CHILDREN'S HEART CENTRE
(CHI at Crumlin)
External Patient Telephone Admission information

Full Name: ....
Address:
..... Addressograph .....
HCR..... .....
.....

PATIENT DETAILS	
Name: *please print*	**Date:**
Gender: Male □ Female □ Unknown □	**Date of Birth:** **Age:** **Weight:**
Referring Hospital	***Receiving Hospital*** *(CHI at Crumlin)*
Hospital:	*Receiving Consultant: print name*
Handover given by: print name	*Booking accepted by: print name*
Grade:	*Grade:* *NMBI:*
NMBI:	*Phone before departure: Yes* □
	Time of call: time stamp Estimated time of arrival:

SUMMARY OF PATIENT

(include Antenatal Diagnosis and Obstetric History as appropriate)

***PEWS..... Date:..... Time:..... *** *(if applicable)*

OBSERVATIONS

Airway Patency: **SPO2:**

Work of Breathing:

Details: *Room Air* □ *Airvo* □ *Nasal Prongs* □ *Blow By* □

Oxygen: **Mode of Delivery:** **HFNC:** **FIO2:**

Blood Gas:

Venous Blood Gas □ **Time taken:** **Result**

Capillary Blood Gas □ **Time taken:** **Result**

Blood Results:

Time of Delivery *(if newborn):* **Mode of Delivery** *(if neonate):*

Apgars:

5 Minute Score: **10 Minute Score:**

Appearance:

BP: **Temperature:** **Heart Rate:** **Respiratory Rate:** **Blood Sugar:**

Infusion Therapy Yes □ No □

Intravenous □ **Subcutaneous** □ *Electronic Pump* □ *Elastomeric pump* □ *Pre-Filled Infusion Therapy* □

Time of access: **How long insitu:**

Non Oral Administration

Intramuscular Injection □ **Epidural Administration** □

Access: PVC □ PICC □ UVC □ CVC □ **Time of access:** **How long insitu:**

Infection Status:

CHILDREN'S HEART CENTRE
(CHI at Crumlin)
External Patient Transfer Form

Children's Health Ireland at Crumlin

Full Name: ....
Address: ....
HCR..... .....
DOB: __ __ / _____

Addressograph

MEDICATIONS / INFUSIONS

Current Medications	*Dose*	*Frequency*	*Route*	*Last Given*	*Drug Levels*

FEED / DIET

Oral □ Parenteral □ *Insert method* NG □ NJ □ PEG □ Mickey □ Trans Gastric Jejunal □

Breastfeeding □ Partial Breastfeeding □ Spoon Feeds □ Formula □

Does mum wish to breastfeed: Yes □ No □ NA □

Feed Type: ..... **Volume:** ..... **No. of feeds:** .....

Dietary requirements: Pureed □ Mashed □ Regular □ Other □

Fasting on admission: Yes □ No □ **Last ate at**:_____:_____hours **Last drank at**:_____:_____hours

Independent: Yes □ No □ If no, please give details of assistance required.....

Drinks from: Cup □ Bottle □ **Assessment of feeding / swallow:** Yes □ No □ NA □

Takes medication orally: Yes □ No □ *Liquid* □ *Both* □ *Using a spoon* □ *Using a syringe* □

ALLERGIES

Any known Drug Allergies:

Other Allergies:

FURTHER COMMENTS

Nursing Student Name *(print Name):*..... *NMBI:*.....

Registered Nurse Name *(print name):*..... *NMBI:*.....

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