

NEONATAL / PAEDIATRIC TRANSFER REGISTER



UNIT: _____

YEAR: _____



KWAZULU-NATAL PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA

GROWING KWAZULU-NATAL TOGETHER

Document on this form every referral consultation (and every hospital contacted)

Follow up monthly on all babies – record Final outcome once discharged or died.

Year:				Month:			Unit:									
No.	Name IP No. Age (A) & Gender (G)			Reason for referral 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 <u>mother</u> transferred	Arrived at hosp. (Alive/Dead)	Hospital, Date, Time, Final outcome ^o
	A		G													
	A		G													
	A		G													
	A		G													
	A		G													
	A		G													

*Reason for refusal: No need (NN) / No bed (NB) / Not stable (NS); # Skin to skin-Only applicable for neonates ; ^o Final outcome: Alive (A), Dead (D), Transferred back (TB), Discharged home (DH)

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