Gold Cross Critical Care Transport Flow Sheet

If you would like to contact the critical care team directly call (920) 509-0237

Receiving Facility Contact Person / Phone #	Date of Transport	Time of Transport (or ASAP)

Patient Name	Patient Date of Birth	Patient Weight
		_____ kg _____ lbs.

Sending Facility: _____ **Location/Room Number:** _____
Receiving Facility: _____ **Location/Room Number:** _____

Medical Reason For Transport (Document more specifics on Physician Certification Statement)

Equipment Necessary	Precautions/Isolation
□ Oxygen _____ Mode _____ □ Ventilator or BiPAP *(circle one)* □ IV x _____ Fluid(s) _____ □ Invasive lines *(circle appropriate)* ART CVP SWAN-GANZ ICP □ Drips *(label appropriately)* Name/Dose/Rate: _____ Name/Dose/Rate: _____ Name/Dose/Rate: _____ Name/Dose/Rate: _____ _____ □ Blood Products YES NO *(circle one)* □ Initiate during transport YES NO *(circle one)* □ Cardiac Monitor YES NO *(circle one)* □ Drains (*circle appropriately)* NGT/OGT Chest Tube IR or JP FOLEY _____ □ Drains to Suction YES NO *(circle one)*	□ Isolations _____ □ Precautions _____ **Miscellaneous** □ Pertinent Blood Work □ Other Lab Values _____ _____