KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CONSULTATION / TRANSFER FORM

Initial Consultation:			
Date:		Time:	
Details	**Referring/Discharge Hospital**	**Receiving Hospital**	
Hospital and unit:			
Doctor:			
Contact number:			

Maternal Details:									
Name:								Age:	
Obstetric history and risk factors:									
Attended clinic :	Y / N	Rh:		Syphilis Rapid:		RPR:		Titre:	
TB Positive:	Y / N	Date of diagnosis:		Treatment started:					
HIV test result:		Viral load:		ARVs commenced:	Y / N	Date:			
Current condition:									

Baby Details:							
Date of Birth:		Gestational Age:	wks.	Current gestation:	wks.	Steroids?	
Place of Birth:		Mode:		Liquor:		Apgars:	
Birth weight:	g	Birth Length:	cm	Birth COH:	cm	AGA / LGA / SGA	
Current weight:	g	Current L:	cm	Current COH:	cm		
Problems during & after birth & Resuscitation details:	Apgar <7 at 5mins? **Cord PH** (if available):						

Current Condition:									
Current Condition & observations:	Temp:	°C	Pulse:	bpm	BP:		Colour:		Gluc: mmol/l
	Resp:	bpm	SPO2:	%	FIO_2:	%	Support:		
Blood gas (if available)									
Relevant blood results:									

Problem List:	
Current problems and management:	
Resolved problems and management:	

Management Plan:						
Does the baby require transfer:	YES		NO		If NO-Reason:	
Is the baby stable for transfer:	YES		NO		If NO-Reason:	
Bed available at:					**No bed available in KZN?**	
Sign:		**Print:**			**Practice No.**	

Further Consultation:				
Date:	Time:	Hosp. contacted:	Name of Doctor:	Contact no:
Current problem:				
Management plan given by receiving hospital:				

Does the baby require transfer:	YES		NO		If NO-Reason:	
Is the baby stable for transfer:	YES		NO		If NO-Reason:	
Bed available at:					**No bed available in KZN**	

Sign:		**Print:**		**Practice No.**	

Further Consultation:				
Date:	Time:	Hosp. contacted:	Name of Doctor:	Contact no:
Current problem:				
Management plan given by receiving hospital:				

Does the baby require transfer:	YES		NO		If NO-Reason:	
Is the baby stable for transfer:	YES		NO		If NO-Reason:	
Bed available at:					**No bed available in KZN**	

Sign:		**Print:**		**Practice No.**	

Further Consultation:				
Date:	Time:	Hosp. contacted:	Name of Doctor:	Contact no:
Current problem:				
Management plan given by receiving hospital:				

Does the baby require transfer:	YES		NO		If NO-Reason:	
Is the baby stable for transfer:	YES		NO		If NO-Reason:	
Bed available at:					**No bed available in KZN**	

Sign:		**Print:**		**Practice No.**	

Transfer	NB Record in transfer register				
Baby accepted for transfer:		**Date:**		**Time:**	
Receiving Hospital					
Receiving Doctor					
Receiving Nurse					

S.T.A.B.L.E.	**Stabilise baby for transfer- Record once in transport incubator.**	**NB.** Continue monitoring baby on Daily assess. chart.						
S-Sugar:	Monitor dextrostix and provide IV dextrose and/or feeds. Ensure IVT is patent through infusion pump.							
HGT mmol/l:			NNL bag full	Y	N	Well strapped:	Y	N
IVT Patent	Y	N	Infusion Pump	Y	N	Feeds:	NPO	NGT
T-Temperature:	Keep temperature between 36^{5}-37°C. Dry and swaddle /KMC /Incubator.							
Temp:	°C.		Method of warmth:					
A- Airway:	Maintain patent airway. Ensure ETT is secure and chest moving. Provide adequate oxygen: Sats 90-94%							
Chest moving bilaterally	Y	N	Securely strapped:	Y	N	Amt. of O_2	%	Sats: %
Oxygen cylinder full	Y	N	Spare O_2 cylinder	Y	N			
B-Blood pressure:	Ensure good circulating volume. BP mean > gest. age. Cap. refill time< 3secs.							
BP:		Capillary refill time:		Colour :		Bolus given	Y	N
L-Laboratory results:	Send applicable results with baby.							
Results sent:	Y	N						
E- Emotional support:	Mother/caregiver must preferably accompany baby or be transferred as soon as possible.							
Mother informed of transfer?	Y	N	Condition:					
Bed booked at receiving hosp?	Y	N	Unit:					
Time:		**Sign:**		**Print:**				

Patient Transport information	NB Record in transfer register			
Time EMRS called	Name of Operator	Equipment requested		Sign
Time of EMRS arrival	Name of Paramedic	Equipment provided		Sign
Receiving hospital notified	Name of Doctor	Name of Nurse	Time of departure	Sign
Condition on departure:				
NB. Receiving hospital notified if baby demised or transfer cancelled	Name of receiving Doctor	Name of receiving Nurse		Time:

Outcome	Photocopy and file this form in transfer file. Check and record all outcomes monthly.					
Alive & not transferred	**Died & not transferred**	**Died awaiting EMRS**	**Died in transit**	**Died within 24 hours of transfer**	**Died beyond 24 hours of transfer**	**Alive & transferred back to referring hospital**