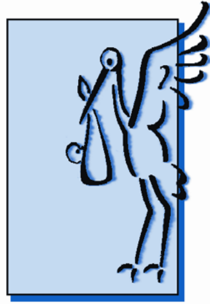

Neonatal Transport Data System
California Perinatal Transport System (CPeTS) Network Database
Managed by California Perinatal Quality Care Collaborative (CPQCC)

Manual of Definitions
For Infants Born in 2011

Version 12.16
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I. REFERRAL

Note: **Items with "*" represent those that MUST be filled out on the online Transport form in order to propagate specific item numbers on the online Admission/Discharge (A/D) Form. The Admission/Discharge (A/D) related Items will be listed as "(A/D Item#)".**

Note: **Infants admitted to embedded NICUs (e.g. an NICU owned and managed by one organization located within a delivery facility owned and managed by another hospital) is not considered an acute inter-facility transport for the purpose of the Transport Data System. No TRS form is required.**

Situational Overrides (applicable to Acute Inter-facility Neonatal Transports)

Unique situations can complicate the data collection required for Acute Inter-Facility Neonatal Transports. Several situations have been identified that will alter the data required (see below). Refer to Appendix J for the summary table.

- **Requested Delivery Attendance: When the referring hospitals requests that the receiving NICU transport team attend the delivery of a suspected high-risk infant (formerly called Delivery Room Attendance Requested) then the referring hospital evaluation (TRIPS Score) C.20a-30a (previously T.15a-25a) are not applicable. When this special situation is selected this area will gray and not be required.**
- **Transport by Referring Center (Self-Transport): When the referring hospital transport team will be used to transport the infant several sections are gray as they are not applicable. These include: C.16 (previously 2), C.17 (previously 3) Date/Time of Transport Team Arrival at Referring Hospital, C.18 (previously T.14b) Transport Team Departure for Referring Facility, and C20b-30b (previously T.15b-25b) Initial Transport Team Evaluation (TRIPS Score).**
- **Transport from Emergency Department (ER) or other non-perinatal setting: When infants are transported from non-perinatal settings some data may be not applicable or not available. In this case the following items will gray out: C.10 (previously T.5) Date/Time of Mother's admission to L&D, C.12 (previously T.6) Date/Time of Birth, C.6a (previously T.10) Prenatally diagnosed congenital anomalies, C.7 (previously T.11) Maternal Gravida, C.8 Antenatal Steroids. Use the current birth weight in C.3 (previously T.7).**
- **Safe Surrender Infants: Infants left at designated Safe Surrender sites frequently have little to no known information about their mother or delivery. In this case the following areas are grayed: C.10 (previously T.5) Date/Time of Mother's admission to L&D, C.6a (previously T.10) Prenatally diagnosed congenital anomalies, C.7 (previously T.11) Maternal Gravida, C.8 (previously T.12a) Antenatal Steroids, C.9**

(previously T.13a/b) Surfactant Administration, C.10 (previously T.5) Maternal Admission to Perinatal Unit or Labor and Delivery, C.33 (previously T.28) Birth Hospital. Other information may need to be estimated such as: C.3 (previously T.7) Birth weight (use current weight if unknown), C.4 (previously T.8) Gestational Age, C.12 (previously T.6) Infant birth date and time.

C.1 Transport Type

A CPeTS Acute Inter-facility Transport is defined as any infant that requires medical, diagnostic, or surgical therapy that is not provided, or that cannot be provided due to temporary staffing/census issues, or due to insurance restrictions at the referring hospital. A CPeTS Acute Inter-facility Transports do not include infants transported solely for feeding and growing or hospice care.

Check type of transport requested.

Requested Delivery Attendance. Check if neonatal transport team was initially requested to attend the delivery.

Emergent. Check if the infant was an emergent transport. Immediate response is requested.

Urgent. Check if response within 6 hours was needed.

Scheduled Neonatal. Check if the infant transport was planned or scheduled. A scheduled transport is selected for an infant whose initial medical/surgical needs have been met, whose condition has been stabilized and who is transferred to a facility in order to obtain planned diagnostic or surgical intervention. The medical needs may be extensive and extremely complex care (e.g., an infant with lethal anomalies).

Other. Check other if the transport does not conform to other definitions. Describe indication.

C.2 Indication for Transport.

Medical Services. Check if the infant was transported for medical problems that require acute resolution.

Surgery. Check if the infant was transported primarily for major invasive surgery (requiring general anesthesia, or its equivalent).

Insurance. Check if the infant was transported for insurance purposes.
Bed Availability. Check if the infant was transported due to bed availability issues at the referring facility.

II. PATIENT IDENTIFICATION: HISTORY

C.3 Birth Weight (A/D Item 1).
Record the birth weight in grams. Since many weights may be obtained on an infant shortly after birth, enter the weight from the Labor and Delivery record if available and judged to be accurate. If unavailable or judged to be inaccurate, use the weight on admission to the neonatal unit or lastly, the weight obtained on autopsy (if the infant expired within 24 hours of birth). (See Appendix J for Pounds to Grams Conversion Table)

C.4 Best Estimate of Gestational Age (A/D Item 3).
Record the best available estimate of gestational age in weeks and days. Where sources disagree, use the following hierarchy: 1. Obstetric measures, based on last menstrual period, obstetrical parameters, or prenatal ultrasound as recorded in the maternal chart. 2. Neonatologist's estimate, based on physical or neurologic examination, combined physical and gestational age exam (Ballard/Dubowitz), or examination of the lens. Record gestational age in weeks and days. In cases when the best estimate of gestational age is an exact number of weeks, enter the number of weeks in the space provided for weeks and enter 0 in the space provided for days. Do not leave the number of days blank.

C.5 Infant Sex (A/D Item 5).
Check Male or Female. Check Unk if sex cannot be determined.

C.6 Congenital Anomalies that were Diagnosed Prenatally (A/D Item 49a).
Check **Yes** if the infant had one or more clinically significant birth defects that were diagnosed during the prenatal period. Do not check yes if infant was identified to have congenital anomalies following delivery that were not diagnosed prenatally.
Check **No** if an infant was not prenatally diagnosed as having one or more of birth defects.
Check **Unk** if this information cannot be obtained.
Describe: Enter up to 5 Birth Defect Codes that were all Diagnosed Prenatally (A/D Item 49b).
In the spaces provided, you may enter as many as five 3-digit code numbers of birth defects from the list in Appendix D. Do not use general descriptions such as multiple congenital anomalies or complex congenital heart disease .
The following Birth Defect Codes require a detailed description in the space provided:
Code 504 - Other Chromosomal Anomaly
Code 601 - Skeletal Dysplasia
Code 605 - Inborn Error of Metabolism
Code 150 - Other Central Nervous System Defects

Code 200 - Other Cardiac Defects
Code 300 - Other Gastro-Intestinal Defects
Code 400 - Other Genito-Urinary Defects
Code 800 - Other Pulmonary Defects
Code 900 - Other Vascular or Lymphatic Defects

The following conditions should NOT be coded as Major Birth Defects:
Extreme Prematurity
Intrauterine Growth Retardation
Small Size for Gestational Age
Fetal Alcohol Syndrome
Hypothyroidism
Intrauterine Infection
Cleft Lip without Cleft Palate
Club Feet
Congenital Dislocation of the Hips

C.7 Maternal Gravida

Enter total number of pregnancies (including current pregnancy) regardless of outcome.

Note: **Only the total number (Gravida) needs to be filled out on-line. The numbers for (P/Ab/L) are to be filled out on the *All California Neonatal Transport Form*.**

P. Enter number of birth experiences (≥20 weeks)
Ab. Enter total number of spontaneous or therapeutic abortions
L. Enter number of living children

C.8 Antenatal Steroids (A/D Item 13).

***Note*:** **Corticosteroids include Betamethasone, Dexamethasone, and Hydrocortisone.**

Check Yes if corticosteroids were administered IM or IV to the mother during pregnancy at any time prior to delivery.
Check No if no corticosteroids were administered IM or IV to the mother during pregnancy at any time prior to delivery.

Check Unk if this information cannot be obtained.

C.9 Surfactant Given (A/D Item 21).

Check Yes, No or UNK. Yes if the infant received an exogenous surfactant at any time. Include this information even if it occurred at the birth hospital prior to transport to your center. Given in Delivery room or Nursery?

III. TIME SEQUENCE

C.10 Date and Time of Maternal Admission to Perinatal Unit or Labor and Delivery.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330) of mother's admission to hospital of delivery. If mother was admitted directly to Labor and Delivery Unit state this date and time. If mother was initially admitted to the Emergency Department, received care and either delivered there or was subsequently transferred to the Labor and Delivery Unit state this date and time.

C.11 Date and Time of Last Antenatal Steroid Administration (A/D Item 13).
Enter the last date corticosteroids were administered using MM/DDYY. Enter the last time corticosteroids were administered using a 24-hour clock (egg, 11:30 PM = 2330).

C.12 Infant Birth Date and Time (A/D Item 4).
Enter the date of birth using MM/DD/YYYY. Enter the time of birth using a 24-hour clock (egg, 11:30 PM = 2330).

C.13 Date and Time of First Dose Surfactant Administration.
Enter date/time at First Dose. Enter the date using MM/DDYY. Enter the time using a 24-hour clock (egg, 11:30 PM = 2330).
Note: the first dose may have occurred prior to or after NICU admission, and may have occurred before transfer, during transport or at your hospital. Check **DR** if the first dose was administered in the Delivery Room. Check **Nsy** if the first dose was administered in the Nursery. Check **NICU** if first dose administered in the NICU.

Check **No** if the infant never received an exogenous surfactant.

Check **Unk** if this information cannot be obtained.

C.14 Referral (and Referring Hospital Evaluation Time).
Enter the date and time of the initial referral communication between referring and receiving providers/facilities. Time should be reported using MM/DD/YYYY and the 24-hour clock (egg, 11:30 PM = 2330). The same time is used for the referral evaluation which should be done within 15 minutes.

C.15 Acceptance Date and Time.
Enter the date and time of the transport acceptance using MM/DD/YYYY and 24-hour clock (egg, 11:30 PM = 2330).

C.16 Date/Time of Transport Team Departure from Transport Team Office/NICU for Referring Hospital.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

C.17/C.18 Date/Time of Arrival of Team at Referring Hospital/Patient Bedside and Initial Transport Team Evaluation.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

C.19 Date and Time of NICU Evaluation within 15 minutes of Arrival at Receiving Hospital.
Enter the date and time of the infant's NICU evaluation within 15 minutes of the arrival at the Receiving Hospital. Time should be reported on the 24-hour clock.

IV. INFANT CONDITION

This section of the record provides consistent information at three specific times for evaluation of overall stability. They should be recorded at referral, within 15 minutes of arrival of the Transport team and then again within 15 minutes of arrival into the receiving NICU.

Date/Times at which infant condition was evaluated (For each of these items, items C.20 through C.29 need to be filled out).

C.14 Referral (and Referring Hospital Evaluation Time)
Enter the date and time of the initial referral communication between referring and receiving providers/facilities. Time should be reported on the 24-hour clock. The same time is used for the referral evaluation which should be done within 15 minutes.

C.18 Date and Time of Arrival of Transport Team at Referring Hospital/Patient Bedside and Initial Transport Evaluation.
Enter the date and time that the transport team arrived at the referring hospital. Time should be reported on the 24-hour clock. The same time is used for the initial transport team evaluation which should be done within 15 minutes.

C.19 Date and Time of Arrival at Receiving NICU and Initial Evaluation
Enter the date and time that the transport team arrived at the receiving hospital NICU. Time should be reported on the 24-hour clock. The same time is used for the initial NICU evaluation which should be done within 15 minutes.

C.20 Responsiveness.
Write the number **0 (zero)** in the designated space if the infant died prior to evaluation, **1 (one)** demonstrated no responsiveness, seizures or received muscle relaxants at the time of referral for transport.
Note: Seizures include compelling clinical evidence of seizures, or of focal or multifocal, clonic or tonic seizures, as well as EEG evidence of seizures, regardless of clinical status. Write the number **2 (two)** in the designated space if the infant appeared lethargic or had no cry at the time of referral for transport. Write the number **3 (three)** in the designated space vigorously withdraws or cries. This also refers to normal age appropriate behavior.

C.21 Temperature (20.0 to 45.0 C or 68 to 113 F).
If the infant's core body temperature was measured and recorded at the time of referral for transport, enter the infant's temperature in degrees centigrade to the nearest tenth of a degree. For centers that measure temperature in degrees Fahrenheit, a Fahrenheit-to-Centigrade conversion table is provided in Appendix K. Use rectal temperature or, if not available, esophageal temperature, tympanic temperature or axillary temperature, in that order. If the infant's body temperature was not measured leave this item blank.
If the infant is being actively cooled please enter the infant's actual temperature.
If the infant was undergoing intentional cooling for therapeutic purposes, indicate Yes on the second line and select type of cooling if applicable: Passive, Selective Head, Selective Body, Other or Unknown.
If the infant was not undergoing intentional cooling, indicate No and skip the method of cooling.

C.22 Heart Rate (0 to 250).
Indicate infant's heart rate.

C.23 Respiratory Rate (0 to 400 HIFI/OSC).
Indicate infant's respiratory rate.
Note: this rate may be spontaneous or assisted by ventilator.

C.24 Oxygen Saturation (SaO2) (0 to 100).
Indicate average oxygen saturation in percentage. If unknown, indicate **Unk**.

C.25 Respiratory Status.
Write the number **1 (one)** in the designated space if the infant was on the respirator at the time of referral for transport. Write the number **2 (two)** in the designated space if the infant had severe respiratory complications, including: apnea, gasping, or was intubated but not on mechanical respirator. Write the number **3 (three)** in the designated space for all

other respiratory status (including none or mild respiratory complications).

C.26 FiO2

Inspired Oxygen Concentration (FiO_2) (21-100). Indicate inspired oxygen concentration (21-100%). If the infant was given supplemental oxygen, write the FIO2 (percentage of oxygen) in the designated space. If the infant was not given supplemental oxygen, leave the designated space blank.

C.27 Respiratory Support.

Write None (0) if required no respiratory support. Write Hood/NC (1) in the designated space if the infant had spontaneous breathing and was supported using an oxygen hood or nasal cannula. Write NCPAP (2) in the designated space if the infant was provided with continuous positive airway pressure (CPAP) using nasal CPAP. Write ETT (3) in the designated space if the infant was ventilated using an endotracheal tube. Do not enter ETT if an endotracheal tube was placed only for suctioning and assisted ventilation was not given through the tube. Write Unk in the designated space if this information cannot be obtained.

C.28 Blood Pressure.

Indicate infant's systolic, diastolic and mean blood pressures.

C.29 Use of Pressors.

Indicate Y (Yes) or N (No) whether vasopressors were administered.

V. REFERRAL PROCESS

C.30 Referring Hospital.

Write the name of the referring hospital in the designated space. Write the telephone number of the Nursery/NICU of the referring hospital in the designated space. Write the referring hospital's CPQCC membership number in the designated space. Please refer to the current Membership Directory on the CPQCC website (www.cpqcc.org) when answering this question. If the referring hospital is not a CPQCC member hospital, this item is not applicable and may be left blank.

Write the name of the referring Obstetrician in the designated space. Write the telephone number of the referring Obstetrician in the designated space.

Write the name of the referring Pediatrician in the designated space. Write the telephone number of the referring Pediatrician in the designated space.

Write the name of the informant from the referring hospital in the designated space. Write the telephone number of the informant from the referring hospital in the designated space.

C.31a Was the infant Previously Transported?
Check **Yes** if the infant was transported previously from another hospital to the referring hospital.

Check **No** if the infant was not transported previously from another hospital to the referring hospital.

C.31b From If transported previously is answered **Yes** , write the name of the original hospital and its CPQCC membership number in the designated spaces. If the original hospital is not a CPQCC member hospital, this item is not applicable and may be left blank.

C.32 Location of Birth (A/D Form Item 7c).
Write the name of the birth hospital in the designated space. Write the telephone number of the Nursery/NICU of the birth hospital in the designated space. Write the birth hospital's CPQCC membership number in the designated space. Please refer to the current Membership Directory on the CPQCC website (www.cpqcc.org) when answering this question. If the birth hospital is not a CPQCC member hospital, this item is not applicable and may be left blank.

C.33 Transport Team On-Site Leader.
Choose only one of the following responses:
Check **Sub-specialist MD** for Neonatologist
Check **Peds** for pediatrician.
Check **NNP** for Neonatal Nurse Practitioner.
Check **Transport Specialist** for Registered Nurse or Respiratory Therapist specializing in Neonatal/Pediatric Transport Services, Practicing under standardized procedures.
Check **Nurse** for Neonatal Registered Nurse.
Check **Other** and specify what type of staff member this is in the space provided.

C.34a Transport Team From.
Choose one of the following responses:
Check **Receiving Hospital** if the transport team is part of the receiving hospital's staff (including those used for both Neonatal and Pediatric

Transports and based in NICU, Pediatrics, PICU, Emergency Department, etc.)

Check **Referring Hospital** if the transport team is part of the referring hospital's staff.

Check **Contract Service** if the transport team is not on staff at the receiving hospital. This may include contracted transport teams from another facility inside or outside of the hospital system of the receiving facility.

C.34b Amended list of Contract Services.
The list has been amended with the list of fixed wing ambulance services in California from the Association of Air Medical Services (www.aams.org). The additional codes are as follows:

800000 = Other Contract Service
800001 = Aeromedevac, Inc.
800002 = Air Rescue - AIRescue International
800003 = CALSTAR - California Shock Trauma Air Rescue
800004 = PHI Air Medical
800005 = Life Flight - Stanford Life Flight Transport Program
800006 = REACH - REACH Air Medical Services, Mediplane, Inc.
800007 = Sierra LifeFlight

C.35 Mode of Transport.
Select type of transport used. Select only one. Primary type of transport used. (e.g. patient was transported by ambulance to airfield or heliport for helicopter transport, would be coded as helicopter).

Ground for ambulance transport or ambulatory transport (e.g. crossing from one hospital to another immediately adjacent facility).

Helicopter for rotor wing transport.

Fixed Wing for airplane transport.

Death. Indicate **No** if the infant did not die.

Check **Yes** if the infant died between the time of referral for transport and prior to arriving at the receiving NICU. Indicate whether the infant died prior to transport team arrival, prior to departure or prior to admission to receiving NICU.

Enter the date of death using MM/DD/YY. Enter the time of death using a 24-hour clock (egg, 11:30 PM = 2330).

Comments. Please add any comments from the transport team of incidents relevant to this transport.

VI. CLINICAL INFORMATION (ALL CALIFORNIA TRANSPORT FORM ONLY)

This information is helpful to provide continuity of care.

Infant name

Singleton/Multiple Births.
(a) Check **Singleton** for any birth
(b) Check **Multiple** for any birth involving more than a singleton infant and for any multifetal gestation.
(c) If Multiple Birth, indicate the infant's birth order (first, second, etc) as well as the total number of infants actually delivered (count both live born and still born infants). For example, the second infant born of triplets would be entered as 2 of 3.

Note: Count both live births and stillbirths at the time of delivery but do not count fetuses which have been reabsorbed in utero and are not delivered.

Current Weight in grams

Diagnosis

Allergies. Check **Yes** if the infant has known allergies, and write in what type of allergies the infant has. Check **No** if the infant has no known allergies. Check **Unk** if there is no indication in the record regarding whether or not the infant has known allergies.

Any Surgeries Enter **Yes** if infant underwent surgery at any time. Enter **No** if infant has not undergone surgery. If Yes, note indication.

Mother's Name

Mother's Birth Date. Enter the date of mother's birth using MM/DD/YYYY.

Insurance Type. Enter the Insurance of the Mother if known.
Note: For transports within the first month of life, Mother's insurance type is assumed to be the infant's insurance type as well.
Medical Record Number at Delivery Hospital

Gravida, Para, Abortions, Living

Rupture of Membranes

(a) Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330) of rupture of membranes.

(b) Record **Duration** of ruptured membranes in hours (last completed whole hour).

(c) Record fluid appearance, check **Clear** if fluid is clear of meconium or Meconium if meconium is present in the amniotic fluid on rupture.

Antenatal conditions- see CPQCC Admission/Discharge Form

This question focuses on antenatal events that may affect the pregnancy and/or delivery of the infant. Check all conditions in the category, which were present in the antenatal period. Check **None** if none of the listed conditions were present. Check **None** only if you have access to a reliable and complete prenatal/medical record or history. Check **Unk** if the information is not obtainable. If a mother presents with no prenatal care and no available medical history, this section should be marked, **Unk**. If a mother presents with no prenatal care, but there is a medical history present on her chart, applicable items may be selected as appropriate.

Hypertension. The medical record should state the diagnosis of hypertension, pregnancy-induced hypertension, eclampsia, preeclampsia, seizures, toxemia, or HELLP syndrome.

Diabetes. Maternal diabetes of any type and severity

Infection. Includes **intrauterine** infections of the amniotic sac and fluid (amnionitis, chorioamnionitis) and those of the uterine wall (endometritis) as well as **other infections** such as which complicate the pregnancy or delivery. Includes Herpes, HIV, or other sexually-transmitted diseases (STD).

Preterm Labor. Uterine contractions resulting in dilation of the cervix at a gestational age of less than 37 completed weeks of gestation.

Bleeding/Abruption/Previa. Bleeding related to complications with the placenta. Placental abruption refers to premature detachment of the placenta from the uterine wall. Placenta previa refers to low implantation of the placenta in the uterus, usually over the cervix.

Other Maternal. Other antenatal maternal complications affecting the infant's health or the course of delivery. Specify the complication in the space provided.

Unknown. Information not obtainable.

Antepartum or Intrapartum Significant Intrapartum Issues. Describe intrapartum complications affecting the infant's health or the course of delivery. Specify the complication in the space provided.

Intrapartum Antibiotics. Indicate **Yes** if maternal antibiotics were given during the current intrapartum admission, and specify type. Indicate **No** if no antibiotics were given during the current intrapartum admission and **Unk** if the information is not obtainable.

Delivery Type.
Choose only one of the following responses:

Check **Spontaneous (Spont) Vaginal** for a normal vaginal delivery. This is any vaginal delivery for which instruments were not used. This includes cases where manual rotations or other head or shoulder maneuvers were used, provided instruments were not also used.

Check **Operative (Op) Vaginal** for any vaginal delivery for which any instrumentation was used. Episiotomies are not considered operative deliveries. Indicate type of instrumentation: Forceps, Vacuum
Check **Cesarean** for any cesarean delivery (elective or emergent). Indicate Primary or Repeat.

Apgar Scores.
Enter the Apgar score at 1 minute and at 5 minutes as noted in the Labor and Delivery record. Enter the additional Apgar scores every 5 minutes (if 5 minute Apgar was <7), if available. Check **Unk** for any score that is unknown. If Apgar score was not done, select **Not Done (N/D)**.
Note: In general, Apgar scores are repeated every 5 minutes until the infant's score is greater than or equal to 7, or the infant has been moved to the NICU for ongoing resuscitation and critical care. If you do not see a 10-minute Apgar score on the infant's chart, but the 5-minute Apgar score is 7 or higher, you can assume that a 10-minute Apgar score was not done, and mark **Not Done** on the form. If the 5-minute Apgar score is less than 7, there should have been a 10-minute Apgar score done. If you are unable to find it in the record, mark **Unk.**

VII. NON CORE FORM - ADDITIONAL CLINICAL INFORMATION

Ventilator Settings
Enter the Type or Mode of ventilation along with Oxygen %, Pressures, Rate and Inspiratory/Expiratory times

Blood Gas Results at time of referral, initial transport or NICU admit.
If arterial blood gas results were clinically indicated and obtained for transport, indicate results. If blood gases not obtained leave this space blank.

a. **pH**
b. **PCO_2**
c. **BE (Base Excess/Deficit)**

Intravenous and Fluid Administration.
If applicable document IV Type, Fluids, Rate and Times

Hemoglobin/Hematocrit.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330) and results.

Blood Culture.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330) and results.

Imaging.
Enter type of imagining done and results as well as the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330).

Chest X-Ray.
Enter results as well as the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330).

Bilirubin.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330) and results.

Neonatal Screening. Hearing. **Indicate Yes if screening completed, No if screening not completed and Unk if the information is not obtainable.**

Metabolic (PKU, T_4, Galactosemia, Hemoglobinopathies). Indicate **Yes** if screening completed, **No** if screening not completed and **Unk** if the information is not obtainable.

Substance Exposure. Indicate **Yes** if screening completed and provide results, **No** if screening not completed and **Unk** if the information is not obtainable.

Medication Administration
If applicable document any medications given in the delivery room, last doses of medication given at the referral center and medications given en route.

Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330). Medication name, Dose and Route

Enteral Feeding.

First Enteral Feeding. Enter the type (Human Milk Only, Human Milk plus Fortifier, or Formula), route administered (PO- oral, OG- oral gavage, NG – nasal gavage, GT – gastrostomy tube, Other – all other enteral feeding routes), and the amount in cc's. Indicate date using MM/DD/YY and time of the first enteral feeding using a 24-hour clock (egg, 11:30 PM = 2330).

If the infant has not yet received his first enteral feeding, this item is not applicable and may be left blank.

Last Enteral Feeding Prior to Transport. Enter the type (Human Milk Only, Human Milk plus Fortifier, or Formula), route administered (PO- oral, OG- oral gavage, NG – nasal gavage, GT – gastrostomy tube, Other – all other enteral feeding routes), and the amount in cc's. Indicate date using MM/DD/YY and time of the last enteral feeding prior to transport using a 24-hour clock (egg, 11:30 PM = 2330).

If the infant has not yet received his first enteral feeding, this item is not applicable and may be left blank.

Last Urine.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

Last Stool.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

Other Clinical Information.

Blood Transfusion.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330

VIII. REFERRING PHYSICIAN AND FACILITY INFORMATION

Write the name of the referring hospital in the designated space. Write the telephone number of the NICU of the referring hospital in the designated space. This should include the OB, Pediatrician and Informant. Write the referring hospital's CPQCC membership number in the designated space. Please refer to the current Membership Directory on the CPQCC website (www.cpqcc.org) when answering this question. If the referring hospital is not a CPQCC member hospital, this item is not applicable and may be left blank. Write the name of the accepting Physician in the designated space. Write the telephone number of the accepting Physician in the designated space.

IX. CARE PROVIDERS

Referring Hospital.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

Transport Team.
Enter the date using MM/DD/YYYY and time using a 24-hour clock (egg, 11:30 PM = 2330)

X. COMMENTS

Please provide your comments in this section.

XI. INFORMATION/MATERIALS TO BE SENT WITH TRANSPORT TEAM

Information/Materials to be Sent with Transport Team.

Indicate all materials and information provided by referring hospital to transport team.

Chart (Patient Record).
Check Maternal and/or Neonatal

Blood Specimen.
Check Maternal and/or Neonatal

Imaging Copies.

Other.
Specify all additional items transported with infant

XII. TRANSPORT ISSUES WITH IMPROVEMENT POTENTIAL

Transport Issues with Improvement Potential Form allows providers form both referring and receiving hospitals, as well as the transport team, to identify aspects of the transport that were either problematic or didn't go as expected, thereby subject to quality improvement. This form is intended for internal use only (i.e., it should not be filed with the infant's chart or submitted to CPeTS) and should be used to alert providers to issues that may benefit from internal Quality Improvement strategies.

Delay in Transport:
Check **Delay in transport** if a transport delay occurred. Describe the situation that resulted in the transport delay in the space provided. Check **Amb./vehicle issues** if the delay was related to problems with the transportation rig or vendor. Check **Traffic** is the delay was related to traffic issues out of the control of the transport team. Check **Missed opportunity for maternal transport** if the delay was related to either an unwitting or deliberate failure to identify a patient who could benefit from maternal transport in time to safely affect that transport. Check **Delay in transferring infant** if the delay was related to either an unwitting or deliberate failure to identify a patient who could benefit from neonatal transport in time to safely affect that transport.

Transport Team Difficulties:
Check **Transport Team Difficulties**, if they occurred, and describe these difficulties in the space provided.

Equipment Difficulties:
Check **Equipment Difficulties**, if they occurred, and describe these difficulties in the space provided.

Unplanned Intervention During Transport:
Check **Unplanned Intervention During Transport** if any unplanned intervention was required. Describe the situation that resulted in the unplanned intervention in the space provided. Check **Airway** if the intervention involved the establishment or maintenance of a patent airway. Check **Vascular Access** if the intervention involved establishing or maintaining functional vascular access. Check **Return to Referring Hospital** if a situation arose requiring that the transport team and infant return to the referring hospital. This may involve a problem with the infant, the transport equipment, the transport rig, or the transport team. Check **Other** if some other situation arose requiring that the transport

team and infant return to the referring hospital, and describe the situation in the space provided.

CPR During Transport:
Check **CPR during transport** if the infant required resuscitation during transport.

Death Prior to Admission to Receiving NICU:
Check **Death prior to admission to receiving NICU**, if the infant being transported expires during the actual transport (i.e., after leaving the referring hospital but before being admitted to the receiving hospital). Please note the **Special Instructions** at the bottom of this form: **For all deaths prior to being admitted at the receiving NICU, complete paper transport form and fax to the CPQCC Data Center at (510) 620-3144.**

None:
Check **None** is there were no identified neonatal transport issues with improvement potential identified during the transport.

Other:
Check **Other** if any issues, other than those identified above, arose during the transport, and describe the situation in the space provided.

Comments:
Please provide your comments in this section.

Referral to Joint Mortality/Morbidity Review:
Check **"Y"** if the transport was referred for Joint Mortality/Morbidity Review by either the referring or receiving hospital, or both. Check **"N"** if the transport was not referred for Joint Mortality/Morbidity Review by either the referring or receiving hospital, or both. Check **"Unk"** if you do not know whether or not the transport was referred for Joint Mortality/Morbidity Review by either the referring or receiving hospital, or both.

If the transport was referred for Joint Mortality and Morbidity Review, write the date of the review in the space provided.

Outcome of Review: Check **Policy/Procedure Change** if the M&M Review requested a change in unit policy and/or procedure. Check **Joint QI Project** if the M&M Review recommended or resulted in a joint QI project between the referring and receiving hospital, and/or the transport team. Check **Education Offering** if the M&M Review recommended or resulted in continuing education or in-service being offered to appropriate providers and/or staff at the referring and/or receiving hospital, or to the neonatal

transport team. Check **Consultation** if the M&M review recommended or resulted in obtaining appropriate consultation for the referring and/or receiving hospital, or the neonatal transport team.
Check **Other** if the M&M Review resulted in any other outcomes not listed above, and describe these outcomes in the space provided.

Follow up: Record the outcome of the quality improvement process stimulated by this worksheet in the space provided. Record any follow up or additional strategies planned to deal with the QI issue identified.

APPENDICES

APPENDIX A: ALL CALIFORNIA NEONATAL TRANSPORT FORM (ACNTF)
CORE CPETS ACUTE INTER-FACILITY TRANSPORT FORM (CCNTF)

APPENDIX B: CPQCC ON-LINE DATA ENTRY (SCREEN SHOTS)

APPENDIX C: BIRTH DEFECT CODES FOR CCNTF ITEM T.10

APPENDIX D: OSHPD FACILITY CODES

APPENDIX E: FAHRENHEIT TO CENTRIGRADE CONVERSION TABLE

APPENDIX F: NEONATAL TRANSPORT DATA SYSTEM CPETS POLICY AND PROCEDURES

APPENDIX G: TRIPS SCORE

APPENDIX H: FREQUENTLY ASKED QUESTIONS (FAQs)

APPENDIX I: NEW AND REVISED ITEMS TO THE CPeTS TRANSPORT FORM