In-Utero Transfer: Inter-Unit Information Sheet

**Initial Information**

Date and time of presentation:  
Maternal demographics:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EDD: |  | Gestation: |  | Blood Group: |  | Parity: |  | Allergies: |  |

Booking Hospital: Named Consultant:

|  |  |
| --- | --- |
| **Reason for Transfer** | Relevant Additional Information |
| S  B  A  R | Microbiology:  Mother and/or infant require isolation |
| Virology: |
| Fetal Medicine/Anomaly: |
| Ultrasound: |
| Management Plan: |
| GBS: |
| Other: |

**Previous In-Utero Transfer?**  Yes  No

**If Yes, Date: Gestation:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Assess Prediction of Pre-Term Birth | Known Risk Factors: | | | | |  | | |
| QUiPP App Results/ qfFN / Cervical Length: | | | | |  | | |
| Amnisure: | | | | |  | | |
| Cervical Assessment: | | | | | Time carried out: | | |
| Spontaneous rupture of membranes | | | | |  | | |
| Maternal Indicators for Transfer | MEWS | |  | | | | | |
| Other Indication for Transfer | Anticipated Need for Higher Level of Care: | | | |  | | | |
| Bed/cot or staffing capacity: | | | |  | | | |
| Other: | | | |  | | | |
| **Antenatal Steroids (<33+6 wk):**  Full course given?  Yes  No  N/A  Which steroid administered:  Date and time of dose(s): | | **Magnesium Sulphate (<30 wk)**  Required?  Yes  No  Bolus given?  Yes  No  N/A  Infusion complete?  Yes  No  N/A | | **Antibiotic Prophylaxis (<37 wk)**  Penicillin  Clindamycin  Erythromycin  None given  Date and time of last dose: | | | **Tocolytics**  Tocolytics administered?  Yes  Which one:  Date and time of last dose:  No |

**Discussion/Counsel with Parents:**Date and time carried out: With whom:  
Clinician(s) present:

If not carried out, why?

**Contraindications to Transfer Noted Following Initial Agreement to Transfer?**  Yes:  No

**Transfer Indicated?**  Yes  No

Date and time agreed: Clinicians present at decision making:

**Transfer Arrangements (for Referring Unit to Complete)**In-Utero Coordination Service (ICS) contacted – 03333 990 210

Date: Time: By: Reference Number:  
Urgency:  NOW  One to Two Hours  Within 4 Hours  
Method:  Land  Air  
Ambulance arrival time: Escort?  Yes, name:  No  
Receiving Unit:

**Transfer Arrangements (for Receiving Unit to Complete)**

Grade and Specialty of receiving unit colleague coordinating with ICS:  
 Capacity established on initial call from ICS  Call back to ICS with capacity information required  
 IUT decision challenged/reversed, reason given:

|  |  |
| --- | --- |
| Date and time left transferring unit: | Date and time arrived at receiving unit: |

**Summary of Transfer Outcome:**

**Did birth occur?**  Yes  No

**Date Discharged: Booking Hospital Notified?**  Yes

**Repatriation date (if applicable):**