RQIA - Northern Ireland Maternal Transfer Proforma


Document Version:
Other version

Queen's University Belfast - Research Portal:
Link to publication record in Queen's University Belfast Research Portal

Publisher rights
Copyright 2019 The authors

General rights
Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.
Northern Ireland Maternal Transfer Proforma

STOP, THINK, IS THIS MOTHER AND BABY FIT FOR TRANSFER

For use when transferring women from one obstetric unit to another, or to another hospital, ICU or outside Northern Ireland

Revised: January 2019

Woman’s details (addressograph):

Name: ___________________ DOB: __________
H&C No. ___________ Hospital No. __________

Woman’s Preferred Contact:

Name: ___________________
Relationship: ___________________
Contact Tele No: ___________________

**Indication for transfer:** (see MHHR & OEWS for further details)

<table>
<thead>
<tr>
<th>Gestation: <em><strong>+</strong></em> weeks</th>
<th>EDC: <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of fetuses: 1, 2</td>
<td>Other: _________</td>
</tr>
<tr>
<td>Chorionicity (if multiple pregnancies)</td>
<td></td>
</tr>
<tr>
<td>Lie &amp; Presentation</td>
<td></td>
</tr>
</tbody>
</table>

Membranes ruptured? (Delete as appropriate):

Yes/No

Date: ___/___/___ Time: ___:

Liquor: ____________________________

Obstetric, Medical & Surgical history:

Parity: _____ + ______

Previous modes of delivery (including year):

__________________________________________________________

__________________________________________________________

Significant current obstetric history (including outcome of fetal anomaly scan):

__________________________________________________________

__________________________________________________________

Significant past obstetric history:

__________________________________________________________

__________________________________________________________

Past medical/surgical history:

__________________________________________________________

Referring Hospital:

Hospital Name: ___________________
Referring Dr/Midwife _______________

Receiving Hospital:

Name: ___________________
Department/Ward: _______________
Contact Tele No of receiving unit: _______________
Doctor/midwife accepting transfer: ___________________
Grade/Band: _______ Bleep/Contact No.: ________
Obstetric Consultant: ___________________

**Woman’s Consent to Transfer:**

Informed Consent Received:  Yes/No

If No, please explain: ___________________

Risk of giving birth during transfer explained:  Yes/No/NA

Allergy Status:

Allergic to: ___________________

Nature of reaction: ___________________

__________________________

Or

If NO Known Allergies

tick box

Infection Status:

(Including GBS carriage in this pregnancy, HIV & Hep B & C)

 ___________________

__________________________

Or

If NO Known Infection

tick box
**Maternal observations Prior to Transfer**

(continue to document on OEWS Chart)

<table>
<thead>
<tr>
<th>Time: ___: ___</th>
<th>HR: ______</th>
<th>RR: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp: _______</td>
<td>BP <em><strong>/</strong></em></td>
<td>O₂ Sats: ______</td>
</tr>
<tr>
<td>OEWS: Total Yellow Score: _____</td>
<td>Total Red Score: _____</td>
<td></td>
</tr>
</tbody>
</table>

---

**Ultrasound findings:**

<table>
<thead>
<tr>
<th>Date: <em><strong>/</strong></em>/___</th>
<th>Fetus 1</th>
<th>Fetus 2 (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presentation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low lying placenta</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>EFW in grams/centile</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IUGR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquor volume</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Umbilical Artery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doppler</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDF:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI &gt;95th centile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI value ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDF:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI &gt;95th centile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI value ______</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Examination:**

Date: ___/___/___  Time: ___: ___

- Uterine contractions - Yes/No (frequency/strength):
  ________________________________

- Speculum/VE not indicated  □

- VE findings: ________________________________

- Speculum findings: ________________________________

---

**Investigations:**

- Blood group: __________________ Rhesus factor: ______

- Bloods sent to lab  Yes / No  (attach results if available)

- Urinalysis: ________________________________

- **Test for Risk of Pre-term Labour**
  - Fetal fibronectin (fFN)  □  Partosure  □
  - US cervical length  □
  - Result: ________________________________

---

- Have neonatal medical staff counselled the woman/partner  Yes / No / Not applicable

---

**Fetal Heart Rate (FHR)**

Time: ____: ____

FHR on auscultation Prior to Transfer _______ bpm

If CTG performed:  Time: ____: ____

<table>
<thead>
<tr>
<th>Normal</th>
<th>Suspicious</th>
<th>Pathological*</th>
</tr>
</thead>
</table>

*If CTG pathological and facilities for obstetric intervention are available consider delivery of baby prior to transfer

**Treatment (See Medicine Kardex):**

Indicate below medicines administered prior to transfer

- Anti-hypertensives (dose and time):
  ________________________________ N/A □

- MgSO₄ (dose and time):
  ________________________________ N/A □

- Tocolytics (dose and time):
  ________________________________ N/A □

- Steroids (dose and time):
  ________________________________ N/A □

- Analgesia (dose and time):
  ________________________________ N/A □

- Antibiotics (dose and time):
  ________________________________ N/A □

Current medication please state
______________________________ N/A □

---

**Discussed with consultant/midwife on call prior to transfer:**  Yes/No

Time decision made for transfer: ____: ____

Discussed with: ________________________________

Time ambulance called: ____: ____

Time ambulance arrived: ____: ____

Time ambulance departed: ____: ____

---

**Proposed Management Plan**
1st Hospital contacted:
____________________________________________________________
Contact name: ________________________________________________
Transfer accepted: Yes/No
Indication for not accepting transfer:
No NICU cots ☐
No maternal beds ☐
Other ☐ please indicate reason ________________________________
____________________________________________________________

2nd Hospital contacted (if applicable):
____________________________________________________________
Contact name: ________________________________________________
Transfer accepted: Yes/No
Indication for not accepting transfer:
No NICU cots ☐
No maternal beds ☐
Other ☐ please indicate reason ________________________________
____________________________________________________________

3rd Hospital contacted (if applicable):
____________________________________________________________
Contact name: ________________________________________________
Transfer accepted: Yes/No
Indication for not accepting transfer:
No NICU cots ☐
No maternal beds ☐
Other ☐ please indicate reason ________________________________
____________________________________________________________

4th Hospital contacted (if applicable):
____________________________________________________________
Contact name: ________________________________________________
Transfer accepted: Yes/No
Indication for not accepting transfer:
No NICU cots ☐
No maternal beds ☐
Other ☐ please indicate reason ________________________________
____________________________________________________________

5th Hospital contacted (if applicable):
____________________________________________________________
Contact name: ________________________________________________
Transfer accepted: Yes/No
Indication for not accepting transfer:
No NICU cots ☐
No maternal beds ☐
Other ☐ please indicate reason ________________________________
____________________________________________________________

TRANSFER CHECKLIST:
Name of Doctor/Midwife chaperone:
____________________________________________________________
Name of Ambulance staff:
____________________________________________________________
Documentation/Equipment for transfer:
Delivery pack ☐ Maternity Hand Held Record ☐
Regional OEWS Chart ☐ Neonatal resus ☐
IV access (If applicable) ☐
Catheter (if applicable) ☐
Transfer Time from care setting: ___:___
Arrival Time at Transfer location: ___:___

If maternal observation are taken during transfer use Regional OEWS Chart

For further details of care following transfer refer to Maternity Hand Held Record and the OEWS Chart

Signature ___________________________ Designation ________________ Date ___/___/___ Time ___:____