PROVINCIAL MATERNAL NEWBORN TRANSFER NETWORK:

PRINCIPLES AND PROCESSES

April 2014

Table of Contents

1.0 Executive Summary

1.1 Purpose

1. Provide clear principles and processes on which to build an effective and efficient provincial perinatal consultation and transfer service that satisfies the needs of newborns, women and perinatal care provider teams.

2. Establish effective communication pathways, processes and protocols to support health care providers with timely direct access to support and consultation services of the Perinatal Transfer Physician specialists: maternal-fetal medicine and neonatology.

3. Articulate the collaborative commitment to maternal and neonatal acute and repatriation provincial flow coordination principles, processes and acknowledged operational implications.

4. Identify comprehensive integrated data collection and reporting mechanisms required for the purposes of Maternal Newborn Transfer Network service assessment, planning, quality improvement and evaluation.

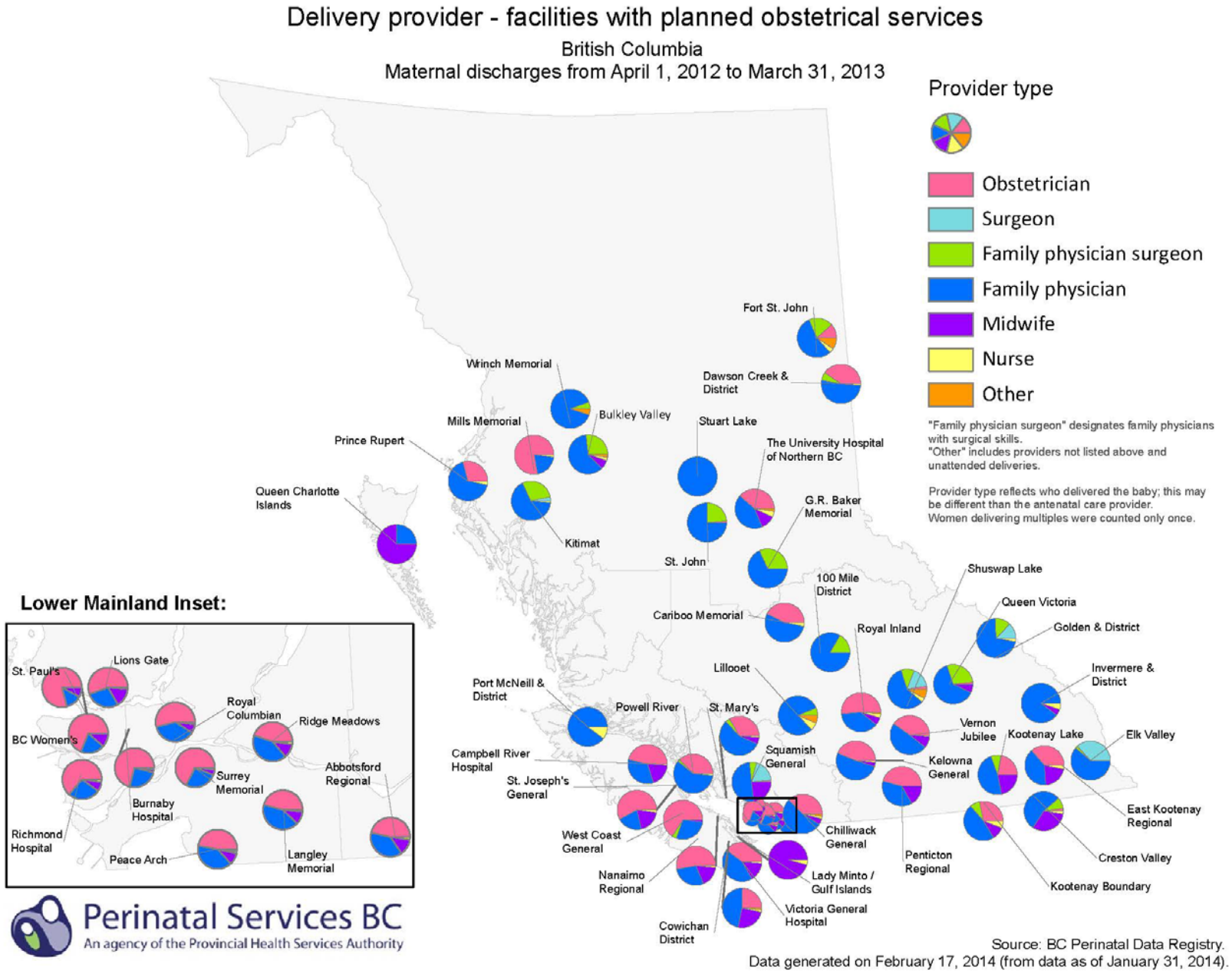
1.2 Context

British Columbia's transfer network supporting critically ill newborn, children, and women requiring maternal/fetal care is well established. The BC Patient Transfer Network (BCPTN), BC Ambulance Service (BCAS), including Patient Transport Coordination Centre (PTCC), Infant Transport Team (ITT), and the uniquely integrated Neonatal Intensive Care Unit - Maternal Fetal Medicine- Pediatric Intensive Care Unit approach to coordinating operations are at the core of system excellence.

Perinatal health care professionals utilize a no-delay 'one number to call' access for consultation requests, triage support and transfer coordination requests. The Perinatal Transfer Physician utilizes a range of clinical decision support resources to ensure comprehensive understanding of Maternal/Fetal and Neonatal Intensive Care Unit bed capacity and utilization demands, Infant Transfer Team demands, clinical expertise and equipment resources requirements. Through BCPTN, the Perinatal Transport Physician communicates with care providers, PTCC for transfer consultation and planning and with the Infant Transfer Team for clinical direction and support.

The Maternal Newborn Transfer Network provides a forum for collaboratively generating and sharing evidence based information required by key stakeholder members for system assessment, planning and coordination of all transfer services, including regional transport solutions. Relevant recommendations are then provided to the Perinatal Services BC Oversight Council and BC Patient Transfer Network.

The effectiveness of Maternal Newborn Transfer Network processes are dependent upon sustained regional Health Authority investment to ensure continued development and operation of transfer related standards, access, education, logistics, resources and coordination of these provincial resources to meet the needs of all stakeholders.


Delivery provider - facilities with planned obstetrical services
British Columbia
Maternal discharges from April 1, 2012 to March 31, 2013
Provider type
Obstetrician
Surgeon
Family physician surgeon
Family physician
Midwife
Nurse
Other
"Family physician surgeon" designates family physicians with surgical skills.
"Other" includes providers not listed above and unattended deliveries.
Provider type reflects who delivered the baby; this may be different than the antenatal care provider.
Women delivering multiples were counted only once.
Fort St. John
Dawson Creek & District
Wrinch Memorial
Bulkley Valley
Mills Memorial
Prince Rupert
Queen Charlotte Islands
Kitimat
Stuart Lake
The University Hospital of Northern BC
G.R. Baker Memorial
St. John
Cariboo Memorial
100 Mile District
Shuswap Lake
Queen Victoria
Golden & District
Royal Inland
Lillooet
Invermere & District
Port McNeill & District
Powell River
St. Mary's
Campbell River Hospital
St. Joseph's General
Squamish General
Vernon Jubilee
Kootenay Lake
Elk Valley
Kelowna General
East Kootenay Regional
West Coast General
Chilliwack General
Penticton Regional
Creston Valley
Nanaimo Regional
Lady Minto / Gulf Islands
Kootenay Boundary
Victoria General Hospital
Cowichan District
Lower Mainland Inset:
St. Paul's
Lions Gate
Royal Columbian
Ridge Meadows
BC Women's
Surrey Memorial
Abbotsford Regional
Burnaby Hospital
Richmond Hospital
Peace Arch
Langley Memorial
Perinatal Services BC
An agency of the Provincial Health Services Authority
Source: BC Perinatal Data Registry.
Data generated on February 17, 2014 (from data as of January 31, 2014).

[1]

Table 1: BC Facilities offering consistent Tier 2/3 specialized maternal/newborn care (2013)

Tiers of Service		Community				Regional		Provincial	
HA	**Site**	**Up to 2A**		**Up to 2B**		**Up to 3**		**Up to 3+**	
		Mat	Neo	Mat	Neo	Mat	Neo	Mat	Neo
NHA	University Hospital of Northern BC			o	x				
IHA	Royal Inland Hospital			o	x				
	Kelowna General Hospital			o	x				
FHA	Surrey Memorial Hospital			o			x		
	Royal Columbian Hospital					o	x		
	Abbotsford Regional General Hospital		x	o					
	Burnaby General Hospital	o	x						
PHSA	BC Women's Hospital					o			x
VCH	St. Paul's Hospital		x					o	
	Richmond General Hospital		x	o					
	Lion's Gate Hospital		x	o					
VIHA	Victoria General Hospital					o	x		
	Nanaimo Regional General Hospital		x	o					

[1] In consideration of the work underway associated with the Maternal/Fetal and Neonatal Tiers of Service Planning Framework, we have begun transitioning this language within this document where applicable. Please note that the "Level" abbreviation (eg. L2/L3) will remain as is until the Tiers of Service Framework is adopted.

2.0 Maternal Newborn Transfer Network: Principles and Processes

2.1 Provincial Principles

1. The 'one-number' call to BCPTN for consultation requests, triage and transfer coordination (including repatriation) is focused on meeting the care needs of the patient through immediate direct communication between the sending/consulting practitioners and the Perinatal Transfer Physician and is designed to ensure there are no delays.

2. Collaboration occurs between the Perinatal Transfer Physicians and the Emergency Transfer Physician at BCPTN to coordinate competing priorities for resources such as air ambulance.

3. The Maternal Newborn Transfer Network is integrated with the Pediatric Critical Care consultation and transfer system (BC Children's Hospital: PICU). It enables immediate contact and support of the sending/consulting practitioner by the PTP, and effectively functions as a single coordinated, inter-dependant, family centered provincial program, in partnership with all key transfer network stakeholders (Health Authorities, BC Emergency Health Services including BCAS (ITT and PTCC) and BC Patient Transfer Network.

4. Every effort should be made to keep mothers and newborns together (including multiple births) at a site that provides the appropriate tier of service required as close to home and/or family supports as possible transfer decisions are made in consideration of all resources available at a facility able to provide the highest tier of service required by the mother/fetus or newborn simultaneously minimizing the number of transfers involved.

5. The outcome for the sick or at-risk newborn is improved when the unborn infant is transported in-utero (antenatally) to a referral centre that can provide immediate intensive neonatal evaluation, support, and stabilization (ACoRN, 2012).

6. All sites work collaboratively to ensure provincial quaternary bed capacity at BC Women's Hospital is maintained. Similarly, all regions work to ensure that Tier 3/3+ bed capacity is maintained. At Tier 2 sites, if the originating site offers the tier of service required, every effort is made to accommodate the mother/newborn pair at that site. Strategies may include the repatriation of another mother/newborn pair to a site closer to home, exceeding census (full capacity as defined by the number of regionally designated bed/staffing resources, borrowing/renting equipment, employing overtime staff, or transferring a stable newborn from the NICU setting to a Pediatric Care setting or Maternity Care setting to room-in with the mother.

7. Comprehensive integrated data is collected and reported from all sites and stakeholder agencies to enable assessment, planning, implementation and evaluation of programs and services with a focus on patient safety and quality across the province.

8. Processes will be developed to establish an interagency, interhealth authority comprehensive, integrated quality assurance and improvement processes to ensure prompt patient safety, risk and event identification and management.

2.2 Provincial Processes

1. The BC Women's Perinatologist/Maternal Fetal Medicine Specialist, Neonatologist and/or Pediatric Intensive Care Unit/Emergency Department Pediatric Intensivist, Pediatrician, or Physician constitute the provincial Perinatal Transfer Physician for all acute provincial transfers requiring the Infant Transport Team, based on established criteria.[2]

2. A Physician, Midwife, Nurse Practitioner, Registered Nurse or delegate[3] at the sending site, with the authority to make decisions regarding the care of a mother/newborn, constitutes the Most Responsible Care Provider.

   Following an assessment by the Most Responsible Care Provider and initiation of a transfer or consultation request from the sending site through the BC Patient Transfer Network, with a single phone call the BC Women's Perinatal Transfer Physician is accessed through the BCPTN avoiding waits and/or system repetition or duplication. The Perinatal Transfer Physician can be directly accessed by the requesting practitioner as frequently as required for ongoing clinical support and care management.

BC Patient Transfer Network coordinates all consultation/advice and transfer calls. For maternal transfers, a consultation with and assessment by an obstetrician when indicated and where available is expected .The Most Responsible Care Provider has the option to engage a BC Women's Perinatal Transfer Physician for consultation/advice at any time, regardless of whether a transfer is required or not. Once a decision to transfer has been confirmed, the BC Women's Perinatal Transfer Physician establishes the transfer logistics (e.g. destination, priority, timeline, mode of transfer, special equipment requirements, Infant Transport Team needs, additional personnel) in coordination with the BC Provincial Transfer Network Clinical Transfer Nurse who confirms the destination, anticipated time frames and clinical information with both the sending and receiving physicians. The Clinical Transfer Nurse will also coordinate with BCAS Patient Transport Coordination Centre.

3. A core patient demographic and clinical information set is required for the purposes of triage/transfer care and is collected and exchanged by the BC Women's Perinatal Transfer Physician concurrently with the BCPTN Clinical Transfer Nurse (or call taker) in order to eliminate duplication of effort and not hinder timely provision of urgent care. [4] Additional system processes requirements including confirmation of patient demographics, transfer logistics, and safety and quality details are achieved seamlessly, without impeding communication between the sending/consulting Most Responsible Care Provider and the BCW's Perinatal Transfer Physician. Any missing data will be confirmed with the sending delegate and the Clinical Transfer Nurse at end of the call.

4. The logistics for all acute transfers requiring the Infant Transport Team (air and/or ground) are coordinated under the direction and clinical care of the BC Women's Perinatal Transfer Physician through the BC Patient Transfer Network.

   a. Prioritizing for acute and repatriation transfers using Infant Transport Team resources are placed above outpatient appointment transfers.

[2] ITT Transfer Priority Setting Criteria
[3] A delegate will be working under the direction of the MRCP
[4] See BC Women's Hospital: MFM Triage Form; Neonatal Triage From

5. Access to Maternal and Neonatal Tier 2 and 3 beds and services is a negotiated process: planned and coordinated by the BC Women's Perinatal Transfer Physician in collaboration with the identified Health Authority Most Responsible Care Provider at individual sites. Decisions are based on interpretation of the Maternal/Fetal and Neonatal Tiers of Service Planning Framework (2013) and on a shared contextual understanding of relative site capabilities at that time (e.g. accommodation for short term internal/external challenges including but not limited to occasional surges in maternal/newborn volume/acuity, infection control considerations, human resource needs, facility structural/access issues, weather, geography and/or transfer logistics).

6. The BC Patient Transfer Network Maternal and Neonatal web pages (https://www.bcbedline.ca/) provide information to the team which assists in identifying antenatal and neonatal bed capacity and determining optimal bed utilization. Each site updates its maternal and neonatal bed status on the webpage daily between 0700 and 1200 hours and promptly whenever the beds status changes in order to provide as close to 'real time' information as feasible. The web page provides an overview of the province's bed status and assists in managing patient flow by decreasing the number of phone calls required in the event of an acute or repatriation transfer, or a site that is closed and needs to divert patients to an alternate site.

7. Sites categorize the status of their maternal and neonatal beds as follows:

Table 2: Bed Status for Maternal and Neonatal Beds at Individual Sites

Maternal & NICU Site Bed Status	Definition
Open	Site is open to external and internal admissions.
Limited	Site is experiencing dynamic NICU, Labour and Delivery Room space, equipment or staffing pressures: consultation regarding potential transfers is needed.
Closed	Site closed to potential incoming transfers.

8. Based on how sites have categorized their bed status on the BC Patient Transfer Network webpage, BC Women's Neonatal Intensive Care Unit Provincial Flow Coordinator and Neonatologist-on-call will consult and categorize the provincial neonatal bed status each day.

Table 3: Bed Status for Provincial 2/3 Neonatal Beds

Provincial NICU Bed Status	Definition
Open	A minimum of 3 beds are available in the province for admissions, with a minimum 3 beds being L3 beds.
Limited	2 or less L3 beds are available in the province for external admissions.
Full diversion	No beds are available in the province across L2 or L3 sites.

9. Provincial considerations influencing transfer coordination decisions**:**
    a. The maternal/fetal and newborn tiers of service needs
    b. Geography, weather, and transportation logistics
    c. The need to support smaller rural and remote sites who may not have resources to sustain infant stabilization for long periods
    d. The need to maintain regional and provincial network maternal/newborn L2/L3 capacity
    e. The need to preserve regional L3 and provincial L3+ capacity: a transfer of a L2 Newborn from a facility providing tier L3/L3+ services to an appropriate facility providing tier L2 services may be indicated.
        - All sites should be proactive in preserving space for L3 infants
    f. When BCW NICU is limited escalation processes must be initiated to transfer infants within a region or within the provincial network in order to maintain availability of at least 1 quaternary bed.
    g. Minimizing the number of transfers experienced by the mother/baby
    h. Avoid transfers that result in separation of inpatient mother/baby and/or set of multiples (twins, triplets) or when discharge home is imminent.
    i. Consider mother/family preference for relocation to a community where they have existing family/social support networks.

10. Neonatal repatriation calls are initiated through the BC Patient Transfer Network and are prioritized in consultation with the Provincial Flow Coordinator or alternate Clinical Nurse Leader, as delegate of the Perinatal Transfer Physician. In repatriation calls, the Perinatal Transfer Physician only needs to be called by the BC Patient Transfer Network as directed or in the absence of the Provincial Flow Coordinator/alternate Clinical Nurse Leader or in situations where clinical decisions or oversight are required as judged by the Infant Transport Team.
    a. For provincial repatriation transfers requiring Infant Transport Team air or ground transfer resources, BC Women's Provincial Flow Coordinator functions as a delegate under the oversight of the BC Women's Provincial Transfer Physician (Neonatal Repatriation Algorithm, 2011).
    b. For regional repatriation transfers that do not require BC Women's Perinatal Transfer Physician oversight or Infant Transport Team resources, medical oversight and coordination responsibilities may be delegated to the Tier 3 or L2B NICU physician assuming responsibility for the regional transfer out of his/her NICU.

11. Repatriation of newborns occurs with input from the Provincial Flow Coordinator/Clinical Nurse Leader alternate as delegate of the Provincial Transfer Physician, based on principles that ensure bed capacity at all the L3/L3+ centers or at minimum, at BC Women's. In critical situations, it may be necessary to transfer a mother and/or newborn to a site which is not closest to their home (e.g. in the same or neighboring Health Authority).

2.3 Communication: Roles and Responsibilities During a Transport

1. The sending site
    a. The sending site is responsible for initiating the arrangements through BC Patient Transfer Network and providing information regarding maternal transfers to an inpatient bed when the newborn is transferred to a higher tier of service.
    b. Provides information to mothers and/or families:
        - Transfer and transport arrangements (benefits & risks, anticipated timelines, mode, type of care during transport, and health care provider during transport).
        - Information about the receiving hospital, including information about the maternity unit and/or intensive care nursery, directions to the hospital and modes of transport, visiting hours, telephone numbers, accommodation for families.
        - Community resources available in the area of the receiving hospital.
        - Potential options and costs of transportation to another hospital (if required) or home community (confirm Information and Social Support for Patients Requiring Transfer).
    c. According to facility policies, obtains guardians' consent & contact information.
    d. Is responsible for providing copies of appropriate documentation including:
        - Copies of prenatal, labour and delivery records, mother's chart with all relevant neonatal history, baby's chart, and pertinent laboratory data.
        - Radiographs (note: if the endotracheal tube has been repositioned since the last chest film and no new radiographs have been taken, this information should be noted on the most recent chest radiograph).
        - Clearly labeled specimens if requested and available, e.g. newborn blood cultures (aerobic +/- anaerobic), maternal blood samples (7ml clotted blood and 2 EDTA tubes), and/or clotted cord blood sample from the placenta (direct antibody Coomb's test).
        - Labeled placenta wrapped in a sealed plastic bag or sealed container (no additives or preservatives).
        - Identification of the infant and hospital separation sheet.
        - Contact information for the baby's parents and family physician.

    (Appendix 2 Draft: BC British Columbia Neonatal Transfer Record provides a checklist associated with management of a neonatal transfer).

2. The receiving site
    a. The receiving site is responsible for ensuring appropriate bed availability.
    b. Communicating with clinical staff regarding pending transfer.

3. BCPTN
    a. Transfer coordination with both the sending and receiving site
    b. Transfer coordination with the PTCC (Patient Transfer Coordination Centre).
    c. Providing arrival times to both sending/receiving sites.

3.0 Glossary and Abbreviations

BCAS	BC Ambulance Service
HA	Health Authority
NHA	Northern Health Authority
IHA	Interior Health Authority
FHA	Fraser Health Authority
VCHA	Vancouver Coastal Health Authority
ITT	Infant Transport Team
MFM	Maternal Fetal Medicine
MNTN	Maternal/Newborn Transfer Network
NICU	Neonatal Intensive Care Unit
OC	Oversight Council
PHSA	Provincial Health Services Authority
PICU	Pediatric Intensive Care Unit
PTCC	Patient Transfer Coordination Centre
PTN	Patient Transfer Network
PTP	Perinatal Transfer Physician
PSBC	Perinatal Services BC

4.0 References

Acute Care of at-Risk Newborns Neonatal Society [ACoRN]. (2012). *Acute Care of at-Risk Newborns: A resource and learning tool for health care professionals*. Edmonton, Alberta: McCallum Printing Group Inc.

Provincial Transfer Network: *Neonatal Repatriation Algorithm* (2011)

Perinatal Service BC: Maternal Newborn Quality and Patient Safety Committee [MNQPSC].Terms of Reference (2012)

Perinatal Services BC: *Draft Maternal/Fetal and Neonatal Tiers of Service Planning Framework (2013)*

Draft VCH and FHA: Perinatal Diversion Policies

ImPROVE Acute Neonatal Transfer Process (2008)

ImPROVE Maternal Transfer Process (2009)

Canadian Association of Pediatric Health Centres (CAPHC) Competencies Profile: Interfacility Critical Care Transport of Maternal, Neonatal, and Pediatric Patients (2011)

BCAS/ITT References

Provincial Transfer Network: Process Map

PSBC: Provincial Transfer Network Charter and Terms Of Reference

Perinatal Levels of Care (2005)

Acute Neonatal Transfer Process: The Access Call (2013)

5.0 Maternal Newborn Transfer Network: Membership 2012/13

Peter Beresford	Regional Department Head of Obstetrics and Gynecology, FHA
Debra-Lyn Watson	
Ruth Johnson	
Geoff Cundiff	Head of the Department of Obstetrics and Gynecology, Faculty of Medicine, UBC
Julie De Salaberry	Neonatal Program Manager, BC Women's Hospital, PHSA
Barbara Dyer	Director of System Improvement, Patient Transfer Network
Michele Fryer	Director, Child, Youth and Family Program, VIHA
Adele Harrison	Neonatologist, Victoria General Hospital, VIHA
Loraine Jenkins	Director Maternal, Infant, Child & Youth, FHA
Patty Keith	Regional Director of Planning Maternal/Child, Regional Programs and Service Integration, VCHA
Mark King	Manager, Patient Transfer Coordination Centre at BC Ambulance Service
Randy L'Heureux	Director of Critical Care Operations, BC Ambulance Service
Brian Lupton	Director of NICU, BC Women's Hospital, PHSA
Gerry Marquette	Medical Director, Maternal, Perinatal Services BC
Erin O'Sullivan	Leader, Perinatal Program Development: Child, Youth and Family Health, VIHA
Rose Perrin	Regional Program Coordinator: Perinatal, Child & Youth Planning, NHA
Lynn Popien	Regional Perinatal Education Coordinator, IHA
Jan Radford	Project Manager, Medical Administration & Quality Outcomes: Maternal, Infant, Child & Youth Program, FHA
Amanda Skoll	Division Head, Maternal-Fetal Medicine Department of Obstetrics and Gynecology, University of BC
Alfonso Solimano	Medical Director: Neonatal, Perinatal Services BC
John Van Aerde	Regional Division Head for Neonatology, FHA
Brenda Wagner	Regional Perinatal Physician Planning leader for VCH/PHC
Kim Williams	Provincial Executive Director, Perinatal Services BC
Marty Willms	Provincial Lead, Provincial Networks, Perinatal Services BC

6.0 Appendices

Appendix 1: Process: Neonatal Repatriation Algorithm (2011)

Neonatal L2/L3 Repatriation Algorithm
Final: Sept 15th, 2011

Repatriation/Mode of Transport decision is made by Sending MD
(sending MD may choose to call receiving MD independently of BC Bedline at this time)

THE SENDING SITE DELEGATE (PFC/ PCC) THEN CALLS BC BEDLINE WITH THE DETAILS (NAME OF THE RECEIVING SITE, MODE OF TRANSPORT, PT. DEMOGRAPHICS)

1.866.233.2337

BC BEDLINE
Receives info from sending delegate, confirms bed by checking the website and calling the site.

BED AVAILABLE ?

YES

1. If sending and receiving MD's have not yet connected, BC Bedline links them now for medical handover, then MD's hang up.

2. BC Bedline calls the sending delegate and links them with PAACC(ITT)/ BCAS(BLS car) to arrange transport.

4. **If same day transport not available?** BCBedline notifies BCW's PFC/PCC who consults and escalates appropriately.

5. BC Bedline provides the ETD and ETA to the receiving site delegate.

NO

1. BC Bedline connects with the receiving site, requests they waitlist the pt transfer, and confirm their timeline for bed availability.

2. BC Bedline notifies the sending site that the pt transfer has been waitlisted and provides them with the timeline.

3. BC Bedline provides an update to everyone Provincially on the 1130 neonatal teleconference.

BED AVAILABLE

Principles for Neonatal Repatriation Transfer using BLS Car (Non-ITT):
- Baby is term (corrected gestation 37-42 wks)
- No need for in-transit O2, incubator, IV or Medication Administrations, NG feeds, has passed infant car seat challenge, no need for incubator transport.
- Weather and distance implications have been considered
- No need for respiratory support or other medical support

Developed by Provincial Perinatal Transport Network September 1, 2011

Appendix 2: British Columbia Neonatal Transfer Record (DRAFT)

British Columbia Neonatal Transfer Record

PROOF

1. Surname Given Name	Date/Time of Birth	Gestational Age at Birth weeks/days	Post Menstrual Age weeks/days	Birth Weight /grams
	Gender ☐ 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 Pumping

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_2 _____ BD _____

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 ☐ MAR 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

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

☐ Hearing Assessment Done Date: _____ ☐ Passed
Follow-up:

☐ Phototherapy
Date Discontinued: _____

☐ Newborn Screen Done (blood spot cord) Date: _____ ☐ Repeat Newborn Screen Needed Date: _____
Immunizations: ☐ Provincial Immunization Attached ☐ RSV Prophylaxis Candidate RSV Given: _____

☐ Passed Car Seat Challenge ☐ Not Done

10. Consultants ☐ Social Work ☐ MCFD ☐ OT ☐ PT ☐ SLP ☐ Dietitian ☐ Other:

11. Complex Care / Teaching

Parent Teaching: Basic Care for Infant: ☐ Bath ☐ Diaper Change ☐ Temperature ☐ Cuddle ☐ Skin-to-Skin ☐ Feeding ☐ Safe Sleep

☐ Complex Care Involvement / Teaching (specify): ☐ RSV Screening / Teaching ☐ Purple Crying ☐ Biliary Atresia ☐ Other: _____

12. Additional Information

13. Transfer Checklist (if applicable * indicates mandatory)

☐ Physician Discharge Order
☐ Copy of Chart (refer to Guide for Completion)*
☐ 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
☐ 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 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 _____