



PROCEDURE

Primary Registered Midwife (RM) (<i>name</i>):	
Second Attendant (<i>name</i>):	
Reason for 911 call:	
Transfer: <input type="checkbox"/> Antepartum <input type="checkbox"/> Intrapartum 1 st stage <input type="checkbox"/> Intrapartum 2 nd stage <input type="checkbox"/> Postpartum <input type="checkbox"/> Newborn	
Date/Time	1. Notification of Emergency
	Call to Emergency Services 911 by whom (<i>name</i>)
	ITT (<i>Infant Transport Team</i>) and/or ALS (<i>Advanced Life Support</i>) requested?
	Arrival of Fire & Rescue
	Arrival EMS
	Arrival of ITT/ALS
Comments or concerns with emergency services:	
Date/Time	2. BC Women's Hospital Delivery Suite: 604-875-2165 Paging: 604-875-2161 St. Paul's Hospital Labour & Delivery: 604-806-8349
	Call to Charge Nurse (<i>CN name</i>):
	If phone link to consulting physician(s) (<i>physician's name</i>):
Comments or concerns with notification of receiving hospital/staff:	
Date/Time	3. Emergency Transport
	Ambulance departed home for hospital: <input type="checkbox"/> RM on board
	Ambulance arrived at hospital
Comments or concerns with transport:	
Date/Time	4. Hospital Admission
	Mother admitted to: <input type="checkbox"/> Delivery Suite <input type="checkbox"/> Assessment Room <input type="checkbox"/> ER <input type="checkbox"/> Other
	Newborn admitted: <input type="checkbox"/> to NICU <input type="checkbox"/> to IN <input type="checkbox"/> with mother <input type="checkbox"/> N/A
	Verbal report given on admission to physician (<i>name</i>):
	Transfer of care to consulting physician (<i>name</i>):
Comments or concerns with admission:	
Further comments/ feedback For extensive comments, please use a separate page. This form is intended for tracking the responsiveness and efficiency of emergency transports. As such, it is neither necessary nor advisable to include a clinical description of the emergency events.	
6. Follow-Up - Department of Midwifery 604-875-3038 or 604-875-3110	
Reminder: Verbal report given to Department Head or Assistant Head within 12 hours	
<input type="checkbox"/> Left message for, OR <input type="checkbox"/> Spoke with (<i>name</i>)	
Reminder: Notify MPP if Reportable Outcome 1-250-952-0839	
Please fax completed form to: 604-875-3261 within 12 hours	
<i>This form is for the sole use of the intended recipient(s) and contains confidential and privileged information. Any unauthorized use, disclosure or distribution is prohibited. If you are not the intended recipient please contact the sender and destroy all copies.</i>	
Registered Midwife Signature:	Date:

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