Our Lady's Children's Hospital, Crumlin, Dublin 12

NURSING TRANSFER LETTER – CHILD >1yrs

First Name: ……. ……..
Surname: ……. ADDRESSOGRAPH ……
HCR No: ….. …….

CHILD'S DETAILS	NEXT OF KIN DETAILS
Name:	Name:
Address:	Address:
DOB:	Home phone No: Mobile No:

GP	PUBLIC HEALTH NURSE	LOCAL PHARMACY
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:

REFERRAL DETAILS		
Admission Date:	Transfer Date:	Length of Admission to Date:
Reason for Referral:		
Referring Consultant:	Receiving Consultant:	
Receiving Hospital:	Phone call to receiving hospital *(name of professional spoken to)*	

*****PEWS (Paediatric Early Warning Score): _____ Date:_____ Time:_____*****

TREATMENT WHILE IN HOSPITAL	
Reason for Admission:	Background History:
Diagnosis:	
Medical / Surgical Treatment:	Medical / Surgical History:
Follow Up Plan & Out Patients Appointments:	

ASSESSMENT AT TIME OF TRANSFER IN OLCHC
Current Problems:
Significant Problems:
Medications prescribed on transfer:
Prescribed medication last given:

Current Medications	Dose	Frequency	Route	Last Given	Drug Levels

*****PHOTOCOPY DRUG KARDEX AND ATTACH TO TRANSFER LETTER*****

ALLERGIES			
Allergic to medication:	Yes □ No □	Name:	Reaction Type:
Allergic to food:	Yes □ No □	Name:	Reaction Type:
Allergic to plasters / tape:	Yes □ No □	Name:	Reaction Type:
Other			

INFECTIOUS DISEASES
Details:

Information obtained from:…… **Date:** …… **Time:**……
Nursing Student *(Print Name)*:……**NMBI:**……
Registered Nurse Name *(Print Name)*:…… **NMBI:**……

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HCR No: ….. …….

Relevant Family / Social History:

Parents/Guardian aware of transfer: Yes □ No □ | **Interpreter Required:** Yes □ No □ *If yes, language spoken:*

RESPIRATORY

Colour:…… **Respirations:** *(bpm)*:…… **Signs of increased work of breathing:** Yes □ No □
If yes: *(document signs)*: …… **Sound:** *(Stridor/Grunt/Wheeze/None)*:……
Nursed on: *Room air/O_2 therapy via* ……0_2 **How many litres**:……CPAP □ BIPAP □ Pressure □ **No**:……
Tracheostomy Tube: Yes □ No □ **Nasopharyngeal Airway:** Yes □ No □ **Type**:…… **Size**:……
Suction Catheter Size:…… **Depth:**…… **Last tube change date**:……
Nursed on O2 sats monitor: Yes □ No □ **SpO2**:…… %

CENTRAL / PERIPHERAL ACCESS

Broviac: Yes □ No □ **CVC:** Yes □ No □ **PICC:** Yes □ No □ **Implanted Port:** Yes □ No □
Insertion site:…… **Insertion Date**:……
Priming Volume:…… **Dressing Changed**:…… **Last flushed**:……
Peripheral Cannula: *(document site)*:……
Current IV Infusion: Yes □ No □ **Fluids**:…… **Rate:** …… **Volume**:…… *ml/kg/day*

CARDIOVASCULAR SYSTEM

Pulse/Apex: *(bpm)*:…… **Blood Pressure:** *(mmhg)*:…… **CRT**:…… **Time**:……

CONTROLLING BODY TEMPERATURE

Peripheral Temperature:……ºC

ELIMINATION

Urine: Per Urethra □ Urinary Catheter □ Suprapubic Catheter □ **Last passed urine at**:……
Strict Intake / Output: Yes □ No □ …… *ml/kg/hr*
Bowels: Per rectum □ Ileostomy □ Colostomy □ **Last motion**:…… **Usual Pattern**: ……
Additional information re: Stoma care / Anal dilatations / Washouts:……
Drains: Chest □ Penrose □ Redivac □ **Other**:…… **Date for removal**:……
N/G Free Drainage: Yes □ No □ NG **Aspirate:** Yes □ No □ …… **Hourly:** Yes □ No □ **Other**:……
Replacing Losses: Yes □ No □ **Fluids Used**: ……

NEUROLOGICAL SYSTEM

Glasgow Coma Scale: □ **Value:**…… **Level Of Consciousness (AVPU):** …… Alert □ Voice □ Pain □ Unresponsive □

NUTRITION

Admission Weight:…… kg **Date**:…… **Transfer Weight**: ……kg **Date:**……
SLT/Dietician: …… **Regime given to Parent/ Guardian:** Yes □ No □
Feed Type: Breastfeeding □ Formula □
Type:…… **Volume**:…… mls **Frequency**:…… **Mls/Kg**:……
Feeding: NPO □ PO □ NG □ Peg □ NJ □ **Other** …… **Tube size**:…… **Last Changed**:……

PERSONAL CLEANSING

Peg Site:…… **Eyes**:…… **Mouth**:…… **Buttock**:……
Wound Location:…… **Wound Appearance**:…… Sutures □ Steristrips □ Dressing □
Date for Removal:…… **Dressing Change**:……

PAIN	PLAY	ADDITIONAL INFORMATION
Analgesia Required: Yes □ No □ **Last Given**:…… **Drug Name**:…… **Dose**:……	Soother / Blanket /Comforter Yes □ No □ *Detail*:……	Religion:…… Ethnicity:…… Baptised: Yes □ No □

Information obtained from:…… **Date:** …… **Time:**……
Nursing Student ***(Print Name)***:…… **NMBI:**……
Registered Nurse Name ***(Print Name)***:…… **NMBI:**……