SPECIAL CARE NURSERY CERTIFICATE

IMPORTANT: Please ensure all sections of this Certificate are completed.

Hospital Name: …… (ATTACH PATIENT LABEL)

Section 1: *Patient and Hospital details (may be completed by Medical or Nursing Staff)*

Admission to Unit	Discharge from Unit	
☐ Transfer in (give details below)	☐ To other Hospital: Name:	Certificate No:
☐ From other Hospital: Name:	☐ Critical Care Transfer	Patient Name:
☐ From Delivery Suite:	☐ To Post Natal Ward:	Date of Birth:
☐ From Post Natal Ward:	☐ To Home:	Multiple Birth (no):
	☐ Deceased	Membership No:
Time: am/pm Date:	Time: am/pm Date:	Fund Name:

Section 2: *Reason for Admission to Special Care Nursery (to be completed by Treating Neonatologist/Paediatrician)*

Number of Weeks Gestation: …….. *Birth Weight: ……gms* *Apgar Score at 5 minutes: ……*

☐ Prematurity (<37 weeks)	☐ Infant of Diabetic Mother	☐ Perinatal Asphyxia
☐ Low Birth Weight (<2000gms)	☐ Hyperbilirubinaemia	☐ Meconium Aspiration
☐ Small for Gestational Age	☐ Hypothermia	☐ Apnoea
☐ Suspected Sepsis / Infection	☐ Cyanotic Episodes	☐ Inability to take oral feeds
☐ Maternal (Chemical/Alcohol Addiction)	☐ Hypoglycaemia	☐ Cardio/Respiratory Monitoring
☐ Convulsions	☐ Respiratory Distress	☐ Growing Premature Infant
☐ Other (Please specify)		

If the infant is in the Special Care Nursery for longer than 7 days, what is the anticipated Length of Stay: ……..days.

Reason for Length of Stay: ……

I certify that it is necessary for this infant to receive treatment in a Special Care Nursery and that the Infant met the criteria for admission to this Nursery for the period shown.

Signature of Neonatologist/Paediatrician …… Name: (Print) …….. Date: …….

Section 3: *Interventions and Management (to be completed by Special Care Nursery Registered Nurse/Midwife)*

Day *Date*	1	2	3	4	5	6	7
Interventions: Please tick for each day							
SCN criteria							
Oxygen therapy (excluding nasal prongs)							
Intravenous therapy/medications							
Continuous cardio-respiratory monitoring							
Transcutaneous monitoring							
Septic workup							
Barrier nursing							
Regular blood glucose monitoring							
Establishment of sucking feeds * (SCN rates do not apply if the only intervention)							
Intra gastric feeds							
Phototherapy * (SCN rates do not apply if the only intervention)							
Other (Please specify)							
TOTAL: Interventions per day							

Additional Information: (Interventions, Investigations, Surgery etc.) ……

……

Please complete the appropriate Section 4 as it pertains to your hospital *(to be completed by Nurse Unit Manager)*

Section 4: *Daily Level of Care (where contract contains note XS006, XS007, XS008 only)*

Level of Care (please tick for each day)	1	2	3	4	5	6	7
NCU1 (SCN1) *Includes 5 or more interventions or exchange transfusion*							
NCU2 (SCN2) *Includes 3-4 interventions*							
NCU3 (SCN3) *Includes 1-2 interventions*							

Otherwise

Section 4: *Daily Level of Care*

Level of Care (please tick for each day)	1	2	3	4	5	6	7
SCN (SCN)							

Signature of Manager: …… Name (Print) ……Telephone No: ……