This Proforma has been agreed and updated.

Please note: This updated version should be used from 1 October 2019.

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

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)_____

_____

Gestation: ___+ ___weeks EDC:__/___/___

No. of fetuses: 1, 2 Other: _____

Chorionicity (if multiple pregnancies) ____

Lie & Presentation

Membranes ruptured? (Delete as appropriate):

Yes/No

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

Liquor: _____

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: _____

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:

_____

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 ☐

Signature _____ **Designation** _____ **Date** ___/___/___ **Time:** __: ___

Maternal observations Prior to Transfer (continue to document on OEWS Chart)

Time: ___: ___ HR: _____ RR: _____

Temp: _____ BP ___ /___ O^2 Sats: _____

OEWS: Total Yellow Score: ____ Total Red Score: ____

Fetal Heart Rate (FHR) Time: ____: ____

FHR on auscultation Prior to Transfer _____bpm

If CTG performed: Time: ___: ___

Normal Suspicious Pathological*

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

Ultrasound findings: Date: ___/___/___	**Fetus 1**	**Fetus 2** (if applicable)
Presentation		
Low lying placenta	Yes / No	Yes / No
EFW in grams/centile		
IUGR	Yes / No	Yes / No
• Liquor volume		
• Umbilical Artery Doppler	EDF: PI >95th centile □ PI value _____	EDF: PI >95th centile □ PI value _____

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

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: ____: ____

Maternity care during transfer (additional notes):

Proposed Management Plan

Signature _____ **Designation** _____ **Date** ___/___/___ **Time** ____: _____

Details of Trust's (Hospital) contacted to arrange transfer

The Regulation and Quality Improvement Authority

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 _____

_____

If maternal observations are taken during transfer use Regional OEWS Chart

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: ___: ___

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

Signature _____ **Designation** _____ **Date** ___/___/___ **Time** ____: _____