Referrals to PIPER Neonatal

1. Overview / Description

Referrals to PIPER Neonatal generally fall into one of three categories

1. A clinical consultation for clinical advice where the referrer believes transfer is not required
2. A request to transfer
3. A clinical consultation where the referrer is uncertain if transfer is required.

2. Related Documents

N/A

3. Definition of Terms

N/A

4. Responsibility

All PIPER medical and nursing staff.

5. Procedure

PIPER provides rapid access to a Consultant Neonatologist. The quality of decision making is enhanced if the most senior clinician responsible for the patient makes the referral where practical.

Factors that impact on decision making for any referral include:

1. The severity of the infant's condition
2. The potential for deterioration
3. The resources & capabilities of the referring hospital – both in general and specifically available at the time of the referral
4. The need for specialist assessment
5. The requirement for treatment &/or therapy only available in a tertiary center.

Specific indications for consultation/transfer include (to be considered in relation to the referring unit's agreed neonatal capability level):

1. Respiratory distress
- All intubated babies require transfer
- Babies commenced on non-invasive respiratory support should be referred if approaching the limits outlined in Statewide Guidelines and local policy.
- Neonates with acute respiratory distress who have an ongoing O_2 requirement of >30% should be in a facility that can provide non-invasive respiratory support
- Infants with significant apnoea should be discussed with PIPER
- Suspected pneumonia should be referred EARLY to PIPER
- Neonates with meconium aspiration requiring respiratory support should be referred to PIPER

2. Low birth weight
- Most infants <1250g should have an initial period of supervision in a Level 6 nursery
- Infants 1250-2000g should be in a centre where specialist paediatric medical and nursing facilities are available
- Extremely premature infants at the margins of viability (22-23 weeks) should be discussed with

a neonatal consultant regarding the advisability of transfer

3. Recurrent apnoea
4. Recurrent Seizures requiring anticonvulsants
5. Perinatal asphyxia
   - Referral to PIPER should be considered whenever an infant:
     - Requires intubation and assisted ventilation during resuscitation
     - Has not established regular respirations within 5-10 mins afterbirth
     - Develops seizure activity
     - May be eligible for therapeutic hypothermia treatment
6. Jaundice (at high risk of requiring an exchange transfusion)
7. Bleeding from any site
   - Discuss babies with subgaleal haemorrhage early
8. Metabolic:
   - Hypoglycaemia unresponsive to treatment
     - Requiring > 12.5% dextrose and >100mls/kg/day of fluids <48 hours of age
   - Encephalopathy
     - Moderate or severe encephalopathy of any cause should be discussed with PIPER.
   - Elevated serum ammonia
   - Laboratory evidence of severe end organ dysfunction
   - Abnormal coagulation profile
   - Liver transaminases > 200
9. Surgical conditions
10. Congenital Heart Disease (suspected or known)
11. Severe or multiple congenital abnormalities
12. Sepsis

Where there is uncertainty regarding the need to transfer an infant, PIPER Neonatal can be consulted at any time.

6. References

N/A

7. Disclaimer

The Paediatric, Infant Perinatal Emergency Retrieval (PIPER) Neonatal and Paediatric guidelines were developed by PIPER clinicians for the sole use within the PIPER service at The Royal Children's Hospital Melbourne.

The authors of these guidelines have made considerable effort to ensure the information upon which they are based is accurate and up to date. Users of these guidelines are strongly recommended to confirm that the information contained within them especially drug doses is correct by way of independent resources. The authors accept no responsibility for any inaccuracies or information perceived as misleading.

8. End of Document