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

NURSING TRANSFER LETTER – INFANT <1yr

First Name: ……
Surname: ……
HCR No: ……

ADDRESSOGRAP

INFANT DETAILS	NEXT OF KIN DETAILS
Name:	Name:
Address:	Address:
DOB:	Home Phone No: Mobile No:
DOB:	

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

New Born Screen: Yes □ No □ Repeat due date:……Newborn Hearing Test: Yes □ No □ *When due*……

Immunisations: BCG □ 6:1 □ 1st / 2nd / 3rd *(please circle received doses)* MMR □ Synagis □ Other □

Information obtained from: ……**Date:** ……**Time:**……

Nursing Student Name *(print name):* …… **NMBI:** ……

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

Author: Amy Power – CNM1 – St. Peters Ward. Created by Deborah O'Grady – NPDU – 04.10.17

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Relevant Family / Social History:

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

CENTRAL / PERIPHERAL ACCESS

Broviac: Yes □ No □ **CVC:** Yes □ No □ **PICC:** 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:**……

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/O2 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 apnoea monitor / O_2 sats monitor: Yes □ No □ **SpO_2:**…… %

NEUROLOGICAL SYSTEM

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

CONTROLLING BODY TEMPERATURE

Peripheral Temperature:…… ºC **Incubator:** Yes □ No □ **Incubator Temperature:**……

NUTRITION

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

ELIMINATION

Urine: Per Urethra □ Urinary Catheter □ **Other:**…… **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 □ **ml Aspirate:** Yes □ No □ **Hourly:** Yes □ No □ **Other:**……
Replacing Losses: Yes □ No □ **Fluids Used:** ……

PERSONAL CLEANSING

Umbilicus:…… **Umbilical Cord Clamp:**…… **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 Name *(print name):* …… **NMBI:** ……

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