

**SENDING RECEIVING BOTH CORE CPETS ACUTE INTER-FACILITY- NEONATAL TRANSPORT FORM – 2019 PLEASE PRINT CLEARLY**

<b>PATIENT DIAGNOSIS</b> Special Situations: <input type="checkbox"/> None <input type="checkbox"/> Delivery Attendance <input type="checkbox"/> Transport by Sending Facility <input type="checkbox"/> Transport from ER <input type="checkbox"/> Safe Surrender					
C.1 Transport type <input type="checkbox"/> Req Del Attend. <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Sched			C.2. Indication <input type="checkbox"/> Medical Serv <input type="checkbox"/> Surgery		
<b>CRITICAL BACKGROUND INFORMATION</b>					
C.3 Birth weight _____ grams		C.4 Gestational Age _____ weeks _____ days		C.5 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk	
C.6 Prenatally Diagnosed Congenital Anomalies <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Describe: _____				C.7 Maternal Date of Birth _____ Unk	
C.8a. Antenatal Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> N/A			C.8b. Antenatal Magnesium Sulfate <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
<b>TIME SEQUENCE</b>					
			<b>Date</b>	<b>Time</b>	
C.10 Maternal Admission to Perinatal Unit or Labor & Delivery					
C.12 Infant Birth					
C.9/13 Surfactant (first dose) <input type="checkbox"/> Delivery Room <input type="checkbox"/> Nursery <input type="checkbox"/> N/A <input type="checkbox"/> Unknown					
C.14 Referral					
C.15 Acceptance					
C.16 Transport Team Departure from Transport Team Office/NICU for Sending Hospital					
C.17 Arrival of Team at Sending Hospital/Patient Bedside					
C.18 Initial Transport Team Evaluation					
C.19 Arrival at Receiving NICU					
<b>INFANT CONDITION</b>			<b>REFERRAL PROCESS</b>		
Modified TRIPS Score: to be recorded on referral, within 15 minutes of arrival at sending hospital and admit to NICU.			C.30 Sending Hospital Name		
			Previous CPQCC ID#		
			Sending Hospital Nursing Contact Information Name/Telephone		
	Referral	Initial Transport	NICU Admit	C.31a Previously Transported? <input type="checkbox"/> Yes <input type="checkbox"/> No	
C.20 Responsiveness				C.31b From:	
C.21 Temperature C°				C.32 Birth Hospital Name	
C.21.a. Too low to register	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	C.33 Transport Team On-Site Leader (check only one)	
C.21.b. Was the infant cooled?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Sub-specialist Physician <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other MD/Resident	
C.21.c. Method of cooling				<input type="checkbox"/> Neonatal Nurse Practitioner <input type="checkbox"/> Transport Specialist <input type="checkbox"/> Nurse	
C.22 Heart Rate				C.34a Team From <input type="checkbox"/> Receiving Hospital <input type="checkbox"/> Sending Hospital	
C.23 Respiratory Rate				<input type="checkbox"/> Contract Service	
C.24 Oxygen Saturation				C.34b Describe (name of Contract Service):	
C.25 Respiratory Status *				C.35 Mode <input type="checkbox"/> Ground <input type="checkbox"/> Helicopter <input type="checkbox"/> Fixed Wing	
C.26 Inspired Oxygen Concentration				<b>Transport Team Informant Names/Telephone Numbers</b>	
C.27 Respiratory Support					
C.28 Blood Pressure Systolic / Diastolic Mean				<b>Comments</b>	
C.28.a. Too low to register	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
C.29 Pressors	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
Additional Information for CPQCC Admit and Discharge Form Only					
Birth Head Circumference _____ cm		Labor Type <input type="checkbox"/> Spontaneous <input type="checkbox"/> Induced <input type="checkbox"/> Unk		Rupture of Membranes > 18 hours <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Delivery Mode <input type="checkbox"/> Spontaneous Vaginal <input type="checkbox"/> Operative Vaginal <input type="checkbox"/> Cesarean <input type="checkbox"/> Unk					
Delayed Cord Clamping <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Time Delayed <input type="checkbox"/> 30-60 sec <input type="checkbox"/> >60 sec <input type="checkbox"/> Unk			
Breathing before Clamped <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Cord milking performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
Death <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Prior to Team Arrival <input type="checkbox"/> Prior to Departure from Sending Hospital <input type="checkbox"/> Prior to Arrival at Receiving NICU					

Responsiveness: 0=Death 1=None, Seizure, Muscle Relaxant 2=Lethargic, no cry  
3=Vigorously withdraws, cry  
 Method of cooling: Passive, Selective Head, Whole Body, Other, Unknown  
\* Respiratory Status: 1=Respirator 2= Severe (apnea, gasping, intubated not on respirator)  
3=Other Respiratory Rate: HFOV = 400  
 Respiratory Support: 0 = None, 1 = Hood/Nasal Cannula, Blowby 2 = Nasal Continuous Positive Airway Pressure, 3 = Endotracheal Tube 9= Unk **Note C11. Intentionally Omitted**