CPeTS All California Acute Inter-facility Neonatal Transport Form - 2008

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

Modified TRIPS Score: to be recorded on referral, within 15 minutes of arrival at referring hospital and admit to NICU.

	Referral	Initial Transport	NICU Admit
Time (24 hour)	C.14	C.18	C.19
C.20 Responsiveness✪			
C.21 Temperature C°			
C.22 Heart Rate			
C.23 Respiratory Rate			
C.24 Oxygen Saturation			
C.25 Respiratory Status✸			
C.26 Oxygen Index* MAP			
C.26 Oxygen Index* FiO_2			
C.26 Oxygen Index* PaO_2			
C.27 Respiratory Support			
C.28 Blood Pressure Systolic/ Diastolic, Mean			
C.29 Pressors	☐Y ☐N	☐Y ☐N	☐Y ☐N
C.30 Blood Glucose	☐ Unknown	☐ Unknown	☐ Unknown

✪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

* Oxygen Index completed if patient is on ventilator

REFERRAL PROCESS

C.31 Referring Hospital Name

C.32 Previously Transported? ☐Yes ☐No
From:

C.33 Birth Hospital Name

C.34 Transport Team On-Site Leader
☐Sub-specialist Physician ☐Pediatrician
☐Other Physician/Resident ☐Neonatal Nurse Practitioner
☐Transport Specialist ☐Nurse

C.35 Team From ☐Receiving Hospital ☐Referring Hospital
☐Contract Service

C.36 Mode ☐Ground ☐Helicopter ☐Fixed Wing

Death ☐No ☐Yes ☐Prior to Team Arrival ☐ Prior to Departure from Referring Hospital ☐ Prior to Arrival at Receiving NICU
For all deaths prior to Receiving NICU admission fax form to the Data Center at (510) 620-3144.

Comments

RN Signature

Patient Identification Stamp

CLINICAL INFORMATION

Infant's Name ☐ Singleton ☐ 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 ☐ Clear ☐ Meconium	

Antenatal Conditions	Antepartum or Intrapartum Issues:	Delivery	Apgar Scores
☐ None ☐ Unk ☐ Hypertension ☐ Diabetes ☐ Infection ☐ Preterm Labor ☐ Bleeding/Abruptio/Previa ☐ Other: _____	Antibiotics ☐Yes, specify below _____ ☐No ☐Unknown	☐ Spontaneous Vaginal ☐ Operative Vaginal ☐Vacuum ☐ Forceps ☐ Cesarean Delivery ☐ Primary ☐ Repeat	Score Unknown 1 __ __ ☐ 5 __ __ ☐ 10 __ __ ☐ 15 __ __ ☐ _____ _____

INFANT CONDITION

Indicate Time				Date Time Results
Ventilator Settings				
Type/Mode				Hemoglobin/hematocrit @
Oxygen concentration				Blood Cultures @
Pressure – Peak /End				X-rays:
Rate				
Inspiratory/expiratory time				
Blood Gases				Hearing Screen: ☐Yes ☐No ☐ Unknown
pH				Metabolic Screen: ☐Yes ☐No ☐Unknown
pO2				Drug Screen: ☐Yes ☐No ☐Unknown
pCO2				**Medication Administration** ☐ Eye care ☐ Vitamin K
Base Excess/Deficit				Date/Time Medication Dose Route
Saturation				

Intravenous Access and Fluid Administration				
Time	Site	Fluid/Type	Rate	
				Feeding Date/Time type/route/volume
				Last Urine @ Stool @

REFERRING PHYSICIAN AND FACILITY INFORMATION (name and telephone number)

Referring Obstetrician Referring Pediatrician

Informant Accepting Physician

CARE PROVIDERS	name /title	signature	Date and time of arrival
Referring Hospital			@
			@
Transport Team			@
			@
			@
			@

COMMENTS	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