National Transport Medicine Programme
• NEONATAL • PAEDIATRIC • ADULT

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Paediatric Transport Flow Sheet

TRANSPORT BY OWN HOSPITAL TEAM **Date:**
Transport (NAS) Ref no: **NAS referral time:** **Team departure time:**

PICU & IPATS referral: 1890 213 213

Referring Hospital _____Unit_____Contact number_____

Receiving Hospital _____Unit _____ Contact number_____

Call made by: Dr_____Referred by (Consultant) _____

Patient accepted: Yes □ No □ (If no?_____)

Accepting PICU Consultant: _____

Specialist Team contacted: Yes □ No □ Consultant _____ Speciality _____

Reason for Transport _____Mode of Transport: Ground □ Helicopter □ Fixed Wing □

Transport Team: Doctor(s) _____ Nurse(s) _____

Biomedical Engineer _____ Other_____

SUMMARY OF PATIENT'S DETAILS

Patient Name: _____ MRN_____ Sex: (Male/Female)
Date Admitted: _____
D.O.B _____ Corrected gest. age: _____ Weight:_____ Estimated: Yes/ No
Religion: _____Baptised Yes/No Other Religious Rites:_____
Surgical □ Medical □ Cardiac □ Cong Abnormality □ Neuro □ Trauma □
Diagnosis_____ PEWS score_____
Current Problems:
_____
_____
_____
_____
_____
_____
Isolation required: Yes/No

PARENTS DATA

Mum's Name_____ Dad's/Partners Name_____
Mobile Phone numbers: _____ Marital Status:_____
Patient Immunisations:_____
Patient Allergies:_____
Parents informed of transport: Yes □ No □ (If no why_____)
Parents - Given Name of Hospital/Unit: Yes □ No □ Given Unit Contact Numbers: Yes □ No □

White copy in receiving unit's patients notes
Yellow copy to referring hospital's patients notes

PHYSICAL EXAMINATION BY TRANSPORT TEAM		
Name:	**Date:**	**Time:**

Respiratory:	**CVS**
Colour	Pulses
Breath Sounds	ECG Rhythm
Respiratory Effort	Murmurs
Oxygen Saturations	Peripheries
	Cap Refill: central peripheral
CNS	**GIT**
GCS /15 AVPU	Abdomen
Posturing : normal/abnormal	Bowel Sounds
Fontanelles/Sutures	NG/OG: On free drainage: Y/N
Pupils size/reaction: Rt / Lt /	Last fluids: Last solids:
	Other
Skin/Extremities	**GU**
Abnormalities	Abnormalities: Urinary Output: Last Bowel Motion:

BLOOD RESULTS				
ABG/VBG/CBG **pH**	**WCC**	**Na+**	**Mg2+**	**Other:**
PC02	**Hb**	**K+**	**P04**	
P02	**Hct**	**Cl-**	**Glu**	
HC03-	**Plt**	**Urea**	**CRP**	
B.E	**aPTT**	**Creat**	**Alb**	
Lactate	**PT**	**Ca^{2+}**	**Bilirubin**	

DRAINAGE			
Time	**On referral**	**On departure**	**On arrival**
Urine Output: mls/colour			
NGT Loss: mls/colour			
Chest Drain: mls/colour			
Other Losses			

MANAGEMENT/STATUS PRIOR TO TRANSFER					
	Intervention	**Time**	**Pre Hosp**	**Ref Hosp**	**Details (size, route, site etc.)**
Airway	Primary Intubation				**Size: Taped at: Oral / Nasal**
	Re-Intubation (for leak/elective)				**Size: Taped at: Oral / Nasal**
	Repositioning ETT				**Re-taped at:**
	Trachy Change/LMA/Surgical Airway				**Size:**
	Chest x-ray				**ET position confirmed Y/N**
Breathing	Ventilator				**Settings:**
	Inhaled Nitric Oxide				**PPM:**
	Chest Drain				**Size: on drainage:**
	Physiotherapy + Suction				**Yes/No Secretions:**
CVS	Inotropes				**Drug: Rate: Drug: Rate:**
	Central Venous Access				**Size: Site: Length:**
	Arterial Line				**Size: Site:**
	Intra-osseous Needle				**Size: Site:**
	Peripheral Access				**Size: Site: Size: Site:**
	CPR/Defibrillation				**Shock: Y/N Drugs: Y/N Compressions: Y/N**
Neuro	CT Scan				**Type:**
	3% Saline/ Mannitol				**Grams/kg:**
	C.Spine Precautions in place				**Y/N**
Misc	Urinary Catheter				**Size:**
	NGT/OGT				**Size: Taped @**

Advice given: **Date/Time:**	**Action taken:** **Date/Time:**
Given By: **Title/Grade:**	**Received By:** **Title/Grade:**

Observations at commencement of preparation for transport and every 15- 20 minutes during transport

Observations: Time												
Stage of transport												
Temperature: Axilla/Core/Skin												
Ambient/Incubator set/temp												
200												
190												
180												
Heart Rate: 170												
160												
150												
140												
130												
120												
110												
100												
90												
80												
70												
60												
Respiratory Rate: 50												
40												
30												
20												
10												
IBP ☐ **NIBP** ☐ **Sys/Dia**												
Mean BP												
Central Cap Refill Time (CRT)												
Respiratory												
O2 Saturations												
ET CO2												
Fi02												
Air Entry R/L												
Resp Effort												
ETT Suction/Secretions												
Ventilation												
Mode:SIMV/VC/VS PC/ PS-CPAP/NIV												
Vent Rate												
Tidal volume												
PIP												
PEEP/CPAP												

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I Time												
I:E Ratio												
Flow rate												
Blood Gases: Art/Cap/Ven												
pH												
Pc02												
PaO2												
HCO3-												
B.E												
Lactate												
Blood Sugar												
Na+												
K+												
Ca2+												
Hb												
NEUROLOGICAL:												
GCS/AVPU												
RT Pupil size/reaction												
LT Pupil size/reaction												

USEFUL DRUG DOSAGE			
Adrenaline	0.1ml/kg 1:10 000 IV 0.1ml/kg 1 : 1000 ETT	Magnesium (asthma dose)	50 mg/kg (0.2 mmol/kg)
Atropine	20 mcg/kg IV, IO, ETT (MIN DOSE 100mcg)	Glucose	2ml/kg 10% Dextrose IV
Adenosine	100mcg/kg IV (MAX DOSE mcg/kg)	Thiopentone	2– 5 mg/kg IV
Morphine	0.1mg/kg IV	Mannitol	0.25g-0.5g/kg IV
Midazolam	0.05-0.1 mg/kg IV	**3% Saline** Add 36 mls 30% saline to 464mls 0.9% saline = 500mls 3% saline	3-5 mls/kg 3% Saline infused over 20 mins. **N.B: Discuss with Consultant before use**
Ketamine	2 mg/kg IV		
Atracurium	0.5 mg/kg IV		
Pancuronium	0.1 mg/kg IV		
Rocuronium	1mg/kg IV		
Suxamethonium	2mg/kg IV		

INFUSIONS

Fluid intake: **mls/kg/day**

Fluid type:

Infusion check:

Presciber Name: (print)_____ Grade:_____ Initials: _____

Nurse/Administrator Name: (print) _____ Grade: _____ Initials:_____

Checker Name: (print) _____ Grade: _____ Initials:_____

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Date/ Time	Solution	Additives	Dose	Prescriber Signature	Admin Signature	Checker Signature	Hourly Amt	Total

Boluses Date/ time	Drug/Fluid + Dose	Prescriber Signature	Admin Signature	Checker Signature

BLOOD PRODUCTS

DATE	TIME	Product	Batch Number	Expiry Date	Prescriber Signature	Admin/Checker Signature

MINIMUM EQUIPMENT LIST (CHECK PRE DEPARTURE LIST AT **BASE HOSPITAL** AND **POST PICU ADMISSION**)			
		Referring Hospital	PICU/Receiving Unit
Patient specific airway equipment			
Transport Bag			
Fridge Drugs/ Drugs Bag			
Transport Form and Folder			
Mobile Phone battery checked			
Arterial/Temp/NIBP/ECG/O2 Saturation cables and leads			
Gases Checked - Oxygen & air (if required)			
Ventilator, tubing, batteries checked			
Braun Pumps x 4, batteries checked			
Monitor, batteries checked			
Laerdel Suction machine, batteries checked & tubing attached			
ET CO2			
POD & Straps/ Vac Mattress/ACRS (age appropriate/as condition indicated)			
Spare Batteries			
CARDIAC Patients checklist			
Air Cylinders	Yes/ No/ NA	Ketamine	Yes/ No/ NA
Prostin	Yes/ No/ NA	Fentanyl	Yes/ No/ NA
Milrinone	Yes/ No/ NA	Muscle relaxants	Yes/ No/ NA

PRE DEPARTURE CHECKLIST	Please tick
Referring & Receiving Consultant informed and plan agreed	
Copies of CXR, CT Scans and Notes	
Transport equipment packed (see minimum equipment list above)	
E.T. secured	
Tube placement checked on CXR	
Blood Gas	
Humidivent/viral filter	
End tidal CO2	
Oxygen/Air available in sufficient quantity	
Patient Specific Airway/drug bag & bagging equipment	
Sufficient and working IV access	
Sedation, analgesia, muscle relaxant	
Patient I.D bands	
Receiving unit contacted **BEFORE UNPLUGGING OXYGEN AND POWER**	

TRANSFER/HANDOVER NOTES

_____

_____

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_____
_____
_____
_____
_____
_____
_____

Signed:_____ **Grade:**_____ **Print:** _____

Date: **Time:**

HANDOVER/SIGN OVER OF PATIENT

Referring Hospital:

Doctor Name: (print)_____**Sign:** _____

Nurse Name: (print) _____**Sign:** _____

Date/Time:

Receiving Hospital:

Doctor Name: (print) _____**Sign:**_____

Nurse Name: (print) _____ **Sign:** _____

Date/Time:

UNTOWARD EVENTS

Ambulance/vehicle related □ **RTA** □	**Equipment:**	**Staff Incident:**
Patient Related: □ **Death** □ **CPR/DEFIB** □ **Inadequate/ lost venous access** □ **Accidental extubation** □**Dislodgement/ blocked ETT** □ **Pneumothorax** □ **Hypotension** □ **Significant desaturation/bradycardia** □ **Extravasation (ART,IO,VEN)**	**Other (including delays, communication problems)**	