ADDRESSOGRAPH

GIG CYMRU NHS WALES | Rhwydwaith Mamolaeth a Newyddenedigol Cymru | Wales Maternity and Neonatal Network

Extreme Preterm Pathway (document 6)
All Wales In-Utero Transport Form

MATERNAL DETAILS

Gravida ..... Para .....
SROM Y / N Date ..... Time .....
Medication .....
Appearance of Liquor .....
Blood Group ..... Rh ..... Antibodies .....
Comments .....

OBSTETRIC HISTORY

Previous pre-term birth/s: Yes / No Details: .....

Obstetric history .....
Medical history .....
Has the woman?

- Received health care treatments (inc. IVF) in other countries outside of Wales during the last year? Yes / No
- If YES, which country: .....
- Details of treatment: .....
- Had any infections / positive screening results during pregnancy? Yes / No
- If YES, please specify .....

US

Pre-term Labour Test: Pos / Neg Fetal fibronectin / Actim partus
Vaginal Examination: Date ..... Time ..... Findings .....
Latest CTG: Date ..... Time ..... Findings .....

Is the woman?

- Currently infected or colonised with organism / virus that is multiresistant or could cause harm to the baby? Yes / No / Unknown
- If YES, Sensitivity of organism .....
- Currently on any antimicrobial treatment? Yes / No
- If YES, please specify .....

HVS: Yes / No Date/s ..... Sensitivities of isolates .....
Urine Test: Yes / No Date/s ..... Sensitivities of isolates .....
Outstanding Micobiology results? Yes / No Please specify: .....
Has the transfer been discussed and consented to by the woman? Yes / No
Comments: .....

FETAL DETAILS

EDD .....
Gestation .....
Multiple Pregnancy Yes / No
No. of foetuses .....

Anomalies Yes / No
Details .....

Date .....

FL ..... AFI .....
Doppler .....
EFW .....
Comments: .....

Maternal Steroids? Yes / No
Medication AC HC
Date ..... Time .....

Magnesium Sulphate? Yes / No
Medication .....
Date ..... Time .....

Fetal Compromise? Yes / No Comments:

Safeguarding Issues? Yes / No
Details: .....

Reported? Yes / No
NB - Review woman's notes

TRANSFER FROM:	**TRANSFER TO:**
Health Board / Trust / Site	Health Board / Trust / Site
Consultant Obstetrician	Consultant Obstetrician
SPR:	**Duty SPR informed** **Labour Ward Co-ordinator informed** **Neonatal Unit informed** ***NB - All must be informed prior to transfer***
Named midwife for transfer:	

PERSON COMPLETING FORM:

Name: Designation: Signature:

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Name:					
NHS Number:			**Unit Number:**		
TRANSPORT TIMELINE					
	Date	**Time**		**Date**	**Time**
Telephone handover to receiving hospital			Departure from referral hospital		
Ambulance request			Arrival at receiving hospital		
Ambulance booking reference:			Departure from receiving hospital		
Ambulance arrived			Return to referral hospital		
Bluelight mission: Yes / No Reason:					
CHECKLIST PRIOR TO LEAVING REFERRAL HOSPITAL					
Photocopy of handheld notes _____			All Wales in-utero transfer pathway followed?		Yes / No
Prescription Chart _____			Personal belongings		_____
Extreme pre-term counselling			Safeguarding Notes		
Outcome of counselling:					

OBSERVATIONS					
TIME					
***LOCATION**					
TEMPERATURE					
HEARTRATE					
BP S/D	/	/	/	/	/
MEAN					
PAIN / CONTRACTION					

*Location: **D**eparture **T**ransport **R**eceiving

HANDOVER TO RECEIVING HOSPITAL		
Name:	Designation:	Signature:

Transfer notes: (continue on separate sheet if needed)