PATIENT TRANSFER FORM Date:

Surgery to Pediatric Intensive Care Unit Handover Time: Final

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PATIENT DETAILS

Name _____Jane Doe_____ Age:__5 yo___ Weight: __25__ kg

VENTILATOR SETTINGS

a) Mode

i. Pressure Control _____

ii. Volume Control ____25_____

iii. SIMV

1. Pressure Mode _____

2. Volume Mode _____

Patient has a penetrating chest trauma.

b) Rate ____25_____

c) I-time ____0.6_____

d) Tidal Volume or PIP (actual, not above PEEP) __16_____

e) PEEP ___5____

f) F_1O_2 __60%_____

NOTE: Ventilator to be configured only by CCC Registrar or Advanced Respiratory qualified Nurse

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MONITORING LINES

Location of Central Line (circle) Left Right

Number _____ Location of Arterial Line (circle) Left Right

VASOACTIVE AGENTS (Tick)

Dopamine _____ Milrinone _____ Adrenaline _____

Nitric Oxide _____ Other: _____ Other: _____

OTHER

Chest Open ____ Notes: _____