

CORE CPETS ACUTE INTER-FACILITY NEONATAL TRANSPORT FORM – 2024

PATIENT DIAGNOSIS Special Situations: <input type="checkbox"/> None <input type="checkbox"/> Delivery Attendance <input type="checkbox"/> Transport by Sending Facility <input type="checkbox"/> Transport from ER <input type="checkbox"/> Safe Surr.			
C.1 Transport type <input type="checkbox"/> Delivery <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Scheduled		C.2. Indication <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Bed Availability/Insurance	
CRITICAL BACKGROUND INFORMATION			
C.3 Birth weight	grams	C.4 Gestational Age	weeks days
C.5 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined <input type="checkbox"/> Unknown		C.6 Prenatally Diagnosed Congenital Anomalies <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Describe:	
C.7 Maternal Date of Birth		<input type="checkbox"/> Unknown	
C.8a. Antenatal Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A		C.8b. Antenatal Magnesium Sulfate <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
TIME SEQUENCE		Date	
Time			
C.10 Maternal Admission to Perinatal Unit or Labor & Delivery			
C.11 Infant Birth			
C.12 Maternal/fetal transport not done due to: <input type="checkbox"/> Advanced Labor <input type="checkbox"/> Bleeding <input type="checkbox"/> Mother Medically Unstable <input type="checkbox"/> Non-Reassuring Fetal Status <input type="checkbox"/> Not Considered <input type="checkbox"/> Unknown			
C.9/13 Surfactant (first dose)		<input type="checkbox"/> Delivery Room <input type="checkbox"/> Nursery <input type="checkbox"/> N/A <input type="checkbox"/> Unknown	
C.14 Referral			
C.15 Acceptance			
C.16 Transport Team Departure from Transport Team Office/NICU for Sending Hospital			
C.17 Arrival of Team at Sending Hospital/Patient Bedside			
C.18 Initial Transport Team Evaluation			
C.19 Arrival at Receiving NICU			
INFANT CONDITION		REFERRAL PROCESS	
Modified TRIPS Score: to be recorded on referral, within 15 minutes of arrival at sending hospital and admit to NICU.		C.30 Sending Hospital Name	
		Previous CPQCC ID#	
	Referral	Initial Transport	NICU Admit
C.20 Responsiveness ☺			
C.21 Temperature C°			
C.21.a. Too low to register	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
C.21.b. Was the infant cooled?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C.21.c. Method of cooling †			
C.22 Heart Rate			
C.23 Respiratory Rate			
C.24 Oxygen Saturation			
C.25 Respiratory Status *			
C.26 Inspired Oxygen Concentration			
C.27 Respiratory Support ☒			
C.28 Blood Pressure	Systolic / Diastolic Mean		
N=Not Done, T=Too low to register	<input type="checkbox"/> N <input type="checkbox"/> T	<input type="checkbox"/> N <input type="checkbox"/> T	<input type="checkbox"/> N <input type="checkbox"/> T
C.29 Pressors	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C.30 Sending Hospital Name		C.31a Previously Transported? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		C.31b From:	
		C.32 Birth Hospital Name	
		C.33 Transport Team On-Site Leader (check only one) <input type="checkbox"/> Sub-specialist Physician <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other MD/Resident <input type="checkbox"/> Neonatal Nurse Practitioner <input type="checkbox"/> Transport Specialist <input type="checkbox"/> Nurse	
		C.34a Team From <input type="checkbox"/> Receiving Hospital <input type="checkbox"/> Sending Hospital <input type="checkbox"/> Contract Service	
		C.34b Describe (name of Contract Service):	
		C.35 Mode <input type="checkbox"/> Ground <input type="checkbox"/> Helicopter <input type="checkbox"/> Fixed Wing	
		Transport Team Informant Names/Telephone Numbers	
		Comments	
Additional Information for CPQCC Admit and Discharge Form Only			
Birth Head Circumference		cm	Labor Type <input type="checkbox"/> Spontaneous <input type="checkbox"/> Induced <input type="checkbox"/> Unknown Rupture of Membranes > 18 hours <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Delivery Mode <input type="checkbox"/> Spontaneous Vaginal <input type="checkbox"/> Operative Vaginal <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown			
Delayed Cord Clamping <input type="checkbox"/> Yes <input type="checkbox"/> 30-60 sec <input type="checkbox"/> 61-120 sec <input type="checkbox"/> >120 sec <input type="checkbox"/> No <input type="checkbox"/> Maternal Bleeding <input type="checkbox"/> Neonatal Causes <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Breathing before Clamped <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Cord milking performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Death <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Prior to Team Arrival <input type="checkbox"/> Prior to Departure from Sending Hospital <input type="checkbox"/> Prior to Arrival at Receiving NICU			
☺ Responsiveness: 0=Death 1=None, Seizure, Muscle Relaxant 2=Lethargic, no cry 3=Vigorously withdraws, cry † Method of cooling: Passive, Whole Body, Other, Unknown * Respiratory Status: 1=Ventilator 2= Severe (apnea, gasping) 3=Other 9= Unknown Respiratory Rate: High Frequency Ventilation = 400 ☒ Respiratory Support: 0 = None, 1 = Hood/Nasal Cannula, Blowby 2 = Nasal Continuous Positive Airway Pressure 3 = Non-Invasive Ventilation (NIPPV / NIMV) Note: This includes Nasal prongs and masks 4 = Oral/Nasal Endotracheal Tube 9= Unknown			