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| ScotSTAR Neonatal Elective Referral Form | | | | | | | |
| Date transfer required:  Select Date | | | | Date of referral:  Select Date | | | |
| Appointment Time (if applicable) Select Hour : Select Minutes | | | | | | | |
| Referring Hospital: Hospital  Other: Enter if location not listed  Department: Department | | | | Receiving Hospital: Hospital  Other: Enter if location not listed  Department: Department | | | |
| Name of Referrer: Referrer | | | | Contact Number: Contact Number | | | |
| Reason for Transfer: Reason Other reason for transfer: Enter other reason if not listed | | | | | | | |
| Patient Details | | | | | | | |
| Name: Name | | | | | | | |
| CHI: CHI | Gestation at birth: Weeks Weeks Days Days | | | | | | Birth Weight: Birth Weight |
| Sex: Sex | Current gestation: Weeks Weeks Days Days | | | | | | Current Weight: Current Weight |
| Brief History:  Enter history here | | | | | | | |
| Current Clinical Condition: | | | | | | | |
| Respiratory: Respiratory Support  FiO2: Oxygen  (if applicable)  Mode: Enter here  Pressures: Enter here  Tidal Volume: Enter here  Rate/ Flow: Enter here | | | Total ml/kg/day: Enter here  Feeding type: Type  Feeding method: Type  Feeding frequency: Frequency  IV Access: Yes/No  Arterial Access: Yes/No  Central/PICC line: Yes/No | | | IV infusions / drugs:  Fluid/Drug 1  Fluid/Drug 2  Fluid/Drug 3  Fluid/Drug 4  Fluid/Drug 5  Fluid/Drug 6  Fluid/Drug 7 | |
| Other relevant details:  Enter here | | | Current Phototherapy: Yes/No | | | Cool bag for EBM: Yes/No | |
| Social Issues (only those relevant to Transport): Yes/No  Parents / Carer travelling: Accompanied  Weight of Parent/ Carer (journeys by aircraft only): Enter here | | | | |
| Receiving unit aware of transfer: Yes/No Date receiving unit aware: Select Date | | | | | | | |
| Infectious Disease Risk: | | | | | | | |
| Has mother or baby been colonised with MRSA at any time: MRSA | | | | | | | |
| Has the mother or baby been an inpatient in a hospital outwith Scotland in the last year: Outwith Scotland  If yes, please specify location: Enter location here | | | | | | | |
| Is the referring unit currently experiencing infectious outbreak/undertaking enhanced infection precautions: Yes/No  If yes, please specify reason: Enter reason here | | | | | | | |
| *If yes to any of the above, the receiving unit must be made aware by the referring team and an appropriate plan agreed for how the patient will be managed on arrival* | | | | | | | |
| **Please now email this form** to **[scotamb.scotstarelective@nhs.net](mailto:scotamb.scotstarelective@nhs.net" \t "_blank)** with the email subject as:  **“**Elective transfer request (Baby’s name): referring hospital to receiving hospital” | | | | | | | |
| To be completed by ScotSTAR | | | | | | | |
| Date Received: Select Date | | Team allocated:Team | | | Time: Select Hour : Select Minutes | | |
| Clinical update :  Enter here | | Bed Confirmed: Yes/No | | | Time slot allocated for Job: Enter here | | |
| Transfer completed: Yes/No  Date: Select Date Time: Select Hour : Select Minutes | | | | | |
| If transfer cancelled: Cancellation Date: Select Date Time: Select Hour : Select Minutes  Reason: Enter here | | | | | | | |