

California Perinatal Transport System (CPeTS)

Transport Activity Report

- Managed by CPQCC -

Add New Infant ID

Network ID Hospital No. Birth Year

Click on the arrow to the left of a category to display the respective part of the form.

[Click here](#) to toggle the display of the entire form.

All sections of the transport-in form should be filled out.

Do not fill out the form if the infant was never admitted to your NICU but died during the transfer process.

The CPeTS form was revised on 04-05-2008. Part of the revisions involved re-ordering the items on the form. [Click here to access a sortable table that shows old and new item numbers.](#) For your convenience the old item numbers are shown in parentheses on the form as well.

Situational Overrides applicable to this transport:

- No special situation
 Delivery Room Attendance
 Transport by referring center (Self Transport)
 Transport from ER or other non-perinatal settings
 Safe surrender infants

▼ Referral (Items C.1-C.2)

C.1 Transport Type (previously T.1)

- Requested DR Attendance Emergent Urgent Scheduled Neonatal
 Other (Describe)

C.2 Indication for Transfer (previously T.2)

- Medical DX/RX Services Surgery Insurance Bed Availability

A baby that is transferred into your hospital for reasons of growth/discharge planning, chronic, or hospice care is not eligible and you do not need to fill out this form.

▼ Patient Identification/History (Items C.3-C.9)

C.3 Birth Weight (previously T.7) grams Not MeasuredC.4 Best estimate of gestational age (previously T.8) a) Weeks: b) Days: UNKC.5 Infant Sex (previously T.9) Male Female UnknownC.6 a) Congenital anomalies that were diagnosed prenatally (previously T.10) Yes No Unknownb) Enter up to 5 birth defect codes that were all diagnosed prenatally: [Click here to select from a list of codes](#)Code 1: Code 2: Code 3: Code 4: Code 5:

Enter birth defect description for codes 100 150 200 300 400 504 601 605 800 900:

C.7 Number of Mother's Pregnancies Including the Current Pregnancy (Gravida) (previously T.11) UNKC.8 Antenatal Steroids (previously T.12a) Yes No UnknownC.9 Surfactant Use (previously T.13a/b)











a) Was Surfactant given in Delivery Room Yes No Unknown

b) Was Surfactant given at any time? Yes No Unknown

▼ **Time Sequence** (Items C.10-C.19)

Enter dates as MM-DD-YYYY or MMDDYYYY or MMDDYY. Note that for non January one-digit dates MDYY or MDYYYY will also work. Your date will be converted by the application to the compliant format MM-DD-YYYY and then checked for errors. Alternatively you can click the calendar icon to the right of the entry box to select the date using a calendar.

Enter times as HH:MM or HHMM or HMM. Your time will be converted by the application to the complicant format HH:MM.

- C.10 Date/Time of Maternal Admission to Labor & Delivery (previously T.5)  at
- C.11 Date/Time of Last Antenatal Steroid Administration (previously T.12b)  at NA UNK
Click here to copy maternal admission date and time.
- C.12 Date/Time of Infant Birth (previously T.6)  at
Click here to copy maternal admission date and time.
- C.13 Date/Time of Surfactant (previously T.13c)  at NA UNK
Click here to copy birth date and time.
- C.14 Date/Time of Referral (previously T.3)  at
Click here to copy birth date and time.
- C.15 Date/Time of Acceptance (previously T.4)  at
Click here to copy referral date and time.
- C.16 Date/Time of Transport Team Departure for Referring Hospital (previously T.32)  at
Click here to copy acceptance date and time.
- C.17 Date/Time of Arrival of Transport Team at Referring Hospital (previously T.33)  at
Click here to copy transport team departure date and time.
- C.18 Date/Time of Initial Evaluation by Transport Team within 15 Minutes of Arrival at Referring Hospital (previously T.14b)  at
Click here to copy date/time of transport team arrival at referring hospital.
- C.19 Date/Time of NICU Evaluation within 15 Minutes of Arrival at Receiving Hospital (previously T.14c)  at
Click here to copy date/time of initial evaluation (date/time of acceptance for Situation B/Self Transport).

▼ **Infant Condition** (Items C.20-C.30)

Each of the following items has to be filled out for referral, within 15 minutes of arrival at referring hospital and NICU admission. For your convenience the times entered in the previous section are shown above each relevant section.

	at Referral	at Initial Evaluation	at NICU Admission
C.20 <u>Responsiveness</u> (previously T.15)			
Death (0)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None, Seizure, Muscle Relaxant (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lethargic, no cry (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vigorously withdraws, cry (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C.21 <u>Temperature (20 to 45°C or 68 to 113°F)</u> (previously T.23)	<input type="text"/> °C <input type="text"/> °F	<input type="text"/> °C <input type="text"/> °F	<input type="text"/> °C <input type="text"/> °F
C.22 <u>Heart Rate (0 to 400)</u> (previously T.20)	<input type="text"/>	<input type="text"/>	<input type="text"/>
C.23 <u>Respiratory Rate (0 to 400)</u> (previously T.16)	<input type="text"/>	<input type="text"/>	<input type="text"/>
C.24 <u>Oxygen Saturation (SaO₂) (0 to 100)</u> (previously T.17)	<input type="text"/> <input type="checkbox"/> UNK	<input type="text"/> <input type="checkbox"/> UNK	<input type="text"/> <input type="checkbox"/> UNK
C.25 <u>Respiratory Status</u> (previously T.18)			
Respirator (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Apnear, gasping, <u>OR</u> intubated but not on respirator (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C.26 Oxygen Index (for infants on respirator only)
(previously T.19)

a) Mean Airway Pressure (MAP) (0-40)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA
b) Inspired Oxygen Concentration (FiO ₂) (21-100)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA
c) Arterial Oxygen (PAO ₂) (0-500)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA	<input type="text"/>	<input type="checkbox"/> UNK	<input type="checkbox"/> NA

C.27 Respiratory Support (previously T.25)

None (0)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hood / NC (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nasal CPAP (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ETT (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C.28 Blood Pressure (previously T.21)

a) Systolic (0-140)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK
b) Diastolic (0-100)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK
c) Mean (0-100)	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK

C.29 Use of Pressors (previously T.22)

<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
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C.30 Blood Glucose (0 to 500) (previously T.24)

<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK	<input type="text"/>	<input type="checkbox"/> UNK
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at Referral at Initial Evaluation at NICU Admission

▼ **Referral Process (Items C.31-C.36)**

C.31 Referring Hospital (previously T.26)

C.32 a) Was the infant previously transported? (previously T.27) Yes No

b) Previous Transfer Referring Hospital
 NA

C.33 Location of Birth (previously T.28)

Click here to copy the Referring Hospital.
Click here to copy the Referring Hospital of the Previous Transfer.

C.34 Transport Team On-Site Leader (previously T.29)

Sub-specialist MD Pediatrician Other MD/Resident Neonatal Nurse Practitioner Transport Specialist
 Nurse

C.35 a) Transport Team From: (previously T.30a) Receiving Hospital Contract Service Referring Hospital

b) Select Contract Service Provider Code: (previously T.30b)
 NA

C.36 Mode of Transport (previously T.31) Ground Helicopter Fixed Wing

Check here to mark this record as deleted [Click here for help.](#)

Check Form

List Pending Items

List Confirmed Unknown Items

Only click on Submit Data once. Depending upon how busy the system is, it can take more than a minute to complete a subm

Add user comments here

Administrators Only Section

Allow Errors to be written to CPQCC database

Add comments here (CPQCC data center staff only).

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