.
8. Investigations	
	Indicate any other treatments or investigations omitted in the Assessment Section
Abnormal Lab Values + / or Blood Culture Results attached	Complete checkbox if a copy of the lab tests is attached to this record.
Imaging Results attached	Complete checkbox if a copy of the imaging results is attached to this record. Complete documentation Section 13 on page 2 if additional space needed.
9. Screening	
Newborn Screen Done (blood spot card)	Complete checkbox if the newborn screening has been done. Document the date (dd/mm/yyyy).
Repeat Newborn Screen Needed	Complete checkbox if repeat newborn screening is needed and record the due date (dd/mm/yyyy).
CCHD Screen Done	Complete the checkbox if the Critical Congenital Heart Disease screen was completed
Date	Record the date (dd/mm/yyyy)
Passed	Complete checkbox if the baby passed the CCHD screen
Follow-up	Record follow-up plans if the baby failed the CCHD Screen
Eye Exam Done	Complete checkbox if an eye exam has been completed.
Date of Last Exam	Document the date (dd/mm/yyyy) of the last eye exam.
Due	Record the date (dd/mm/yyyy) for the next eye exam.
Results	Provide brief description of results of eye exam.
HUS Done	Complete checkbox if a head ultrasound has been completed.
Date of Last Exam	Document the date (dd/mm/yyyy) of the last head ultrasound.
Due	Record the date (dd/mm/yyyy) for the next head ultrasound.
Results	Provide brief description of results of head ultrasound.

Completion of the Form

Item	Description
Hearing Screen Done	Complete checkbox if the hearing screen has been completed.
Date	Document the date (dd/mm/yyyy) of the last hearing exam.
Passed	Complete checkbox if the baby passed the hearing screen.
Follow-up	Record follow-up appointment date (dd/mm/yyyy) if baby failed the hearing screen.
Phototherapy	Complete checkbox if the baby received phototherapy.
Date Initiated	Date (dd/mm/yyyy) phototherapy was first initiated
Date Discontinued	Document the last date (dd/mm/yyyy) phototherapy was discontinued.
Immunizations	Complete checkbox to indicate if immunization was given. Document date when the next immunization is due. Include copy of the MAR that indicates that immunizations were given. Use Notes to document any adverse effects or if not all the immunizations were given at assigned time.
RSV Prophylaxis Candidate	Complete the appropriate checkbox to indicate if the baby is a candidate for Respiratory Syncytial Virus prophylaxis.
RSV Prophylaxis Given	Document the date (dd/mm/yyyy) Respiratory Syncytial Virus prophylaxis was administered. If not given complete the checkbox.
10. Consultants	
	Complete the appropriate checkbox if the following consultants are involved in the care of the baby at the time of transfer.
Social Work	Complete the name and contact information if Social Work is involved. Include Social Work notes with copy of chart. Indicate briefly in Section 12 reason for involvement.
MCFD	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 Section 12 reason for involvement, and if MCFD aware of transfer.
SLP	Include Speech Language Pathologist notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.
Dietitian	Include Dietitian notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.
OT	Include Occupational Therapist notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.
LC	Include Lactation Consultant notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.
PT	Include Physiotherapist notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.
Other	Indicate involvement of any other specialty or allied health. Include notes with copy of chart. Indicate briefly in "Additional Information" section reason for involvement.

Completion of the Form

Item	Description
11. Complex Care / Teaching	
Parent Teaching	Complete the appropriate checkbox(es) to indicate parent teaching completed. When indicating "Other," specify what parent teaching has been completed.
Basic Care for Baby	
Bath	
Diaper Change	
Temperature	
Cuddle	
Skin-to-Skin	
Feeding	
Safe Sleep Positions / Environment	
RSV Screening / Teaching	
Purple Crying	
Biliary Atresia	
Maintenance of Milk Supply	
Safe Storage and Handling of Human Milk	
Complex Care Involvement / Teaching (specify)	Attach a copy of the current Nursing Care Plan and appropriate information required for continuing care
Other	
12. Socioeconomic Issues / Needs	
Housing	Indicate if parent/family requires housing.
Receiving facility notified of housing need?	Indicate if receiving site has been notified of housing need. Add additional lines for narrative documentation if needed.
13. Other	
	Continue documentation here if additional space needed to record concerns identified in any of the previous sections.

Completion of the Form

Item	Description
14. Transfer Checklist	
	This section is a list of activities involved in preparing a baby for transport. The asterisk (*) indicates mandatory activities.
2 ID Bands on Baby *	Ensure there are 2 identification bands attached to the baby.
Copy of Chart *	<p>Relevant sections of the chart to be photocopied or printed if sending site uses electronic health records and sent with the baby, including:</p> <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 (include nursing notes from last 72 hours, and any other pertinent notes if indicated). > 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
ID Bands Checked with RN /Transport Team *	Identify the baby with a member of the transfer team and sign record.
Parents Notified of Transfer *	<p>Ensure family is aware of pending transfer.</p> <p>Provide the parents with the receiving facility's contact phone number and address.</p> <p>Check with the parents to ensure that their contact numbers are correct.</p>
Copy of Medication Administration Record *	Photocopy current Medication Record.
Patient Discharge Summary from Sending Facility *	Check chart for medical discharge physical exam and summary notes.
Physician Discharge Order *	Check chart for physician's order for the baby's transfer.
Parents to Accompany Mother Partner	Indicate if mother or partner are to accompany if there is available space.

Completion of the Form

Item	Description
Pumping Initiated (dd/mm/yyyy)	Indicate if mother has begun expressing breast milk. Include date (dd/mm/yyyy) when hand expression or pumping first initiated.
Report Given to Receiving Facility	Ensure the receiving agency is aware and prepared for patient care requirements. Complete checkbox if telephonic / verbal handover has been given to RN at receiving facility.
Signed Transfusion Consent	Check if there is a signed consent form for the transfusion of blood products if appropriate and send with the copied / printed patient chart.
Acute Transfer	Complete checkbox(es) to confirm if the items were sent with the baby. Ensure any requested specimens are clearly labeled, for example:
Maternal blood	Maternal blood sample
Cord blood	Cord blood sample from the placenta. Useful mainly for a direct antibody (Coombs) test
Placenta	Placenta, wrapped in a sealed plastic bag or placed in a bucket with a lid (no additives or preservatives)
Baby's Blood Culture	Baby's blood cultures (aerobic ± anaerobic)
Other Lab Work	
Vitamin K administered	Complete checkbox if vitamin K was administered.
Erythromycin administered	Complete checkbox if erythromycin was administered.
Repatriation Transfer	Complete checkbox(es) if items sent with the baby.
EBM double checked and in cooler	Double check all expressed breast milk being sent with the baby prior to placing it in the cooler. Place labelled expressed breast milk in cool bag with gel packs and send with the baby if appropriate.
Personal belongings	Ensure the baby's belongings are sent with patient.
Medications	Send any patient-specific medication(s) if appropriate.
Environment for Transfer	
Incubator	Complete checkbox which environment the baby is being transferred in.
Car seat	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
Car bed	Ensure baby is safely secured in a Transport Canada–approved car bed as per manufacturer instructions. See https://www.tc.gc.ca/media/documents/roadsafety/TP14772e.pdf
Incubator Temperature and Humidity	Record the incubator temperature and humidity settings.
Dressed	
Covered	Complete checkbox to indicate if the baby is dressed or covered with a blanket.

Completion of the Form

Item	Description
Care Transferred to Infant Transport Team	Complete checkbox to indicate who the care of the baby was transferred to.
Ambulance Transfer with MD RN	
15. Nurse(s) Completing Form	
	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.
Baby left sending hospital	Record the date and time the baby left the sending hospital in the care of the transport team identified above. Contact receiving unit regarding estimated time of arrival of baby and transport team.

References

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Appendix

BC Neonatal Transfer Record

British Columbia Neonatal Transfer Record

1. Surname Given Name		Date/Time of Birth (dd/mm/yyyy) (hh:mm)	Gestational Age at Birth (weeks / days)	Post Menstrual Age (weeks / days)	Birth Weight (grams)
Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk.		Neonatal Daily Classification			
Attending MD/RM		Discharge Diagnosis			
Receiving Physician		G	T	P	A L
APGAR Scores					

Maternal / Birth History
Antenatal Steroids
Prophylactic Antibiotics

2. Parent or Guardian Name(s)

Hometown of Baby

Contact Number

Language Preferred

Current Isolation Status
☐ Photos of Baby to Mother
☐ Mom Expressing Breast Milk

3. Vital Signs

Time (hh:mm)

HR

RR

SpO2

BP

MAP

4. Assessments

Respiratory

Airway: ☐ ETT # @ ____ cm ☐ Oral ☐ Nasal Date/Time: ____ (dd/mm/yyyy) (hh:mm) Exubated Date/Time: ____ (dd/mm/yyyy) (hh:mm) ☐ LMA # ____

Current Ventilator Settings: Mode: ____ Rate: ____ PIP/PEEP: ____ I:T ____ VT: ____

Non-Invasive Respiratory Support: ☐ Biphasic ☐ CPAP ☐ LFNP ☐ HFNP Setting: ____ FiO2: ____ Date Initiated: ____ (dd/mm/yyyy)

Surfactant ☐ Date ____ (dd/mm/yyyy) # of Doses ____

Date and Time of last ☐ ABG ☐ CBG: ____ (dd/mm/yyyy) (hh:mm) Results: pH ____ pCO2 ____ pO2 ____ HCO3 ____ BD or BE ____

Cardiovascular

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)

Site/Route	Rate
Infusion #1 Solution/Dose	mL/kg/day
Infusion #2 Solution/Dose	
Infusion #3 Solution/Dose	

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

Additives
☐ Human Milk Fortifier
☐ Microlipids
☐ Liquid Protein
☐ Sodium
☐ Other

Method: ☐ BR ☐ B ☐ OG ☐ NG ☐ NJ ☐ G-tube ☐ GJ-tube Date Inserted & Location of Gastric Tube ____ /cm depth

Amount	Frequency	Syringe pump over minutes
Last Fed (dd/mm/yyyy)	<input type="checkbox"/> Feeding Concerns (specify) ____	
(hh:mm)	<input type="checkbox"/> Infant Feeding Assessment Tool Attached	

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

7. Medications ☐ Copy of Medication record attached

8. Investigations ☐ Abnormal Lab Values +/- Blood Culture Results attached ☐ Imaging Results attached

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BC Neonatal Transfer Record

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Obtaining Copies of the BC Neonatal Transfer Record

For sites wishing to order forms or to obtain ordering information,
please refer to the PSBC website:

perinatalservicesbc.ca/health-professionals/forms

If you have any questions or feedback about any of the PSBC
perinatal forms, please email **psbc@phsa.ca** or call **604-877-2121**.

