Reset Form | Print

Queensland Government

Royal Brisbane and Women's Hospital

NeoReturn REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Note: This form is an interactive form that must be PRINTED and SIGNED upon completion. A digital signature on this form is not valid authentication.

REFERRAL

Notification date to NeoReturn: ..../..../.... Time notified: ....:.... hrs

Ready for transfer - Date: ..../..../.... Transport required to: ☐ Accepting hospital ☐ Airport

Referring Hospital:

☐ MMH: ☐ SCN ☐ C/S ☐ P/M

☐ RBWH: ☐ SCN ☐ ICN

☐ Other: .....

Authorising Consultant: .....

Accepting Hospital: .....

Accepting Consultant: .....

Nursing Acceptance: .....

Bed available on referral: ☐ Yes ☐ No Comments:

PATIENT INFORMATION

Baby's name: .....

Birth hospital: .....

Retrieval: ☐ Yes ☐ No Colonisation: .....

Date of birth: ..../..../.... Gestational Age: ..... Birth weight: .....

Age in days: ..... Corrected Age: ..... Current weight .....

NEONATAL DIAGNOSES / ISSUES

1.	2.
3.	4.

TRANSPORT REQUIREMENTS (Referring hospital recommends)

Restraint: ☐ Cosy Pod ☐ Baby capsule ☐ Neocot

Monitoring: ☐ SpO_2 ☐ Other: .....

Oxygen: ☐ Nil ☐ SNO_2: ..... mL/min

Frequency of desaturations in 24hour period ☐ <5 ☐ 6-12 ☐ >12

Milk / Expressed Breast Milk: ☐ Yes ☐ No (Maximum of 2 eskies per baby)

PARENT AND FAMILY INFORMATION

Parent's name: ..... Mobile: .....

Parent's name: ..... Mobile: .....

NeoReturn information given to parent: ☐ Yes ☐ No Name of parent accompanying baby: .....

Parent email: .....

Parental considerations: .....

Clinician name: ..... Signature: .....

Designation: ..... Date: ..../..../.... Email referral to NeoReturn@health.qld.gov.au

OFFICE USE ONLY: Referral received: ..../..../.... Expected date of transfer: ..../..../....

NeoReturn URN: .....

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