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 ☐ M ☐ F ☐ Unk.	Neonatal Daily Classification		
Sending Facility	Attending MD/RM	Discharge Diagnosis		Today's Weight (grams)
Receiving Facility	Receiving Physician	G T P A L	APGAR Scores	

Surname | Given name

Address

Phone number | Personal health number

Maternal / Birth History

Antenatal Steroids ____ Delivery Type ____

Prophylactic Antibiotics ____ Other ____

2. Parent or Guardian Name(s)		Newborn Exposure to (check if positive) ☐ HIV ☐ Hep B ☐ Hep C ☐ Substance ☐ Unk. ☐ 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 (hh:mm)	HR	RR	SpO_2	BP / MAP	T

4. Assessments

Respiratory

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

Current Ventilator Settings: Mode: ____ FiO_2: ____ Rate: ____ PIP/PEEP: ____ I:T ____ VT: ____

Non-Invasive Respiratory Support: ☐ Biphasic ☐ CPAP ☐ LFNP ☐ HFNP Setting: ____ FiO_2: ____ Date Initiated: ____ (dd/mm/yyyy)

Surfactant ☐ Date ____ (dd/mm/yyyy) # of Doses ____ ☐ Caffeine Discontinued Date/Time ____ (dd/mm/yyyy) (hh:mm)

Date and Time of last ☐ ABG ☐ CBG: ____ (dd/mm/yyyy) (hh:mm) 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		

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 (dd/mm/yyyy) /cm depth

Amount	Frequency	Syringe pump over ____ minutes
Last Fed (dd/mm/yyyy) ____ (hh:mm) ____	☐ Feeding Concerns (specify) ____ ☐ 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 +/or Blood Culture Results attached ☐ Imaging Results attached

9. Screening

☐ Newborn Screen Done (blood spot card) Date: ________ (dd/mm/yyyy)

☐ Repeat Newborn Screen Needed Date: ________ (dd/mm/yyyy)

☐ CCHD Screen Done Date: ________ (dd/mm/yyyy) ☐ Passed

Follow-up:

☐ Eye Exam Done Date of Last Exam: ________ (dd/mm/yyyy) Due: ________ (dd/mm/yyyy)

Results:

☐ HUS Done Date of Last HUS: ________ (dd/mm/yyyy) Due: ________ (dd/mm/yyyy)

Results:

☐ Hearing Screen Done Date: ________ (dd/mm/yyyy) ☐ Passed

Follow-up:

☐ Phototherapy Date first initiated: ________ (dd/mm/yyyy) Date last discontinued: ________ (dd/mm/yyyy)

Surname ________ Given name ________

Address ________

Phone number ________ Personal health number ________

Immunizations:
☐ 2 months ☐ 4 months ☐ 6 months
☐ MAR indicating immunizations given attached

Next due (dd/mm/yyyy) ________

Notes ________

RSV Prophylaxis Candidate: ☐ Yes ☐ No

RSV Prophylaxis Date Given: ________ (dd/mm/yyyy) ☐ 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
☐ RSV Screening / Teaching ☐ Purple Crying ☐ Biliary Atresia ☐ Maintenance of Milk Supply
☐ Safe Storage and Handling of Human Milk

☐ Complex Care Involvement / Teaching: (specify) ________

☐ Other: ________

12. Socioeconomic Issues / Needs

☐ Housing required by parents? ☐ Receiving facility notified of housing need? ________

13. Other

14. Transfer Checklist (if applicable * indicates mandatory)

☐ 2 ID Bands on Baby *
☐ Copy of Chart (refer to Guide for Completion) *
☐ ID Bands Checked with RN / Transport Team *
☐ Parents Notified of Transfer *
☐ Copy of Medication Administration Record *
☐ Patient Discharge Summary from Sending Facility *
☐ Physician Discharge Order *

☐ Parents to Accompany
 ☐ Mother ☐ Partner
☐ Pumping Initiated ________ (dd/mm/yyyy)
☐ Report Given to Receiving Facility
☐ Signed Transfusion Consent

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 ☐ Car Bed

Incubator Temperature and Humidity

☐ Dressed
☐ Covered

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

15. Nurse(s) Completing Form

Printed Name	Signature	Date (dd/mm/yyyy)	Time (hh:mm)

Baby Left Sending Hospital: Date (dd/mm/yyyy) ________ Time (hh:mm) ________

☐ Place original document on medical record of patient at sending hospital ☐ Place copy of document on medical record of patient at receiving unit.