

California Perinatal Transport System (CPeTS)

Transport Activity Report

- Managed by CPQCC -

Edit Infant ID

Network ID

Hospital No.

Birth Year

2009

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.

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 Measured

C.4 Best estimate of gestational age (previously T.8)

a) Weeks: Days: UNK

C.5 Infant Sex (previously T.9)

- Male
Female
Unknown

C.6 a) Congenital anomalies that were diagnosed prenatally (previously T.10)

- Yes
No
Unknown

b) Enter up to 5 birth defect codes that were all diagnosed prenatally: Please see Appendix D of the 2009 Manual of Definitions for list of birth defect 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)

UNK

C.8 Antenatal Steroids (previously T.12a)

- Yes
No
Unknown

C.9 Surfactant Use (previously T.13a/b)

- a) Was Surfactant given in Delivery Room
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 compliant 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

The dates provided imply 0 day(s), 12 hour(s), and 0 minute(s) between maternal admission and antenatal steroid treatment.

- C.12 Date/Time of Infant Birth (previously T.6)  at
- C.13 Date/Time of Surfactant (previously T.13c)  at    NA  UNK

The dates provided imply 0 day(s), 0 hour(s), and 5 minute(s) between birth of infant and surfactant treatment.

- C.14 Date/Time of Referral (previously T.3)  at
- C.15 Date/Time of Acceptance (previously T.4)  at

The dates provided imply 0 day(s), 2 hour(s), and 0 minute(s) between referral and acceptance of transfer.

- C.16 Date/Time of Transport Team Departure for Referring Hospital (previously T.32)  at
- C.17 Date/Time of Arrival of Transport Team at Referring Hospital (previously T.33)  at

The dates provided imply 0 day(s), 0 hour(s), and 20 minute(s) between date/time of transport team departure for and arrival at referring hospital.

- C.18 Date/Time of Initial Evaluation by Transport Team within 15 Minutes of Arrival at Referring Hospital (previously T.14b)  at
- C.19 Date/Time of NICU Evaluation within 15 Minutes of Arrival at Receiving Hospital (previously T.14c)  at

The dates provided imply 0 day(s), 0 hour(s), and 35 minute(s) between date/time of initial evaluation and NICU admission.

**Infant Condition** (Items C.20-C.29)

**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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None, Seizure, Muscle Relaxant (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lethargic, no cry (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vigorously withdraws, cry (3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 (SaO<sub>2</sub>) (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

<p>C.25 <u>Respiratory Status</u> (previously T.18)</p> <p>Respirator (1)</p> <p>Apnear, gasping, <u>OR</u> intubated but not on respirator (2)</p> <p>Other (3)</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> UNK <input type="checkbox"/> NA	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> UNK <input type="checkbox"/> NA	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> UNK <input type="checkbox"/> NA
<p>C.26 <u>Inspired Oxygen Concentration (FiO<sub>2</sub>) (21 to 100)</u></p>	<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
<p>C.27 <u>Respiratory Support</u> (previously T.25)</p> <p>None (0)</p> <p>Hood / NC (1)</p> <p>Nasal CPAP (2)</p> <p>ETT (3)</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>C.28 <u>Blood Pressure</u> (previously T.21)</p> <p>a) Systolic (0-140)</p> <p>b) Diastolic (0-100)</p> <p>c) Mean (0-100)</p>	<input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK	<input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK	<input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK <input type="text"/> <input type="checkbox"/> UNK
<p>C.29 <u>Use of Pressors</u> (previously T.22)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>at Referral</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>at Initial Evaluation</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>at NICU Admission</b>

**Referral Process (Items C.30-C.35)**

C.30 Referring Hospital (previously T.26)

C.31 a) Was the infant previously transported? (previously T.27)  Yes  No

b) Previous Transfer Referring Hospital

NA

C.32 Location of Birth (previously T.28)

C.33 Transport Team On-Site Leader (previously T.29)

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

Nurse

C.34 a) Transport Team From: (previously T.30a)    Receiving Hospital    Contract Service    Referring Hospital

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

NA

C.35 Mode of Transport (previously T.31)    Ground    Helicopter    Fixed Wing

Check here to mark this record as deleted

Comment Box