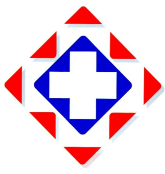

NETS - ACT
Elective Transfer Booking Form

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: F_iO_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 PIP PEEP IT

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

IV fluids:

Drainage: IDC ☐ OG ☐ NG ☐ Size/s

Medications:

Feeds:

TRANSPORT PLAN

Transfer date: Time: Preferred vehicle: Road: ☐ FW: ☐

Transport nurse (NETS ACT):
Transport doctor (NETS ACT):
From (hospital):
To (hospital):
Referring doctor:
Accepting doctor:
Patient location (ward):
Patient destination (ward):
Ambulance service pickup point: ward / airport / other
Ambulance service handover: airport / hospital

Equipment: Incubator: ☐ Portacot: ☐ Capsule: ☐ Ambulance service to supply:

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

Email this form to NETS at ccc@nets.health.nsw.gov.au
Please call CCC (1300 36 2730) on the day of travel if confirmation has not been received

Clinical Coordination Centre use only

CCL:

ASNSW booked:
Date: Time: Booking reference:

Form returned by Fax to NETS ACT ☐
(fax: 6244 3112)