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 |
| SBAR | [ ]  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/AWhich steroid administered:Date and time of dose(s): | **Magnesium Sulphate (<30 wk)**Required?[ ]  Yes [ ]  NoBolus given?[ ]  Yes [ ]  No [ ]  N/AInfusion complete?[ ]  Yes [ ]  No [ ]  N/A | **Antibiotic Prophylaxis (<37 wk)**[ ]  Penicillin[ ]  Clindamycin[ ]  Erythromycin[ ]  None givenDate and time of last dose: | **Tocolytics**Tocolytics administered?[ ]  YesWhich 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):**