Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Infant Referral History

NATIONAL NEONATAL TRANSPORT PROGRAMME

(To be completed by referring hospital when the NNTP is requested to conduct transport)

Transport Completed by NNTP: Yes☐ No☐ Other Team Name: _____

Infant Details			Date:	
Surname:	First Name:	Sex:	Date of Birth:	Hospital No.:
Address:		Time of Birth:	Birth Weight:	Gestational Age:
		Current Age:	Current Weight:	Corrected Age:

Referral Details	
Reason for Referral:	
Referring Hospital:	Unit in Referring Hospital:
Referring Consultant:	Phone / Ext / Bleep
Receiving Hospital:	Unit in Receiving Hospital:
Receiving Consultant:	Phone / Ext / Bleep
Date & Time of Referral:	Time of Decision to Transport:

Maternal Details		
Surname First Name	GP Address	
Date of Birth Contact Details Marital Status Ethnicity/Language	LMP EDD Blood Group Antibodies	
Religion Consanguinity Smoking Alcohol/Substance Abuse	Hep B Status Hep C Status HIV Status Serology TPHA	Previous Group B Status Rubella Varicella

Past Medical History

Family History

Father's Details	
Name:	Contact Details:

Past Obstetric History

Year	Place	Sex	Gestation	Delivery	Birth Weight	Outcome

Current Pregnancy

Problems During Current Pregnancy:

Medications in Pregnancy:

Ante-natal Diagnoses:

FH/Social Problems/Child Protection Issues:

Hospital of Booking:	Hospital Where Delivered:

Labour & Delivery Details

Type of Labour

Type of Delivery	Indication
Rupture of Membranes	Duration
Maternal Pyrexia	Intrapartum Antibiotics

Signs of Fetal Distress Meconium: Gd:

Drugs in Labour

Antenatal Steroids Y/N	No. of Doses and Time Given

Initial Condition at Birth

Apgars: @1 min @5 mins @10 mins	Cord pH:	Vit K. IM/PO

Details of Resuscitation:

Observations in the First 12 hours

Admission Temp	Largest Base Deficit
Lowest Blood Sugar	FIO2 Highest Lowest

Assessment at Time of Referral

Current Problems	Significant Previous Problems
1	1
2	2
3	3
4	4
5	5

General

Colour	Temperature Core
Trauma?	Abnormalities?
Skin	Other

Cardiovascular System

HR	BP S/D	BP Mean	Cap Refill Time:
Pulses		Murmurs	

ECG/ECHO

Management to Date:

Respiratory System

Resp. Rate:	Sa02: Pre-ductal; Post-ductal;	Fi02 %	Intubated? Y/N

Ventilation Status: (Please Tick Boxes)

ET Ventilation ☐ ET CPAP ☐ Nasal CPAP ☐ BIPAT ☐ Nasal Prong O2.....lts ☐ Self Ventilating ☐

ET tube size	ETT Position at lips (cm)

Ventialtion Mode: (Please Tick Boxes)

Pressure Control ☐ Pressure Support ☐ SIMV ☐ IMV ☐ Assist Control ☐ High Frequency ☐ Other ☐

Inspiratory Time	PiP	PEEP/CPAP	Rate	Htz	AMP
Surfactant? Y ☐ N ☐	1st Dose		2nd Dose		
NO Therapy?	PPM		MAP	O2 Index	
CXRay					
Management to Date:					

Gastro Intestinal System

Abdominal Appearance	
O / NGT aspirates?	
Enteral Feeding Y ☐ N ☐	Bowels Open Y ☐ N ☐
Abd X Ray	
Management to Date:	

Urinary System

Genitalia
Urine Output
Urine Analysis

Central Nervous System

Alert? Y ☐ N ☐	Sedated? Y ☐ N ☐	Paralysed? Y ☐ N ☐
Irritable? Y ☐ N ☐	Abnormal Movements / Seizures?	
Tone	Fontanelles	Pupils
Cranial Ultrasound	EEG	
Management to Date:		

Investigations

Blood gases

Date				
Time				
Site				
pH				
pCO2				
pO2				
HC03				
BE				
Lactate				

Haematology

Date				
Time				
Hb				
Hct				
WCC				
Platelets				
Clotting				
Blood group				

Other

Chemistry

Date				
Time				
Glucose				
Na+				
K+				
Cl-				
Urea				
Creatinine				
Ca++				
Mg++				
Phosphate				
Albumin				
Bilirubin Total/Direct B				
CRP				
Meth Hgb				

Microbiology

Date		
Blood culture		
Surface swabs		
LP		
Urine		

Treatment

Current medications

Drug	Dose	Frequency and Times	Route	Last Given

Fluids

Total ml/kg/day

Current Infusions

Line	Fluid	Volume	Additives	Rate	Dose	Signature

Enteral Feeds

Vol. x Freq	Type	Mode: PO / NGT	Time of Last Feed:

Screening Tests

Gutherie Test?	Yes ☐	Date:	No ☐	Date Next Due:
Eye Exam?	Yes ☐	Date:	No ☐	Date Next Due:
Hearing Test?	Yes ☐	Date:	No ☐	Date Next Due:
Other:				

Other Information

Infant Seen by Mother?	**Photos Given to Mother?**
Intending Method of Feeding: Breast / Bottle	**Religious Rites?**

Comments

Handover

	Name:	Grade:	Signature:
NNTP Doctor			
NNTP Nurse			
Referring Doctor			
Referring Nurse			

Care Handed Over	Date	Time

Document Completed by

Name	Grade	Signature
Date	Time	Bleep/Phone

Please photocopy as required