NEONATAL INTENSIVE CARE UNIT

Request for Neonatal Transport and Consult Services

DATE ______________________________
YYYY/MM/DD

TRANSPORT STATUS : ☐ URGENT/STAT ☐ URGENT ☐ ELECTIVE; REFERRING CENTER: _______________ ☐ CCPQ

DATE (YYYY/MM/DD)			**CONTACT INFORMATION** - NAME___________ ___________________ - PHONE NUMBER ______________________ **BABY'S NAME** ______________________ **MOTHER'S FIRST NAME AND LAST NAME** ______________________ **RAMQ NUMBER** ______________________ EXPIRATION DATE (YYYY/MM) ______________
TIME:	CALL	00:00	
	DECISION TO TRANSPORT	00:00	
	TEAM MADE AWARE	00:00	

BIRTH: ____/___/___ AT ___:___ ☐ MALE ☐ FEMALE GESTATIONAL AGE: _______ WEEKS
YYYY-MM-DD 00:00 BIRTH WEIGHT: ________KG APGAR: ___[1], ___[5], ___[10]

REASON FOR CONSULTATION AND PRESENTING PROBLEMS: ____

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MATERNAL AND PAST HISTORY: Maternal Age: _____ G ___ P ___ A ___ GBS status _____

Mode of Delivery: _________ ROM: _____ h Cord pH: ______ Antenatal: ☐ Steroid ☐ $MgSO_4$

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CURRENT STATUS

Last Vital Signs	Cardiorespiratory	Physical Exam
Time: ______________ 00:00	☐ Not Intubated	☐ Congenital anomalies noted
Temperature in Celsius: _______	☐ Non-invasive ventilation	Findings:
Heart Rate: ______________	☐ Intubated	______________
Respiratory rate: ____________	Mode of support: ______________	______________
Blood pressure: ______________	ETT #: ______ fixed at ______ cm	______________
Capillary refill: ___________ sec	PIP: _____ PEEP: ____ Rate: ___	______________
Saturation ______ % in _____ F_iO_2	Current intravenous: ___________	______________
Neurological status: ______________	Inotropic support: ______________	______________ ______________

Original-Medical Record Yellow copy-Transport Record

LABORATORIES AND INVESTIGATIONS

Blood gases:

Time: ____ pH: ____ pCO2: ____ BIC: ____ BE: ____

Time: ____ pH: ____ pCO2: ____ BIC: ____ BE: ____

Time: ____ pH: ____ pCO2: ____ BIC: ____ BE: ____

Glucose: ________ ________ Lactate: ________

Complete Blood Count:

White Blood Count: _______ Hemoglobin: _______

Platelets: _______ Blood culture ☐

Other investigations and results: ____

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MEDICATIONS AND INTRAVENOUS

Venous access: ____________________

Fluids: __________ at __________ ml/kg/day

Volume expenders: _________________

Antibiotics:

☐ Ampicillin Doses: ___________________

☐ Gentamicin/Tobramycin Doses: ___________________

☐ Other: _____________ Doses: ___________________

☐ Surfactant given ☐ Inotropes ___________ mcg/kg/minute

PLANS AND RECOMMENDATIONS

Needs a physician on transport ☐ Yes ☐ No

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☐ Recommend to transfer placenta with the patient for pathological analysis

Neonatologist, Fellow, Resident, Neonatal Nurse Practitioner or Nurse's name:

______________________ ______________________ ______________ __________

(Name in print letters) (Signature) (License number) (YYYY/MM/DD)

Name of Neonatologist advised: ______________________ ______________

(Name in print letters) (License number)

FOLLOW-UP AND OUTCOMES

Date: __________________ **Time:** __________

YYYY-MM-DD 00:00

Call back:

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________________________________ Initials _____

Newborn status:

Ventilation / Airway: ____________________________

Cardiovascular: ____________________________

Other: ____________________________

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