SUBJECT: Transport Procedure

OBJECTIVE:
To avoid compromising the patient, to ensure a predictable response for transportation requests, and to provide the highest quality of care. The approach to transport must be logical and organized, providing all the appropriate forms and information necessary in the event of maternal or neonate transport from to another facility.

Transport should be considered when the resources immediately available to the maternal, fetal, or neonatal patient are not adequate to deal with the patient's actual or predicted medical or surgical complications.

Process for Utilization:
1. The referring staff can help the mother, fetus, or neonate most by calling for assistance as soon as the need for transport becomes apparent and by using the time before transport to stabilize the patients and prepare for transport.
2. The decision should be made by the initial physician and consultant, both of whom should be well-informed of the resources of each center. The receiving physician is usually the one that activates the transport team.
3. The main concern during transport is to maintain optimum care. The choice of a ground or air ambulance is based on distance from one hospital to another and facilities available to support the patient during the transfer. The mode of transport is decided on by the transport team or the receiving physician.

I. Maternal conditions for consideration of transport.
   A. Obstetrical complications
      1. Premature rupture of membranes (at < 35 weeks gestation or < 2000gm. expected birth weight)
      2. Premature labor (at < 35 weeks gestation or < 2000gm. expected birth weight)
      3. Any condition creating the probability of birth at < 35 weeks gestation or < 2000gm. expected birth weight.
         a. Severe hypertensive complication
         b. Multiple gestation
         c. Intrauterine growth retardation
         d. Third trimester bleeding
         e. Rh isoimmunization
   B. Medical complications
      1. Severe organic heart disease, functional class III or IV
      2. Poorly controlled Diabetes Mellitus
      3. Acute or chronic respiratory disease
4. Thyrotoxicosis
5. Renal disease with deteriorating function or increased hypertension
6. Drug overdose

C. Surgical complications
   1. Trauma requiring intensive care or surgical correction beyond the capabilities of
      or where the procedure may result in the onset of premature labor
   2. Acute abdominal emergencies at < 35 weeks gestation or with a fetus weighing < 2000gm.
   3. Thoracic emergencies requiring intensive care or surgical correction

II. Neonatal conditions for consideration of transport
   A. Gestation <35 weeks or weight <2000gm.
   B. Neonatal sepsis or infection
   C. Respiratory distress and metabolic acidosis persisting after 2 hours of age
   D. Neonatal blood loss
   E. Hypoglycemia (unstable)
   F. Hemolytic disease of the newborn
   G. Neonates of mothers taking hazardous drugs
   H. Neonates of diabetic mothers (unstable)
   I. Congenital malformations requiring surgical care or observation
   J. Neonates needing more than routine observation or care.
   K. Others if persistently unstable.

Equipment/Supplies:
- Transport packet (MedStar referral form, Transfer Record, Transport Checklist)
- Photocopy machine

Procedure:
- Physician will make arrangements for transport with the appropriate receiving physician.
- It is essential that the referring physician provide the receiving physician with specific clinical information on the patient being referred.
  I. Maternal information and documentation should include:
     a. Reason for admission
     b. Age
     c. Date of last menstrual period
     d. Estimated date of confinement
     e. Gravida, para, and abortion
     f. Relevant health problems
     g. Perinatal history
     h. Blood type
     i. Reasons for transfer
j. Therapy administered, including drugs
k. Intake and output

II. Neonatal information and documentation should include:
   a. Gestational age and weight
   b. Perinatal history
   c. Temperature, pulse and respirations
d. Color
e. Hematocrit
f. Oxygen requirement and blood gas levels
g. Respiratory activity (particularly presence of apnea or need for assisted ventilation)
h. Blood glucose (lab and/or fingerstick)
i. Pertinent radiological findings
j. Reasons for transfer

- Therapy administered, including drugs

- Get name of receiving facility from physician.
- Notify Clinical Coordinator of impending transport.
- Clinical Coordinator or designee must phone the receiving facility to ensure they have available space, qualified personnel for the treatment of the patient, and that they agree to accept the patient.
  - Document on the transfer record.
- Clinical Coordinator or designee must phone MedStar to obtain ETA.
- Transport forms are found in the transport folder in the back of the lower file drawer.
  - Forms are filled out as completely as possible.
  - Make sure physician completes sides 1 and 2 of Transfer Record: “Physician Certification” and “Treatment Refusal/Transfer Request/Transfer Refusal/Transfer Request”
- Make photocopies of all chart documents including lab slips. (Transport crew does not have access to WatchChild or Meditech documents.)
- Include any x-rays that have been done.
- If transporting neonate:
  - Photocopy and include any pertinent information from mother’s chart.
  - Include cord blood for neonates.
  - If needed, include a tube of mother’s blood clearly marked MOTHER’S BLOOD.
- On arrival of transport team, but only after the team has received a full report and all tests and procedures are completed, the patient can be discharged and notation made in the chart: Care assumed by MedStar (Nurse’s name).
- The nurse caring for the patient will remain with the patient until he/she leaves the department, assisting the transport team as necessary.
Documentation:

- Forms and instructions from receiving hospital will be completed prior to arrival of transport team. All pertinent chart forms will be copied and ready for the transport team.
- Significant events occurring and procedures done will be reflected in the chart until patient is discharged from.
- Document discharge time in the Nurse’s Notes.

Refer To:
Transfer Record 10/03 Modified to Procedure

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Director of Med/Surg and BirthPlace

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Chairman of OB-Peds

Effective: 8/88
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