NEWBORN TRANSFER RECORD

Mother's Address ____

____ Postal Code ____________

Phone (H)______________________ Phone (C)______________________

Next of Kin:_____________________ Relationship____________________

Phone (H)______________________ Phone (C)______________________

Infant's Addressograph or Label
Please complete if label not available

Baby's Last Name ______________ Baby's First Name ______________

DOB : DD MM YY

HSN

CPI#

Identification Band Applied #____________________

Bed Line Called: DD MM YY **@ ______ hrs Saskatoon 1-888-831-2225 Regina 1-866-766-6050**

Referring Physician ______________________________ Receiving Physician ___________________________________

Referring Hospital ____________________________________ Phone____________________ Fax________________

Receiving Hospital ____________________________________ Phone____________________ Fax________________

NICU Transport Team: Arrival___________ hrs Departure___________ hrs

Medical Social Work Contacted: ☐ Yes ☐ No Name: _________________________ Phone: ______________

If baby's condition worsens, do parents have spiritual needs for baby? ☐ Yes ☐ No Pictures taken of baby? ☐ By Parents ☐ By hospital

List of Documents Attached to Newborn Transfer Record

If not available at time of transport, please FAX as soon as possible.

Maternal Records	Newborn Records	
❑ **Prenatal Record**	❑ **Resuscitation Records**	***Other: (Please specify)***
❑ **Obstetrical Nursing Database**	❑ **Lab Reports, including Cord Gases**	
❑ **Labor & Birth Records**	❑ **Ultrasound Scans / Reports**	
❑ **Applicable Nurses notes**	❑ **Applicable Physicians notes**	

REASON FOR NEONATAL TRANSFER: ____

____

____

Maternal History

Maternal Age_____ T____ P____A____ L____ G____

LMP______ EDD__________ Confirmed by: ☐ Dates ☐ U/S

Antenatal Problems____

____

If maternal serology unavailable, please do rapid test and report maternal blood group, HIV and Hep B status.

Blood Group	**GBS Status**		**Rubella Titre**
	☐Negative	**HIV** ☐Negative ☐Positive	
	☐Positive	**Hep B** ☐Negative ☐Positive	
Antibodies	☐NK	**Hep C** ☐Negative ☐Positive	☐NK
		VDRL ☐Negative ☐Positive	
		Glucose Screen:	

Risk factors for neonatal sepsis

☐ SRM ☐ ARM ☐ PROM ☐ PPROM

Rupture of membranes: Date / Time ______________

Intrapartum Antibiotic Prophylaxis: ☐ Yes ☐ No

\# of Doses: _______ Antibiotic: ________

Additional concerns: __________________________

____

NEWBORN HISTORY

DATE / TIME OF BIRTH: DD MM YY @ ___________ Hrs ☐ Singleton ☐ Multiples

Transfer Date: DD MM YY @ ___________ Hrs of Age

☐ Male ☐ Female Gestational Age: _______ weeks _______ days Birth Weight: ____________ grams/kg

Mode of delivery: ☐ SVD ☐ Forceps ☐ Vacuum ☐ Caesarean section: ☐ Elective ☐ Emergency ☐ Repeat

APGAR @ 1 min_____5 min_____10 min_____15 min_____20 min_____

Amniotic Fluid: ☐ Clear ☐ Meconium ☐ Trachea suctioned via ETT x _____ for: small______ mod______ large______ secretions

Oxygen: ☐ Free flow ☐ PPV ☐ Mask ☐ Endotracheal Intubation O_2 ______% at ______ L/min SpO_2________

ET Tube Size: _____mm Marking at lip _____cm Placement confirmed by: ☐ CO2 detector ☐ X-ray

Cardiac Compression: ☐ Yes ☐ No Length of time _____ min

UVC Access: ☐ Yes ☐ No Epinephrine 1:10,000 _______ml Via: ☐ ET ☐ IV Date / Time______/______

T-piece settings: PIP______ PEEP _____

Capillary Refill: ______seconds

Respirations: Spontaneous ☐ Assisted ☐ Breath Sounds:______________________

Retractions: ☐ Mild ☐ Moderate ☐Severe

Cord Gases Arterial pH_______ PCO2 ______ HCO_3_______ Base Deficit _________

Delayed Cord Clamping: ☐ Yes ☐ No _________ seconds

Intravenous Access: ☐ Yes ☐ No Site _______________ Date _______________ Total Fluid Volume @ ______ ml/kg/day

Total Fluids Received Prior to Transfer: ________ mls.

IV Solution: __________________@ _______ ml/hr.

Other IV Solutions: 1) _________________ @ _______ ml/hr. 2)________________ @ _______ ml/hr.

Medications: Vitamin K given: ☐ Yes ☐ No Date/Time DD / MM/ YY Dose_______________

Eye Prophylaxis ☐ Yes ☐ No Date/Time DD / MM/ YY Agent_______________

Blood Culture Obtained (prior to antibiotics): ☐ Yes ☐ No Date/Time___________

CBC & Diff Obtained: ☐ Yes ☐ No Date/Time__________

Other Medications:

Ampicillin _______ mg @____________IV

Cefotaxime ______mg @____________IV

Gentamicin ______mg @____________IV

Other Medications given: (specify)____

Voided: ☐ Yes ☐ No Last void @_______hrs Meconium Passed: ☐ Yes ☐ No

☐ Emesis: Amount__________ Color__________

☐ NPO ☐ Last feeding @:_______ Type / Amount: ______________________________

If any signs of respiratory distress or appears unwell, do not attempt oral feeding.

Plans to Breastfeed: ☐ Yes ☐ No Pumping Initiated ☐ Yes ☐ No

☐ Blood Glucose: Time ________ mmol/L_________ ***If < 2.6 mmol/L consult neonatologist for management***

Vital Signs (last done at): Time:_____ Temp______ RR______ HR______ SaO2______ B/P______ Mean______

****monitor VS frequently until transport team arrives***

Dysmorphic features / anomalies: ☐ Yes *Describe:*____

Newborn Metabolic Screen: ☐ Yes ☐ No Date/Time: _____________

Bilirubin: ☐ Yes ☐ No Date/Time:_______________

Other Investigations: ____

____

Communication is important
Referring Physician and family would appreciate a telephone call from the receiving physician

Copy as required or download from the Internet at
www.usask.ca/nursing/cne/perinatal/guidelines.php

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