referapatient

National Adult Critical Care Transfer Service Network
ACCTS (South East)
Adult Critical Care Transfer Service

Please review the whole form before starting. Press TAB to move to the next field.

What type of transfer referral is this?*
Escalation of care

Urgency*
Non-Urgent
Select EMERGENCY for time critical referrals and NON-URGENT for planned referrals.

What is the patient's first name?*
Unknown
You may not know the first name so it's OK to enter a placeholder name e.g Foxtrot.

What is the patient's last name?*
Unknown
You may not know the last name so it's OK to enter a placeholder name e.g Delta.

Date of Birth*
01 01 1900
You may not know the date of birth so it's OK to enter 01/01/1900.

Age
125
Automatically calculated.

Gender*
Select

Medical record number*

NHS Number*
0000000000
This can't be left blank.The NHS number is very helpful (we receive lots of referrals using names like Foxtrot Delta with a date of birth of 01/01/1900). If you don't know the NHS number enter 0000000000.

Patient's address*
Please include postcode and home telephone number.

Discussed with clinical supervisor*
I am the responsible consultant or primary care physician

COVID-19 status*

- ○ Positive
- ○ Negative
- ○ Swab sent - pending
- ○ No swab sent

Record if outside of average adult parameters
i.e. Bariatric; extreme height
Otherwise: N/A

Height (cm)*
For example 175

Height estimated or measured?*
Measured

Weight (kg)*
For example 75

Weight estimated or measured?*
Measured

Referring hospital*
Select

Date of admission to hospital*

Has patient been admitted to critical care?*
No

Patient's exact location at referring hospital*

Contact number at referring hospital (Of unit or ward)*
Full contact number dialable from external line

Access to patient location*
What is the best entrance for critical care, ED, theatres, etc. Please consider the transfer team won't have swipe cards to access secure areas.
Pertinent to unit (consider building works etc)

Receiving hospital details (if known)

Receiving hospital: Royal Surrey County Hospital, Royal Surrey County NHS Foundation Trust

Intended location at receiving hospital
Unknown

Contact number at receiving hospital (Of unit or ward): Full contact number

Receiving consultant (Enter name of receiving consultant): Full name

Contact number of receiving consultant (Enter direct number of receiving consultant)

Access to patient location at receiving unit
What is the best entrance for critical care, ED, theatres, etc. Please consider the transfer team won't have swipe cards to access secure areas
Pertinent to unit (consider building works etc)

Clinical details

What is the admission diagnosis?*

History of presentation and summary of stay*
Please provide a synopsis of admission to date including: presenting symptoms, progression of disease, clinical progression in intensive care, date of intubation etc.
Relevant to referral, inclusive of reason/decision for transfer

Have any other hospital specialties been involved in the care of this patient?*
- (●) No
- ( ) Yes

Past medical history*
Relevant to referral

Allergies*
Relevant to referral. Otherwise N/A

Regular medications*
Relevant to referral. Otherwise N/A

Does the patient have any treatment limitations?*
Have any decisions been made about treatment limitations, including resuscitation?
Relevant to referral.

Relatives and next of kin*
N/A

Are relatives aware of transfer?*
- (●) Yes
- ( ) No

Current status

Airway*: Own

Difficult airway*
- ( ) Yes
- (●) No

Breathing

Type of ventilatory support*: None

Current FiO2*:

What is the trajectory of FiO2 over last 24 hours?*: Improving

Current SpO2*:

Has the patient been proned?*

- ○ Yes
- ◉ No

Circulation

What is the trajectory of the patient's cardiovascular status over the last 24 hours?*: Improving

Vasopressors / Inotropes*

- ☐ None
- ☐ Adrenaline
- ☐ Dobutamine
- ☐ Dopamine
- ☐ Enoximone
- ☐ Metaraminol
- ☐ Milrinone
- ☐ Noradrenaline
- ☐ Phenylephrine
- ☐ Terlipressin
- ☐ Vasopressin

Other vasoactive drugs*

- ☐ None
- ☐ GTN
- ☐ Labetalol
- ☐ SNP

Disability

Sedated*

- ○ Yes
- ◉ No

Other sedative or analgesic drugs

Please describe anything not covered in the above options

Relevant to referral.

Paralysed*

- ○ Yes
- ◉ No

Glasgow Coma Scale - Eyes*: 1

Glasgow Coma Scale - Verbal*: 1

Glasgow Coma Scale - Motor*: 1

Right Pupil*: Reactive

Left Pupil*: Reactive

Gastrointestinal

Feeding*

- (•) None
- ( ) Oral
- ( ) NG
- ( ) NJ
- ( ) PEG
- ( ) TPN

Details and issues

Relevant to referral

Renal

Renal function*

Static

Does the patient require Renal Replacement Therapy (RRT)?*

- ( ) Yes
- (•) No

Lines and Drains

Lines*

- [ ] None
- [ ] Central Venous Catheter
- [ ] Arterial line
- [ ] Vascath
- [ ] PA Catheter
- [ ] PICC Line
- [ ] Peripheral cannulae

Date of insertion of line(s)

For each please provide sites and dates of insertion (if known).

N/A

Drains

For each please provide sites and dates of insertion (if known)

Relevant to referral.

Microbiology

Notable results and further details *

Any positive cultures etc

Unknown

Relevant to referral and IPC measures required.

MRSA status* Unknown

CPE status* Unknown

VRE status* Unknown

ESBL status* Unknown

Antimicrobials*

Which antimicrobials, indication, start date, etc

N/A

Imaging

CXR / CT / MRI / Echo / Other*

Copy and paste reports

N/A

Is there anything important that has not been covered above?

Additional information

Relevant to referral, i.e. Transfer for tomorrow (date).

Upload an image or document file

Choose file

Your Details

Who shall I say has written this referral?*

Title | Name

Enter your title and name; for example Dr D Howser

What is your Grade?*

Select

This is important information to the team.

What is your bleep/ phone number?*

Full contact number

The team may need to contact you.

What is your personal mobile telephone number?*

Numerics only. Do not use spaces

Don't worry this will NOT be shared with ANYONE. Your mobile number is required for two-factor authentication when logging into your account.

What is your email address?*

The latest response from the team will be emailed. I can only accept a secure organisation email address (not a personal one).

Which Hospital or service provider are you referring from?*

Select

Your Speciality or Service at that Hospital or provider?*

Select