[redacted]

St. Joseph Health Systen
Bryan, Texas

MEMORANDUM OF TRANSFER

Section A (to be filled out at transferring hospital)

1. Name of hospital:
   Grimes St. Joseph Health Center
   210 South Judson
   Navasota, TX 77868
   936-825-6585

2. Patient's full name: Baby Boy [redacted]
   Address: [redacted]
   Phone Num
   Sex: M X F ____ Age NB
   National Origin: Hispanic Race H
   Religion: ____
   Physical handicap: Newborn c HIE

3. Next of kin information (if known)
   Name: [redacted]
   Address: Same as above
   Phone number: (____)
   Next of kin notified: X Yes ____ No

4. Date of arrival: 8/5/16 Time: 0503

5. Initial contact with receiving hospital:
   Date: 8/5/16 Time: 0602
   Name of contact person at receiving hospital:
   Khattab

6. Accepting physician secured by transferring physician:
   Date: 8/5/16 Time: 0602
   Name of accepting physician: Khattab
   Address: 6221 Fannin St
   Houston, TX 77030
   Phone number: (832-824-5550

7. Transferring physician's signature or signature of hospital staff acting under physician's orders: Williams MD
   Phone number: (____)
   Address: 2801 Franciscan Drive
   Bryan Texas 77802

8. Accepting hospital secured by transferring hospital:
   Date: ____/____/____ Time: ____
   Name of accepting hospital administration person:
   Mm

9. Transferring hospital administration signature: Karen Boone, RN
   Title: Director Maternity Services Time: 0915

10. Certification for transfer: ____

11. Type of vehicle and company used: Ambulance
    Equipment Needed: Isolette
    Personnel Needed: ____

12. Name of Facility transported to: Texas Childrens Hovson
    City: ____

13. Diagnosis: HIE

14. Condition on transfer: X
    Stable ____ Unstable ____

15. Attachments:
    X-Ray X MD Progress Note: X
    Lab Reports ____ Nurses Progress Notes ____
    H&P ____ Medication Record ____
    Other ____

16. Transfer Rationale: X
    a. Medical Necessity: ____
    b. Patient Request: ____

17. Attachments by transferring hospitals:
    ____

PHYSICIAN CERTIFICATION: Based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks of the transfer to the patient and in the case of labor, the unborn child.

Benefit and Medical risks requiring transfer:
HIGHER LEVEL OF CARE FOR BODY COOLING
AUTO ACCIDENT

Williams MD
Physician's Signature

Section B (to be filled out at receiving hospital)

1. Name of hospital: Transfer Center MC-A5501
   Address: Texas Children's Hospital PO Box 300630
   Houston TX 77230-0362
   Phone number: (____)
2. Date of arrival: 08/05/16 Time: 1256
3. Hospital administration signature: Khattab
   Title: ____
   Date: 8-5-16 1310

4. Receiving physician assuming patient responsibility:
   Date: 08-05-16 Time: 1257
   Name: ____
   Address: Nena Khattab
   Phone number: (____)
5. If response to transfer was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any time extension agreed to be transferring hospital. Use additional sheet, if necessary
   ____
6. Method of pay: ____

MEMOTRANS

Texas Children's Hospital kangaroo crew
INTENSIVE CARE TRANSPORT TEAM

Service: Kangaroo Crew
Base: Neo Team
Unit: Unit 997
Shift: Day Shift
Type of Svc: Interfacility Unscheduled
Response Code: Emergency
Mode to Ref: No Lights/Sirens
Outcome: Treated, Transported by Kangaroo Crew
Amb. Transport Code: Initial Trip

Date: August 5, 2016
Team: Critical Care
Crew 1: *~~Gompbell, RN, Melissa~~ Nurse
Crew 2: *Estlinbaum, RRT, Ray Other
Crew 3: Williams, EMT, Reginald EMT
Crew 4: Mallet, RN, Elizabeth Nurse
Other: dischler, nnp
* designates an ALS Provider
Mode to Rec: No Lights/Sirens

Location: St. Joseph Hospital Bryan - Neonatal ICU
2801 Franciscan
Bryan, TX 77802
Ref. Zip: 77802
Ref County: Brazos
Ref. MD: carmichael
Ref. RN: rickela

Receiving: *Hospital*
Texas Children's Hospital
Neonatal ICU
6621 Fannin Street
Houston, TX 77030-2303
832-824-1000
Rec. MD: reyes
Rec. RN: leanna
Destination Basis: Emergent - Higher Level of Care
Dest. Basis Comment: nicu d71

Online Medical Control:

Last Name: First:
Citizenship: United States
DOB:
Age: 6h Sex: M Weight: 3.5 kg
Height:
Subscriber: No

Prenatal Care: Routine
Fetal HR: Birth Weight: 3.5 kg
Delivery Type: Cesarian, Emergent Gestational Age: 0 wks / 0 days

Newborn Care: Erythromycin, Newborn Care / Vitamin K
Infant Complications: Meconium aspiration

Odometer	Times
Ld Miles: 103	Notified: 06:15
	Dispatch: 06:15
	Acknowledged: 06:15
	EnRoute: 07:03
	At Ref: 09:10
	Leave Ref: 10:56
	At Rec: 12:45
	Transfer Care Dest: 12:55
	Available: 13:05

Chief Complaint (Category: Neonate, Hypoxic-Ischemic Encephalopathy)

HIE

Secondary Complaint

pneumothorax

History of Present Illness

Full term infant born today. Infant with decels and non reassuring heart tones. C-section d/t failed vbac. Meconium present at birth. Initial APGARS 1/2/5. No spontaneous movement, gag or cough noted. Transfer to TCH initiated by OSH to facilitate active cooling. Patient being transferred to TCH MC NICU for further medical management and evaluation.

Medical History	Current Medications	Allergies
see epic Obtained From: Not Recorded	see epic	None

Neurological Exam

Level of Consciousness: Agitated Loss of Consciousness: No
Chemically Paralyzed: No
Neuro Comments: +gag reflex noted
Mental Present: Irritable

Glasgow Coma Scale	E	V	M	Tot
Int:	4	1	6	= 11
Qual: Patient Intubated				

Pupils | Motor | Sensory

Neurological Exam

	Left	Right
Size:	4mm	4mm
React:	Reactive	Reactive
React:		

LA:	Normal	Normal
RA:	Normal	Normal
LL:	Normal	Normal
RL:	Normal	Normal

Apgar Score
At 1 min.: 1
At 5 min.: 2
At 10 min.: 5

Airway

Status: Secured / Intubated
Secured via: Endotracheal
Tube Size: 3.5 mm , 10 cm depth
Ventilator: Mode: SIMV Rate: 35
FiO2: 40 TV: Peep: 6
PIP: 22 MV:

Respiratory

Effort: Assisted
Sounds: L: Coarse R: Coarse
Comments: itime 0.3

Cardiovascular

Cap. Refill: Greater than 2 Seconds
Edema: Not Appreciated
Art Line: Umbilical Artery
Heart Tones: Normal

Pulses

	Left	Right
Carotid:		
Radial:	Normal	Normal
Femoral:	Normal	Normal

Injury Details

Reason for Encounter: Non-Injury
Drugs/Alcohol?:

Initial Physical Findings

Assessment

Tubes/Drains: OG: 8 (Suction: Gravity)

Skin: Cold, Dry, Pale
Skin Findings:
Head Findings: fontanels soft, flat
Chest/Lung: Breath Sounds-Equal
Heart: Normal
Generalized Ab: Bowel Sounds-Absent

Fluids Before & During Transport

	INTAKE		OUTPUT	
	Before	During	Before	During
CRYS:	7 mL	21 mL	EBL: mL	mL
			UO: 0 mL	0 mL
FEEDINGS:	mL	mL	BM: Yes	No

IVs Prior to Assessment

IV#	Gauge	Site	Solution	Rate
1	24	left hand	D10	7
2		UAC	NS with 1 unit heparin/ml	0.5ml/hr

Medications / Infusions Prior to Assessment

Time	IV# / Other Route	Medication	Concentration	Dose
	IV#1	Ampicillin	100mg/ml	305mg

Impression / Diagnosis

Initial Patient Acuity: Critical (Red)

Activity

Time	H.R.	B.P.	MAP	RA SpO2		Resp	Rhythm	ECG Method	Temp	CRW*	
	H.R. Method	Method				Resp Effort				Pain Scale/Pain Score:	FIO2%
Action	Comment										
07:03	Departing TCH.										
09:10	Arived at outside hospital.										
09:20	Arrived at patient's bedside, initial patient assessment done. Patient agitated upon assessment with spont. movement										
09:24	131	52 / 34	40	98		38	Normal Sinus Rhythm, (REG)		96°F Axillary		
	Art. Line					Assisted				cries 1	21
	passive cooling										
09:30											

Activity

Time	H.R.	B.P.	MAP	RA SpO2		Resp	Rhythm	ECG Method	Temp	CRM*	
	H.R. Method	Method				Resp Effort				Pain Scale/Pain Score:	FIO2%

Action	Comment
	Reviewed and obtained copies of patient's medical record with relevant imaging studies from outside hospital. Pt. assessment completed.
09:40	CXR done
09:45	ETT placement verified by CXR and bilateral breath sounds. Bilateral pneumothorax noted. ETT in low position at T5 UAC high #2
09:50	ETT withdrawn by 0.5cm and resecured at 9.5cm at the lip NNP withdrew UAC as well by 1cm
09:51	Chris Dischler, NNP contacted Reyes MD at TCH covering transport, assessment reviewed, plan of care reviewed using ISBARQ standerd. Interventions implemented as directed by MD. Will withdraw ETT by 0.5, needle decompress right pheumothorax, and obtain pre cooling lab work.
10:00	
Airway	Needle decompression right chest performed by Dr. Carmichael, no air evacuated, needle catheter left in place and secured to chest with tegaderm Needle Thoracotomy performed by Other. Performed by Dr. Carmichael
10:15	118 / 53 / 32 — 39 — 100 — 35 — Normal Sinus Rhythm, (REG) — 96°F Axillary Art. Line — Assisted — cries 1 — 21
10:25	
Ventilator	Loaded in transport incubator with neutral thermal environment, secured via infant restraint harness, papoose style. Cardiac and pulse oximetry monitoring with alarms set per policy. Ventilator settings changed by Ray Estlinbaum, RRT: Mode:Assisted / Controlled, Breath Type:Volume Control, Rate:30 bpm, fiO2:21, TV:16 mL, PEEP:6 cm, I:Time:0.35 seconds.
10:30	
Labs	Lab values obtained by Jennifer Bee, RN. Na: 132 mEq/L , Cl: 100 mEq/L , K: 3.7 mEq/L , Ca: 1.25 mEq/dl , Glu: 60 mg/dl , pH: 7.3 , PO2: 32 , PCO2: 94 , HCO3: 15 , BE: -10 , OTHER VALUES: lactate 8.7 u/l , EPOC reader 5229
10:40	Infant taken to Mother's room to see Mother/Family prior to departure.
10:41	Visitation information given to parents. Consent for transport reviewed and signed by parent.
10:45	106 / 68 / 38 — 48 — 98 — 38 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Art. Line — Assisted — cries 0 — 21
10:56	Patient loaded into ambulance, en route to TCH.
11:00	
Med.	Active cooling initiated Morphine Sulfate, 0.35 MG via IV - Push given by Elizabeth Mallet, RN. Authorization: Via Protocol. Pt. Response: Improved. slow push, give with the initiation of active cooling
11:00	98 / 58 / 32 — 40 — 98 — 32 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Art. Line — Assisted — cries 0 — 21
11:10	
Med.	Gentamicin, 14 MG via IV - Drip, concentration: 5mg/ml, given by Elizabeth Mallet, RN.
11:13	33.5°C Rectal
Med.	Morphine Sulfate , 0.01 MG/KG/MIN via IV - Drip given by Elizabeth Mallet, RN
11:30	96 / 54 / 30 — 38 — 97 — 32 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Art. Line — Assisted — cries 0 — 21
11:42	33.5°C Rectal
	Report called to receiving unit Charge RN LeAnn @ TCH.
12:00	88 / 54 / 30 — 38 — 95 — 30 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Art. Line — Assisted — cries 0 — 21
12:11	33.5°C Rectal
Labs	epoc 5229/abq Lab values obtained by Elizabeth Mallet, RN: HGB: 13.3, HCT: 39, NA: 129, K: 4, CL: 97, GLU: 56, PH: 7.33, PO2: 94.5, PCO2: 37, HCO3: 19.5, BE: -6.4, SAT: 968%.
12:30	100 / 62 / 40 — 47 — 94 — 30 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Electric Monitor - Cardiac — Auto. Cuff — Assisted — cries 0 — 21
12:45	33.5°C Rectal
Ventilator	Ventilator settings changed by Ray Estlinbaum, RRT: fiO2:25. Patient with desaturations into 70's
12:46	Family not present during transport of child.
12:47	Arrived at TCH
13:00	110 / 62 / 34 — 43 — 98 — 42 — Normal Sinus Rhythm, (REG) — 33.5°C Rectal Electric Monitor - Cardiac — Art. Line — Assisted — cries 0 — 25
	Report given by Chris Dischler, NNP to accepting, Chondi MD at bedside via ISBARQ format.

* *Assessment made by*

Factors Affecting Care: Other: waiting for NNP

Dispatch Factors: Other:waiting for NNP

Paperwork from Referring: Chart, Consent For Transprt, ID Band, Imaging Studies X-Ray/CT Scans, M.A.R., M.D. Order To Transfer, M.O.T.

Paperwork to Receiving:	Chart, Consent For Transprt, ID Band, Imaging Studies X-Ray/CT Scans, M.A.R., M.D. Order To Transfer, M.O.T.

Campbell, RN, Melissa: _____

Estlinbaum, RRT, Ray: _____

Mallet, RN, Elizabeth: *Electronically Signed on 08/05/2016 15:58:24 CST*

Receiving Physician: _____