## Workflow for management on transport of neonates with suspected or known cardiac disease

1. Transfer Center gets a request for the transport of a neonate with suspected or known cardiac disease.
2. Transfer Center pages Transport RN (TRN).
3. TRN answers page and speaks with referring MD.
4. If TRN determines transport meets criteria for deployment of either a high-risk team (RN/RT/NNP) or low risk team (RN/RT), the relevant team is deployed immediately. If TRN determines need for high-risk team, TRN will ask Transfer Center to contact TLC MD to be 'patched into call' with referring MD.
5. After gathering information, TRN contacts TLC MD (if not 'patched into call' in step 4), and discusses the patient's status to obtain specific management recommendations as needed.
6. If TLC MD determines that optimal care of the infant requires input from Cardiology, he/she will contact the Cardiology attending on-call for the NICU, discuss the patient's condition, obtain any relevant specific recommendations, and plan for a 3-way conference call with the Cardiologist (as required) when the team calls back for report. If TLC MD and Cardiologist deem it necessary to speak with the referring MD immediately, they will ask Transfer Center to initiate a 3-way conference call with the referring MD.
7. After discussion with the TLC MD, TRN calls referring MD back* to advise him/her of recommendations to be carried out while team is en route. * unless referring MD has been spoken to by either TLC MD or Cardiologist in Step 6.
8. TRN calls the team to update them of the patient's details and plans for care.
9. Once the transport team has assessed the patient at the referring facility, the Transport RN/NNP will call the TLC MD back via the Transfer Center.
10. TLC MD, on being contacted by the Transfer Center, will ask the Transfer Center to 'patch in' on a 3-way conference the Cardiologist on-call (if deemed necessary by prior conversation in Step 6).
11. Patient care plans will be discussed and a consensus reached to allow for quick stabilization and rapid transport back to TCH. Destination (NICU or CVICU) will depend on the consensus reached between the Cardiologist and the TLC MD.
12. Irrespective of the neonate's ultimate destination (NICU or CVICU), the TLC MD will remain the 'medical control' for the transport; the Cardiologist will be a consultant to help optimize care of the infant being transferred to TCH.
13. Admitting MD will depend on the destination of the neonate – Baylor Neo for the NICU, CVICU attending for neonates to be admitted to the CVICU. Transfer Center will be informed of the destination at the end of the 3-way conference call.

** During the second half of each academic year, the TLC fellow will also be 'patched in' on TRN's call to the referring MD. This is for fellow education and not for patient care.