NEONATAL TRANSFER REGISTER

UNIT: _____

YEAR: _____

KWAZULU-NATAL PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA

Document on this form every referral consultation (and every hospital contacted)
Follow up monthly on all babies – record outcome once discharged or died.

	Year:				Month:											
No.	**Name and IP No.**	**Decision to refer Date, time & MO**	**Receiving hospital & MO**	**Consult time:**	**Consult outcome Accepted /Refused**	***Reason for refusal:**	**EMRS phoned Date & time**	**EMRS arrived Date & time**	**EMRS Case No.**	**Total time from decision to departure**	**Trans. skin to skin Y/N**	**Date mother trans-ferred**	**Arrived at hosp. (Alive/ Dead)**	**Final Result (Alive/ Dead)**

*Reason for refusal: No need / No bed / Not stable

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