Elective Retrieval Booking Form

Print Form

Email Form

To be completed by referring hospital. For emergencies always call 1300 36 2500.
Email completed form to NETS

Name: MRN:

Address: DOB:

Sex:

Postcode:

Date: Age: Weight: kg

Birthweight: kg Gestation: weeks

Diagnosis and history (or provide discharge summary):

CLINICAL INFORMATION

Temp: HR: RR: BP: BSL:

O_2 sat: FiO_2: Flow: lpm

Current condition:

O2 delivery:

Crib O_2 ☐ Head box ☐ Prongs ☐ Nasal catheter ☐ Face mask ☐

ETT ☐ (size) mm NP tube ☐ Other: ☐

Ventilation:

Mode: CPAP ☐ SIMV ☐ IPPV ☐ CMV ☐

Parameters: Rate PEEP PIP IT

Vascular Access: IV ☐ IA ☐ UAC ☐ UVC ☐ IO ☐ CVL ☐

IV fluids:

Drainage: IDC ☐ OG ☐ NG ☐ Size/s

Medications:

Feeds:

TRANSPORT PLAN

Preferred transfer date: Preferred time:

From (hospital):

Referring doctor:

Patient location (ward):

Parent accompanying? Yes: ☐ No: ☐ Parent's weight (air only): kg

Bed confirmed? Yes: ☐ No: ☐ Bed available (time):

at Hospital:

by Accepting doctor:

in Ward:

Please notify any changes in the patient's condition or treatment.

Form submitted by: **Role:**

NETS will respond by email to this request. If a copy by fax is required, please provide a fax number

CHECK LIST for Referring Hospital

Images ready to send with patient?	Yes: ☐	No: ☐	Not applicable: ☐
Blood/lab results ready?	Yes: ☐	No: ☐	Not applicable: ☐
Referral letter ready?	Yes: ☐	No: ☐	Not applicable: ☐
Discharge summary ready?	Yes: ☐	No: ☐	Not applicable: ☐
Parents aware?	Yes: ☐	No: ☐	Not applicable: ☐

Comments:

Email this form to NETS at ccc@nets.health.nsw.gov.au

Please call CCC (1300 36 2730) on the preferred transfer date if confirmation has not been received

Clinical Coordination Centre use only

CCL:

Plan: Date Time

Road ☐ RW ☐ FW ☐

Coordinator: