

**CPETS ALL CALIFORNIA ACUTE INTER-FACILITY NEONATAL TRANSPORT FORM - 2009**

**REQUIRED DATA: DATA POINTS REQUIRED BY THE CALIFORNIA PERINATAL TRANSPORT SYSTEM AND CALIFORNIA CHILDRENS SERVICES**

C.1 Transport type  Requested Delivery Attendance  Emergent  Urgent  Scheduled  Other

C.2 Indication  Medical Services  Surgery  Insurance  Bed Availability

**PATIENT IDENTIFICATION/HISTORY:**



C.3 Birth weight \_\_\_ \_\_\_ \_\_\_ grams C.4 Gestational Age \_\_\_ weeks \_\_\_ days C.5  Male  Female  Unknown



C.6 Prenatally Diagnosed Congenital Anomalies  Yes  No  Unknown Describe:

C.7 Maternal Gravida C. 8 Steroids  Yes  No  Unknown

C.9 Surfactant Given  Yes  No  Unknown  Delivery Room  Nursery

TIME SEQUENCE	Date	Time
C.10 Maternal Admission to Perinatal Unit or Labor & Delivery		at
C.11 Last Antenatal Steroid Administration (last dose)		at
C.12 Infant Birth		at
C.13 Surfactant (first dose)		at
C.14 Referral (and Referring Hospital Evaluation)		at
C.15 Acceptance		at
C.16 Transport Team Departure from Transport Team Office/NICU for Referring Hospital		at
C.17 Arrival of Team at Referring Hospital/Patient Bedside and Initial Transport Evaluation		at
C.18 Initial Transport Team Evaluation		at
C.19 Arrival at Receiving NICU and Initial Evaluation		at

INFANT CONDITION				REFERRAL PROCESS	
Modified TRIPS Score: to be recorded on referral, within 15 minutes of arrival at referring hospital and admit to NICU.				C.30 Referring Hospital Name	
				C.31 Previously Transported? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Referral	Initial Transport	NICU Admit	From:	
Time (24 hour)	C.14	C.18	C.19	C.32 Birth Hospital Name	
C.20 Responsiveness 				C.33 Transport Team On-Site Leader <input type="checkbox"/> Sub-specialist Physician <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other Physician/Resident <input type="checkbox"/> Neonatal Nurse Practitioner <input type="checkbox"/> Transport Specialist <input type="checkbox"/> Nurse	
C.21 Temperature C°				C.34 Team From <input type="checkbox"/> Receiving Hospital <input type="checkbox"/> Referring Hospital <input type="checkbox"/> Contract Service	
C.22 Heart Rate				C.35 Mode <input type="checkbox"/> Ground <input type="checkbox"/> Helicopter <input type="checkbox"/> Fixed Wing	
C.23 Respiratory Rate				Death <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Prior to Team Arrival <input type="checkbox"/> Prior to Departure from Referring Hospital <input type="checkbox"/> Prior to Arrival at Receiving NICU	
C.24 Oxygen Saturation				For all deaths prior to Receiving NICU admission fax form to the Data Center at (510) 620-3144.	
C.25 Respiratory Status *				Comments	
C.26 FiO <sub>2</sub>					
C.27 Respiratory Support 					
C.28 Blood Pressure Systolic/ Diastolic, Mean					
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	RN Signature	

 Responsiveness: 0=Death 1=None, Seizure, Muscle Relaxant 2=Lethargic, no cry 3=Vigorously withdraws, cry  
 \* Respiratory Status: 1=Respirator 2= Severe (apnea, gasping, intubated but not on respirator) 3=Other  
 Respiratory Support: 0 = None, 1 = Hood/Nasal Cannula. 2 = Nasal Continuous Positive Airway Pressure, 3 = Endotracheal Tube

Patient Identification Stamp

<b>CLINICAL INFORMATION</b>										
Infant's Name			<input type="checkbox"/> Singleton <input type="checkbox"/> Multiple ___ of ___		Current Weight			grams		
Diagnosis			Allergies			Surgeries				
Mother's Name:				Birthdate			Insurance Type			
Medical Record Number				Gravida ___ Para ___ Abortions ___ Living ___						
Rupture of Membranes Date/Time @				Duration ___ hours Fluid <input type="checkbox"/> Clear <input type="checkbox"/> Meconium						
Antenatal Conditions <input type="checkbox"/> None <input type="checkbox"/> Unk <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection <input type="checkbox"/> Preterm Labor <input type="checkbox"/> Bleeding/Abruptio/Previa <input type="checkbox"/> Other: _____		Antepartum or Intrapartum Issues:  Antibiotics <input type="checkbox"/> Yes, specify below _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			Delivery <input type="checkbox"/> Spontaneous Vaginal <input type="checkbox"/> Operative Vaginal <input type="checkbox"/> Vacuum <input type="checkbox"/> Forceps <input type="checkbox"/> Cesarean Delivery <input type="checkbox"/> Primary <input type="checkbox"/> Repeat			Apgar Scores Score Unknown 1 ___ <input type="checkbox"/> 5 ___ <input type="checkbox"/> 10 ___ <input type="checkbox"/> 15 ___ <input type="checkbox"/> _____ _____		
<b>INFANT CONDITION</b>										
<b>Indicate Time</b>							<b>Date Time Results</b>			
<b>Ventilator Settings</b>										
Type/Mode				Hemoglobin/hematocrit			@			
Oxygen concentration				Blood Cultures			@			
Pressure – Peak /End				X-rays:						
Rate										
Inspiratory/expiratory time										
<b>Blood Gases</b>				Hearing Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
pH				Metabolic Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
pO2				Drug Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
pCO2				<b>Medication Administration</b>			<input type="checkbox"/> Eye care <input type="checkbox"/> Vitamin K			
Base Excess/Deficit				Date/Time		Medication		Dose Route		
Saturation										
<b>Intravenous Access and Fluid Administration</b>										
Time	Site	Fluid/Type	Rate	<b>Feeding</b>			<b>Date/Time type/route/volume</b>			
Last Urine				@			Stool		@	
<b>REFERRING PHYSICIAN AND FACILITY INFORMATION</b> (name and telephone number)										
Referring Obstetrician					Referring Pediatrician					
Informant					Accepting Physician					
<b>CARE PROVIDERS</b>		name /title			signature			Date and time of arrival		
Referring Hospital								@		
								@		
Transport Team								@		
								@		
								@		
								@		
<b>COMMENTS</b>				Patient Identification Stamp						

**DO NOT PLACE IN MEDICAL RECORD**  
**CONFIDENTIAL NEONATAL TRANSPORT ISSUES WITH IMPROVEMENT POTENTIAL FORM**

Delay in transport, describe: \_\_\_\_\_

Related to  Ambulance/vehicle issues  Traffic  Missed opportunity for maternal transport  
 Delay in transferring infant

Transport Team Difficulties, describe: \_\_\_\_\_

Required elements of neonatal transport form incomplete, describe: \_\_\_\_\_

Equipment Difficulties, describe: \_\_\_\_\_

Unplanned Intervention During Transport, describe: \_\_\_\_\_

Related to  Airway  Vascular Access  Return to Referring Hospital  Other \_\_\_\_\_

CPR during transport

Death prior to admission to receiving NICU

None

Other, describe

Comments


Referred for Joint Mortality/Morbidity Review  Yes  No  Unknown Date of Review

Outcome of Review:  Policy/Procedure Change  Joint Quality Improvement Project  Education  Consultation  
 Other: describe

Follow up:


Patient Identification Stamp