Provincial Council for Maternal and Child Health

building a brighter future

Acute Neonatal Transfer Record

*Grey boxes indicate required fields

Date of transfer yyyy mm dd	
Time ☐ am ☐ pm	
MT Number	
eCHN Consent ☐ Yes ☐ No	

ADDRESSOGRAPH

Patient name	Sex ☐ male ☐ female	Health Card Number	
Mother's name		Home phone	Work phone
Address		Cell phone	Contacted/informed about transfer Yes No
Father's name		Home phone	Work Phone
Address		Cell phone	Contacted/informed about transfer Yes No
PATIENT'S PAEDIATRICIAN/GP/OBS/MIDWIFE			
Paediatrician		Phone	
Family MD		Phone	
Obstetrician		Phone	
Midwife		Phone	
REFERRING HOSPITAL (transferring patient FROM)			
Hospital name			
Referring Resident/Fellow/NP		Phone	
Staff MD		Phone	
RECEIVING HOSPITAL (transferring patient TO)			
Hospital name			
Phone number at Receiving Hospital (for contact during transfer)			
Accepting MD		Phone	
MD contacted/informed about transfer Yes No	Comments		
REFERRING DIAGNOSIS/CLINICAL SUMMARY			

Provincial Council for Maternal and Child Health

building a brighter future

*Grey boxes indicate required fields

ADDRESSOGRAPH

SECTION I: MATERNAL INFORMATION - MATERNAL HISTORY

Marital status	Married	Common law	Single	Consanguinity	Yes	No	
Ethnicity/language	Maternal	Paternal		Interpreter required	Yes	No	
Maternal age	GP		L	SA	TA		
Allergies	NKA	Yes (list)					
Other maternal/family details/health							
Previous neonatal issues							

MATERNAL SEROLOGY

Blood group	☐ A	☐ B	☐ O	☐ AB	RH Factor	☐ Positive	☐ Negative
Antibodies				Rhogam	Yes	No	Date
HBsAG	Positive	Negative	Unknown	Rubella	Immune	Non-immune	Unknown
VDRL	Reactive	Non-Reactive	Unknown	Group B Strep	Positive	Negative	Unknown
HIV	Positive	Negative		Antenatal record unavailable			
Other blood/serology details							

MATERNAL RISKS

Cigarettes	Yes	No	Alcohol	Yes	No
Prescribed drugs				
Non-prescribed drugs				
Other maternal risks				

SECTION II: ANTENATAL CARE

Antenatal care	Regular	Poor	None	Not recorded
LMP	EDC		Gestation by dates	
Antenatal meds				

DIAGNOSTICS

U/S date	Results
BPP date	Results
Amniocentesis date	Results
NST date	Results
MSS date	Results
Other	

Problems/issues
Diabetes
Hypertension
Other

Acute Neonatal Transfer Record

Provincial Council for Maternal and Child Health
building a brighter future

*Grey boxes indicate required fields

ADDRESSOGRAPH

SECTION II: LABOUR & DELIVERY - MATERNAL ADMISSION

Date	Time	Birth Hospital
Temperature	B/P	FHR
HgB	WBC	Plts

Onset of labour	Spontaneous	Induced	Augmented	No labour	Date	Time
Rupture of membranes	Spontaneous	Artificial	Date	Time	Hrs PTD	
Liquor	☐ Clear	☐ Foul	☐ Blood	Mec ☐ Thin	Mec ☐ Thick	
Volume	Normal	Oligohydramnios	Polyhydramnios			
Full Cervical dilation	Date		Time			
Medication in labour	General anaesthesia		Epidural		Spinal	

Date	Time	Medication	Dose

Fetal distress	☐ Yes	☐ No	Date	Time
Non-Reassuring Fetal Heart Rate	Date		Time	
Fetal monitoring continuous	Yes	No	Internal	External

Other labour details

INFANT DELIVERY

Date	Time	Sex	☐ Male	☐ Female	☐ Unknown
Birth weight	Delivered by	Singleton	Twin	Other	

Delivery type	☐ Vaginal	☐ C/S: Elective	☐ C/S: Emergency		
Presentation	Vertex	Breech	Footling	Other	
Assistance	☐ Forceps	☐ Vacuum			
Umbilical cord	Normal	Knot	Nuchal	Prolapsed	Number of Vessels

Other delivery details

Placenta delivery	Normal	Abnormal	Unknown	Date	Time	
Sent to Pathology	Yes	No	Brought to HSC	Yes	No	Unknown

RESUSCITATION

☐ Suction	☐ O_2	☐ Intubation (_____time)	☐ Suction below cords	☐ CPAP (_____min)	☐ IPPV
☐ Cardiac compressions (duration_____min)		☐ Epinephrine (X____via____)		☐ Sodium bicarb	☐ Narcan
☐ Volume expander	☐ Blood products				

Spontaneous respirations @_____min of age

APGAR scores	1 min	5 min	10 min	15 min

Provincial Council for Maternal and Child Health
building a brighter future

*Grey boxes indicate required fields

ADDRESSOGRAPH

SECTION IV: REFERRAL HOSPITAL STABILIZATION

Attending MD		ACTS Team requested for delivery	Yes No
Referral Hospital (if different from birth hospital)		ACTS Team present at delivery	Yes No

INTERVENTIONS

Line access	PIV	UAC (____cm)	UVC (____cm)	PAL (_____site)	PICC (_____site)	I/O (_____site)
Solutions	D5W	D10W	D12.5W	Other		

TFI (cc/kg/day)	N/S w/heparin	Boluses
NGT size	ETT size	**Oral/nasal** _____cm/_____# of attempts
Thoracentesis		Chest drain site Size

Other interventions

Medications Vitamin K Erythromycin

Date	Time	Medications	Dose/frequency	Last dose

Initial labs ☐ Blood culture ☐ Brought to HSC ☐ At referring hospital ☐ PKU

CBC Date/time	Hgb	Hct	Plt	WBC
Glucose			Other	

GAS/VENTILATION

Date/time	Type	pH	pCO_2	PO_2	HCO_3	Base	Vent rate	PIP	PEEP	FiO_2	SPO_2
	Cord UA/UV										

Diagnostic results (CXR, AXR, U/S, CT scan, Echo, ECG, EEG, MRI, Hearing test)

Care in transit (for use by non-ACTS Team)

Comments during transport Delayed Reason

Other events in transit Deterioration Cardio/resp. arrest Equipment failure

Death (if Yes, at referring site with ACTS Team At referring site before ACTS Team En-route

SECTION V: SIGNATURES (sign and print name and include professional designation: MD, RN, RRT, etc)

Signature	Print name	Date
Signature	Print name	Date
Signature	Print name	Date