



Paediatric Critical Care Transport Record													
TRANSPORT BY OWN HOSPITAL TEAM (IPATS will use sep NAS Ref no: NAS referral)	,	Date: Team depart	ure time:										
PICU & IPATS referral: 1800 222 378													
Referring Hospital	Unit	Contac	t number										
Receiving Hospital	Unit	Contac	t number										
Call made by: Dr	Referred by (Consult	ant)											
Accepting PICU Consultant:													
Transport Team: Doctor(s)													
Nurse(s)													
Ambulance Crew													
SUMMARY OF PATIENT'S DETAILS													
	MADNI		Cour (Mada /Formala)										
Patient Name:  Date Admitted:		<del></del>	Sex: (Male/Female)										
D.O.BCorrected gest. age:		rht: (kg)	Estimated: Yes/ No										
Diagnosis	***:8	(1.6)	Estimated. Tesy 110										
Current Problems:													
Relevant Past Medical History:													
PARENTS DATA													
Mum's Name	Dad's/Part	tners Name											
Mobile Phone numbers:													
Marital Status:													
Patient Immunisations:													
Patient Allergies:													
Parents informed of transport: Yes □ No □ (If no why			)										
Child Protection Issues: Yes $\square$ No $\square$	Consent for transport	taken: Yes 🗆 No 🗆											
Parents - Given Name of Hospital/Unit: Yes □ No □	Given Unit Contact No	umbers: Yes 🗆 No 🗆											







PHYSICAL EXAMINATION BY STAFF TRANSPORTING THE PATIENT																				
Head	and Neck							(	CNS/PNS											
Heart	/CVS								MSK/Skin											
Chest/Resp							Р	Pelvis/Perineum												
Abdor	men								ther											
710001	iicii																			
	Interve	ntior	1			Time	Detai	ls (size, rou	te, site e	tc.)										
Α	Primary						Size:	15 (5120) 100	Taped a		Oral / N	Nasal								
			n (for leak,	/elective)			Size:		Taped a		Oral / N									
	Reposit						Re-ta	ped at:												
		ston	ny/LMA/Su	rgical			Size:													
	Airway	rou					ET and the angle of the Alle													
В	Chest x- Ventilat						ET position confirmed Yes /No Settings:													
U			al Suctionin	g			Yes/N		retions:											
	Inhaled			0			PPM:													
	Chest Drain						Size:													
С	Inotrop	es					Drug:	Drug: Drug:												
								Rate: Rate:												
			ous Access				Size: Site: Length:													
	Arterial				-		Size: Site: Size: Site:													
	Periphe		s Needle				Size: Site:													
	reliplie	ı aı A	ccess				Size: Site:													
	CPR/De	fibril	lation				Shock: Y/N if yes: joules/kg Drugs: Y/N Compressions: Y/N													
D	CT Scan						Type:							· ·						
			/lannitol					Mls/kg		or	Gra	ams/kg:								
			autions in p	olace			Yes/N	lo												
	Urinary		eter				Size:													
Othor	NGT/O		o /I ob\				Size: Taped @													
Other	Investiga	ation	is (Lab)																	
DI OO	D DECLUI																			
	D RESULT		HC03-		wc	<u> </u>		аРТТ		CI-		Mg2+		Bili						
pH	VDG/CDG	,	B.E		Hb			PT	Urea			P04		Other:						
PC02			Lactate		Hct			Na+	Creat			CRP		Other:						
P02			Glu		Plt			K+ Ca+ Alb												
INFUS																				
Fluid	intake:			mls/kg	g/day	<u>or</u>	9	% maintena	nce											
Fluid	type:																			
Date/	Time	Dru	g	Amount		Solutio	on	Volume	Concen	tration	Dos	se	Prescriber	Admin/C	heck					
,	3			added		Solution			(1ml/hr =)		7030		Signature	Signature						
										/kg/										
										/kg/										
						1			<u> </u>	/kg/										
									-	/kg/										
						1			1	/kg/										







Boluses									
Date/Time	Drug/Fluid & Dose		Prescriber Signature		Admin	Signature	Checker Signature		
Blood Products	5								
Date/Time	Product	Batch number	Expiry Date	Prescriber S	Sign	Admin Sign		Checker	
					•		·	•	
					•		·		

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

1 At referring hospital unit 2 Patient Transport Trolley 3 On departure from unit 4 On switch over to ambulance/aircraft gas & power

supply 5 En route in ambulance/	anciait	U U	i ai i ivai a	it receivii	ig uitit 🖊	On transf	er to bed	/cot/incu	bator			
Observations: Time												
Stage of transport (no. as above)												
Temperature: Axilla/Core/Skin												
Ambient/Incubator set/temp												
200												
190												
180												
Heart Rate: 170												
160												
150	1											
140												
130	1											
120												
110	1											
100	1											
90	†											
80												
70	†											
60												
Respiratory Rate: 50												
40												
30												
20												
10												
IBP NIBP Sys/Dia												
Mean BP												
Central Cap Refill Time (CRT)												
	<u> </u>											
Respiratory												
Respiratory												
Respiratory 02 saturations												
Respiratory 02 saturations ETC02												
Respiratory  02 saturations ETC02 Fi02 Ventilation Mode: VC/PC/SIMV/												
Respiratory  02 saturations ETC02 Fi02 Ventilation Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow												
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate												
Respiratory  02 saturations ETC02 Fi02 Ventilation Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow												
Respiratory  02 saturations ETC02 Fi02  Ventilation Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP												
Respiratory  02 saturations  ETC02  Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow  Vent rate  Tidal volume  PIP  PEEP/CPAP												
Respiratory  02 saturations  ETC02  Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow  Vent rate  Tidal volume  PIP  PEEP/CPAP  I Time												
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio												
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio High flow rate L/min	At base				On dep	arture			On arri	val to IPC	CU	
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio High flow rate L/min Drainage	At base				On dep	arture			On arri	val to IPe	CU	
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio High flow rate L/min Drainage Time	At base				On dep	arture			On arri	val to IP(	CU	
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio High flow rate L/min Drainage  Time Urine Output: mls/colour	At base				On dep	arture			On arri	val to IP0	CU	
Respiratory  02 saturations ETC02 Fi02  Ventilation  Mode: VC/PC/SIMV/ PS-CPAP/NIV/High Flow Vent rate Tidal volume PIP PEEP/CPAP I Time I:E ratio High flow rate L/min Drainage Time	At base				On dep	arture			On arri	val to IP(	CU	

Feidhmeannacht na Seirbhíse Sláinte Health Service Executive





Other Lo	sses																		
Neurological																			
	ime									Τ		1							
	/15																		
RT Pupil size/reac	•																		
LT Pupil size/reac																			
MINIMUM EQUIPMENT LIST (CHECK PRE DEPARTURE LIST AT BASE HOSPITAL AND POST PICU ADMISSION)																			
	Please tick							Please tick											
Patient specific airway equipm					D	efibril	lator &	pads	5										
Patient specific emergency drugs							E	T CO2	monito	ring	(if intuk	oate	d)						
Emergency drug list printed (www.ipats.ie)							V	entilat	tor, tub	ing, l									
Bagging equipment & ambu b	ag						G	ases C	hecked	- Ox	ygen (8	k air	if re	quired)					
Transport Bag											alculate				1				
Transport Form and Documen	tation	1					Ir	nfusior	Pump	s x 4,	, batteri	es o	heck	ed					
Mobile Phone battery checked	t						S	uction	machir	ie, b	atteries	che	cked	&					
							tı	ubing a	attache	d									
Patient Monitor, batteries che	cked								atteries										
ECG/O2 Saturation/Arterial/											ttress /I								
Temperature/NIBP cables and	leads	;								ropr	riate/as	cor	ditio	n					
							ir	ndicate	ed)							DI			
PRE DEPARTURE CHECKLIST			Pleas	se tick			_	1 1	1000						Ple	ease ticl	(		
Referring & Receiving Consultation informed & plan agreed	ant						E	na tida	al CO2										
Copies of CXR / CT scans											ing IV a								
Doctor's referral letter, notes	and d	rug					S	edatio	n, analg	gesia	, muscle	e re	laxan	t					
kardex																			
E.T. secured									I.D ban										
E.T. placement checked on CX											nt pack				_				
Blood Gas (post intubation) /G Humid vent/viral filter	lucos	е						Team brief with ambulance crew  Receiving unit contacted BEFORE											
Humid vent/virai fiiter									-		acted <b>B</b> GEN AN			D					
TRANSFER/HANDOVER NOTE	S							INFLO	GGIIVG	OAT	OLIV AIV	י טו	OVVL	.1\					
Signed:				Gra	ade:				Da	nte:						Time:			
HANDOVER/SIGN OVER OF PA	ATIEN	Т		Gir					50							inne.			
Referring Doctor (Print)			Sign				Receivi	ng Doo	ctor (Pri	nt)				Sign			Ti	ime	
			-					-	•										
Referring Nurse (Print)			Sign				Receivi	ng Nu	rse (Pri	nt)				Sign					

