



Neonatal/Pediatric Referral Transport Checklist

Patient Name _____ Referral Date _____

Referring Hospital _____ Referring Doctor _____

Referral Diagnosis _____

DOB _____ *Birth Time _____ *Birth Weight _____ *GA _____

Present Weight _____ Allergies _____ *Apgars _____

Parents Name _____ Parents Phone _____

* = Neonatal Only

Essential Information	Yes	No
Copy of patient's chart (including discharge summary/doctors progress notes, 48 hours of nurses notes, recent labs and ABG's, medication record)		
Include 4 copies of face sheet (demographic sheet)		
*Copy of Mother's chart including labs and DR record		
Copy of X-rays		
*Vit K / Eye Prophylaxis given		
*Newborn screen done		
Hx infectious disease exposure		
Immunizations up to date		
Parents available for consent		

Cultures (include date obtained):

Blood _____ Urine _____
 CSF _____ ETT _____
 Other _____

Laboratory Data (include date & time):

CBC _____
 Diff/Plts _____
 Electrolytes _____

Oxygenation/Ventilation:

FIO2 _____ Hood _____ NC _____ LPM _____
 CPAP _____ FaceMask _____
 Mechanical Ventilation _____
 Vent Settings _____
 ETT Size _____ Lip-Tip _____
 X-ray Placement _____
 Latest ABG:(date/time) _____



Present Status:

VS: T _____ HR _____ RR _____ BP _____

Level of Consciousness _____

Glucose _____ HCT _____

Last 12 hrs I & O: In _____ Out _____

Last Void (time) _____ Last Stool (time) _____

Last Fed (time/type/amount) _____

Chest Tubes:

Location: _____ bubbling? _____ Draining? _____

1. _____

2. _____

Medications

Medication	Dose	Route	Time

Arterial/Venous Access

Type	Site	Solution (+ additives) Running	Rate	X-Ray Position