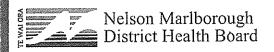


Given Name:	Gender:
Family Name:	
AFFIX PATIENT LABEL HERE	
Date of Birth:	_ NHI#:
1	

BOOKING FORM - ADULT

STATE OF THE PROPERTY BUUNI	NG FURNI - ADULI	
Date of assessment: Diagnosis: Procedure:		
ICU bed required? YES NO Day Stay? YES Estimated Theatre time (mins) Surgery time + routine anaesthetic time	NO Suitable for Registrar Estimated Nights in Hospital	Suitable for Wairau
Additional Anaesthetic time (mins) Total Operation Time	Completed by Anaesthetist Planned Date	
Operation Code: Procedure Code:	Grade: CPAC Score:	
Clinical Override Comment: Please book for surgery Urgent Semi-urgent Roll STOP WARFARIN YES NO N/A STOP ASPIRIN? YES NO N/A Yes Pre-op outpatient appointment required? Frozen section required? (Instructions ioaded to Oracare comments) X - ray or image intensifier required Particular instruments/ implants required Surgical requirements coordinated by Surgical Secretaries	utine ACC Elective Special Instructions Instructions loaded to Oracare comments Pre-admission Risks Identified (State	
Estimated time off work (if applicable) Surgical Consent Signed Yes No	Patient available at short notice? Direct patient to Preadmissions hub when c Language	YesNo omplete.
Office Use Only CERTAINTY Date entered on to Concerto NOT MET THRESHOLD Waitlisted? YES NO By Total operation time entered	Surgery in Wair	au Nelson Date

Review date: September 2016

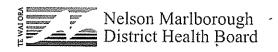


Given Name: _	Gender:
Family Name:	AFFIX PATIENT LABEL HERE
Date of Birth: _	NHI#:

INFORMED CONSENT TO PROCEDURE
PROCEDURE
I, agree that the procedure described as
will be performed on me / my child / my ward (person on whose behalf I can legally consent) - Cross out that which does not appl
I have discussed this with
Health Professional Designation whose signature appears on the following page. He/she has explained the reasons for and possible risks of the procedure, relating to clinical history and condition.
I have had adequate opportunity to ask questions and have received all the information I want. I understand that I can ask for more information if I wish. I am aware that I can withdraw consent at any time.
The reasons for and possible risks of this procedure have been explained, including:
>
BLOOD/BLOOD PRODUCTS There are according when blood and/ or blood areducts are required to control blooding or clotting issues. There are right and
There are occasions when blood and/ or blood products are required to control bleeding or clotting issues. There are risks and benefits of transfusing blood and blood products and the need for the use of these products are related to the type of procedure being performed. If there is a chance of blood products being required, a discussion should occur between the patient and healthcare team. With my signature on the next page I agree to the use of blood products.
BLOOD SAMPLE SCREENING
Staff of the healthcare team may be directly exposed to my blood or other body fluids. With my signature on the next page I agree blood samples being taken and tested. These samples will be tested only to identify such contagious diseases as are considered considerable risk e.g. hepatitis and HIV. I understand I will be informed of results if I request them, and any need for further medic referral. The results of these tests are confidential to me, the health professional(s) and the team member involved.
REQUEST FOR BODY PARTS
I can have any body parts or body tissue returned to me. I understand that in certain situations this may not be possible. With my signature on the next page I acknowledge discussion about body parts has taken place.
PHOTOGRAPHIC CONSENT
Procedural images such as photographs/videos may be taken as required by the health care team. With my signature on the next page I authorise NMDHB to use the images for specific clinical, educational or scientific purposes that have been discussed with and acknowledge that these photographs remain the property of NMDHB. Confidentiality will be maintained.

IMMUNISATION AND SCREENING

I understand the purpose of the ______ screening or immunisation, (cross out what does not apply) the risks and benefits, the follow up plans, and availability of counselling and support services.

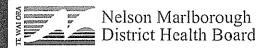


No.1 N.411		Gender:
Nelson Marlborough District Health Board	Family Name:	TIENT LABEL HERE
	Date of Birth:	
BY SIGNING THIS CONSENT FORM I GIVE M		
There the consults of a section to the section		YES NO N/A
Have the operation/procedure described above		
Receive Blood /blood products if required		
I request that my body parts/tissues be returned to r	me	
NMDHB taking and holding procedural images		
I AGREE THAT I HAD OPPORTUNITY TO DISC	euss	
		YES NO N/A
Risks and benefits of the procedure		
Risks and benefits of not having the procedure		
Risks and benefits of receiving or not receiving blood	d/blood products transfusion	
Risks and benefits of immunisation or screening		
I have also offered the patient the opportunity to ask	questions and questions have been a	asked I have answered them appropriately
and to the best of my ability.		
Signed		Date
D 1 11 11 11 11 11 11 11 11 11 11 11 11		
Patient/person legally entitled to co	onsent - print surname	
•		m t.wii
•		Date
SignedInterpreter (if applicable) -		Date
SignedInterpreter (if applicable) - Signed	print surname	Date
SignedInterpreter (if applicable) -	print surname	
Signed Interpreter (if applicable) - Signed Health Professional - pri	print surname	
Signed Interpreter (if applicable) - Signed Health Professional - print ANAESTHETIC	print surname Ent surname	Date
Signed Interpreter (if applicable) - Signed Health Professional - print ANAESTHETIC I agree to a local /general /regional block (cross out to the law to the read or had explained, and understand, the ris	print surname Int surname That which does not apply) anaesthetings and benefits of the proposed anae	Datec being given.
Signed Interpreter (if applicable) - I Signed Health Professional - print ANAESTHETIC I agree to a local /general /regional block (cross out to the language) I have read or had explained, and understand, the rise to ask questions about the anaesthetic, alternative professional in the language of the lacknowledge that I should not drive a motor vehicle beverages or make important decisions for 24 hours	print surname Int surname That which does not apply) anaestheticks and benefits of the proposed anaerocedures and risks. To operate machinery or potentially dar	Date c being given. esthetic. I have had adequate opportunity
SignedInterpreter (if applicable) -	print surname Int surname That which does not apply) anaestheticks and benefits of the proposed anaerocedures and risks. To operate machinery or potentially darafter the procedure.	Date c being given. esthetic. I have had adequate opportunity

ANAESTHETIC

I have discussed	l this	with
------------------	--------	------

I have discussed this with			
	Health Professional	Designation	
Discussion/comments:			
	, , , , , , , , , , , , , , , , , , ,		
Signed		Date	
Patient/persor	n legally entitled to consent - print surname		
Signed			

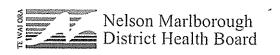


I understand that:

- All proposed treatments will be clearly explained to me/my child and consent will be sought from me. (Written Consent may
 be required before certain treatment interventions are initiated). There will be an ongoing discussion with me/my child or
 family/Whanau and liaison between health professionals in relation to my/my child's treatment or care.
- I have the right to decline any treatment or withdraw my consent at any time.
- Nelson Marlborough District Health Board takes no responsibility for any treatment that is not recommended by the health professional responsible for my/my child's care.
- I understand that if I/my child am taking any herbal medicine/dietary supplements I must inform my Doctor as they may interfere with medication I/my child may be given whilst in hospital.
- I acknowledge that I/my child have been informed of the risk of leaving jewellery in place for any procedure/treatment I/my
 child may undergo, and accept that Nelson Marlborough District Health Board takes no responsibility for injury/loss/damage
 caused if jewellery is not removed as requested.
- Nelson Marlborough District Health Board is a teaching institution. Therefore, I/my child may be asked if students can
 participate in my care. I understand I have the right to decline this if I wish.
- All monies/valuables and other articles retained by me/my child are held entirely at my own risk.
- I have rights while I/my child am/is a patient of Nelson Marlborough District Health Board.

Signed Patient / Legal Guardian	Date
OR Patient/ Legal guardian unable to sign because	
Staff Signature	Date
Designation	

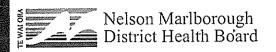
Information collected about you will be used to provide you with healthcare and treatment and for the purposes of administration. Non identifying statistical information will be used by Nelson Marlborough District Health Board and the Ministry of Health. Information about you will be forwarded to your Primary Care Health Practitioner, any provider chosen to continue your treatment and your preferred contact, unless you indicate otherwise.



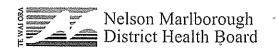
Given Name:	Ge	nder:
Family Name:		
	AFFIX PATIENT LABEL HERE	
Date of Birth:		VHI#:

ADULT PATIENT HEALTH QUESTIONNAIRE

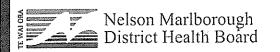
MEDICATIONS List all medications you take. T	This includes tablets like aspirin, inha	alers, eye drops and skin ointment.
Drug	Amount	How Often
	,	
		• "
COMPLIMENTARY & ALTERN		
List all complementary and alter	native medicines or Rongoa Maori y	ou take.
DRUG AND NON-DRUG ALLE		
List all allergies including drugs, I Medication/Other	lotions, sticking plaster, latex, food, e	
Memoanon omo,		Please describe your reaction, e.g. wheeze, rash, vomiting



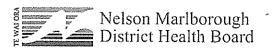
ANAESTHETIC		565	
	Yes	No	Comment
Have you had a general anaesthetic before?		and the same of th	•
Were there any problems? (e.g. nausea and vomiting, airway problems, difficulty breathing or drug reactions)		***************************************	
Has a family member had an unusual reaction to an anaesthetic? If yes, what happened?			
Do you have any concerns about your anaesthetic you would like to discuss with us?			
MEDICAL CONDITIONS			
Do you have or have you ever had?	Yes	No	Comment
Heart attack or heart problems requiring a test, investigation or treatment?			
Cardiac stents/ bypass surgery?			
High Blood pressure?			
Heart Pacemaker?			1. 1. 2. S
Artificial Heart valves?			
Rheumatic heart disease?			
Abnormal heart rhythms?			
Lung problems e.g asthma, emphysema?			
Diabetes?			
Stroke or transient ischaemic attack (TIA)?		A CONTRACTOR OF THE CONTRACTOR	
Epilepsy or seizures?			
Kidney problems?			
Blood clots in legs or lungs?		1	
Blood disorders (State)?			
Muscle/nerve disease?	A A A A A A A A A A A A A A A A A A A		
Rheumatoid arthritis	1,00000		
Thyroid/pituitary Problems?			
Ankylosing spondylitis			
Surgery to neck or back		A. (A. (A. (A. (A. (A. (A. (A. (A. (A. (



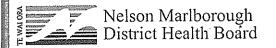
		Yes	No	Comment
Нера	atitis – if yes was it related to an anaesthetic?			
Are	there any other conditions not mentioned above?			
DO Y	OU HAVE?			
		Yes	No	Comment
Ang	ina. If yes, what starts it and how often.			333
1.	Do you get angina with everyday living activities?			Manufacture and Annual Control of the Control of th
2.	Do you get angina at rest?	7		
3.	Do you get angina walking 20 – 100 metres?			
Sho	rtness of breath			
4	I can perform all physical activity without limitation – If Yes do not answer 2,3,4,5 below.	Postar annual VI	The state of the s	
2.	I cannot perform all physical activity, but can easily walk up a hill or flight of stairs - if Yes do not answer 3, 4, 5 below.			
3.	I cannot walk up a hill/flight of stairs without getting short of breath, but I can walk on the flat easily for at least 500m - if Yes do not answer 4,5 below.			
4.	I get short of breath walking 20-100m		Annual Control of Cont	
5.	I get short of breath at rest and am mostly housebound. I cannot carry out any physical activity without getting short of breath.			
Unu	sual thumping in the chest or palpitations		1	
1.	Have you ever attended hospital with palpitations?			
2.	Are the palpitations associated with dizziness or fainting?			
3.	Are the palpitations associated with chest pain or shortness of breath?		Outdoor in the contract of the	
Blac	kouts or fainting. If yes, state reason.		-	
Freq	uent indigestion or heartburn.			
	If yes, is it well controlled with medication?			
Seve	ere snoring or stopping breathing at night		To a control of the c	
1.	If yes, do you feel tired/fatigued/sleepy during the day?			
2.	Has anyone observed you stop breathing during sleep?			



FRAILTY	Yes	No	Comment
Exhaustion Have you had too little energy to do things you wanted to do in the last month. Appetite		, , , , , , , , , , , , , , , , , , ,	
What has your appetite been like?			
No change			
Reduced			
Increased			
Walking Difficulties Because of ill health or physical problems, do you have any difficulties doing the following everyday activities?			
Walking 100 metres	The state of the s	- According to the second	
Climbing a flight of stairs without resting		and a second	
Physical Activity How often do you engage in activities that require a low or moderate level of energy such as gardening, cleaning the car, or doing a walk?			
More than once per week	A		
Once per week			
One to three times per month			
Hàrdly ever or never			
PREGNANCY	Yes	No	Comment
Do you think you might be pregnant?			
SIGNATURE			
Completed by (sign)			Patient/next of kin/caregiver/staff member
. Please give this pack back to the sta Please do not leave until the staff inform you Thank you	ff at the	e Pre Admi essary pre	
a appropriate and the state of			
FRAILTY	05939194375644599555341		
Not frail Pre-frail Frail	ggete en zour daggert		
(American) American (American)			IPS (N A) IPS (N RMO A)



FSA HUB				
Baseline Observations (not require	ed for paediatric patients	3)		
Weight	(kg)	Pulse		
Height	(cm)	BP		
BMI = Kg/m ²		SpO ₂ (Air)		%
HbA,C		GP Letter		
SMOKEFREE PRE-OPERATIVE ASSE	ESSMENT Date		,	
A Smokefree Status NO YES	Brief Advice - Cessation Offe	er 1st 2nd 3rd	Referral? YES	NO (declined)
Smoked in the last 30 days (Z720)	Nurse		NRT card/script	Nelson Wairau
Previously smoked (Z8643)	Doctor		Quit Coach	7920 6833
2nd Hand Smoke (Z587)	Pre-Admissions Coordinator		Aukati Kaipaipa	546 9097 577 8404
· ,	Leaflet given		Quit Line	0800 778 778
SMOKEFREE ADMISSION Date	Ecanct given		www.	0000 //0 //0
A Smokefree Status NO YES	Brief Advice - Cessation Offe	er 1st 2nd 3rd	Referral? YES	NO (declined)
Smoked in the last 30 days (Z720)	Nurse		northat: 120	Nelson Wairau
Previously smoked (Z8643)	Doctor		Quit Coach	7920 6833
2nd Hand Smoke (Z587)	Registered Midwife		Aukati Kaipaipa	546.9097 577.8404
Home Car Work (circle)	Allied Health		Quit Line	
NRT charted NRT used	Other			0800 778 778
Zyban/Champix used	Leaflet given		NRT card/scrip	JC
MULTI-DRUG RESISTANT ORGANISI	alika dikabang lang at distrika 1922 kanta beralagian 19	aki daga sa ini mudis Terminiki di		Yes No
 Has the patient been in an <u>overseas</u> he or as a staff member? If yes, screen for negative. 				
Does the patient have an alert dated w precautions	ithin the last 3 years for VR	E, MRSA or CR-	GNR? If yes, use	contact isolation
KEY	***************************************			
VRE = vancomycin-resistant enterococci				
MRSA = methicillin-resistant Staphylococ				
CR-GNR = carbapenem-resistant gram-n	egative rods			
PRE ADMISSION CHECKLIST				
Code of rights pamphlet issued		Yes		
Do you have someone to stay with you over	ernight following surgery?	Yes No	TBA N/A	
Pre Admissions Hub				Signature



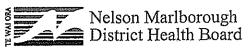
PRE-ADMISSION TESTING

RECOMMENDATIONS AND REQUEST CHECKLIST

Generic Testing	Requested	Results Reviewed	Staff Signature reviewing results	Specific Testing	Requested	Results Reviewed	Staff Signature Reviewing Results
	Date				LFT		
			1	LapChol	Date	· · · · · · · · · · · · · · · · · · ·	
FBC	Date			Breast Surgery	Amylase Date		•
BLS 1/ Ourstine	Date				Ca/PO4 Date		
NA, K Creatine, GFR	Date			Thyroid Surgery	T4/TSH Date	1 · · · · · · · · · · · · · · · · · · ·	e e e e e e e e e e e e e e e e e e e
	Date				PTH Date		1000000
LFT's	Date	i		Gynae Obstetrics	Pregancy test Date		C
	Date			Obstances	Renal Stones KUB within 48 hours of surgery		Samuel 10 10 10 10 10 10 10 10 10 10 10 10 10
HbA1c	Date			Urology	Biopsy result	10 7 - E + 640 ¹⁷	
Coagulation	Date				MSU Date PSA		
NT BNP	Date		- A		Audiogram	· · · · · · · · · · · · · · · · · · ·	
Troponin	Date			ENT	CT Scan		
G&H/Cross Match				Other			
ECG							and country to
CXR	To open a total garage garage	The second secon					Avena American
Urinalysis/MSU	· ·						
Swabs							
Echo Cardiogram							
Lung Function Test							
Other						mayor comment of the facility	

DOCUMENT ACTION TAKEN IF TESTS ABNORMAL

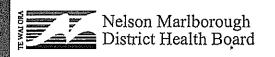
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Given Name: _	Gender:
Family Name:	APPLY DATERIT LAPT HENT
	AFFIX PATIENT LABEL HERE
Date of Birth:	NHI#:

District Health Board	AFFIX PATIENT LABEL HERE Date of Birth: NHI#:
FAST TRACK BOOKING FO	ORM (ELECTIVE) - ADULT INPATIENT
Any new issues since completing Health Questionnaire?	□Y □N □N/A
Any new prescribed medications since completing Health	Questionnaire?
Patient's understanding of Operation/Procedure	
NURSING ASSESSMENT	
COMMUNICATION	ELIMINATION
Any problems	□ _N Continent □ _Y □ _N Stoma □ _Y □ _N
IMPACT OF HOSPITALISATION	MOBILITY
Cultural needs	N Independent $[Y]_N$ Previous trips/falls $[Y]_N$
Advised of Te Pukenga Hauora Service	N Walking aid Y N Other Y N
Religious/spiritual needs	Trosuccio E i E I II
, advised of hospital orapiamory covides	
COGNITIVE	CNS
ImpairmentY	' □N Hearing impairment □ Y □ N Hearing aid □ Y □ N
	Visual impairment Y N Spectacles Y N
	Contact lenses Y N Artificial eye Y N
ТЕЕТН	SELF CARE
Dentures Y N Lower full plate Y	'
Upper full plate Y N Lower partial plate Y Py Crown/bridge Y	Caregiver organised Y N
	,
DIETARY	SUPPORT
Normal diet Y N Alternative remedies Y	Health services currently used
Alcohol Y N Recreational drugs Y	Services advised of admission Y N N/A
PATIENT NEEDS, ISSUES, CONCERNS	
MRSA TESTING (METHICILLIN RESISTANT STAPI	HYLOCOCCUS AUREUS)
MRSA Y N	Additional Transmission Precautions
GP Contacted Y N	Contact Droplet L
Swab results +ve -ve -ve - Treatment Y N	Airborne Other
REFERRALS SENT (SPECIFY)	

Ref: PMR 207 3661709 Review date: September 2015

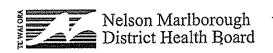


Given Name: .	Gender:
Family Name:	
-	AFFIX PATIENT LABEL HERE
Date of Birth: .	NHI#:

SURGICAL THROMBOPROPHYLAXIS GUIDELINE

Each Risk Factor = 1 Point	Yes	Score 1	Total Risk Sco		
41 - 60 years	is its	Score	IUIAI NISK SU	ii 6	50.86 (8)
Minor surgery					
Major surgery < 1 month					
Varicose veins					
Inflammatory bowel disease			104 01 1		
Swollen		, i			
BMI > 25					
Acute myocardial infarction					
Congestive heart failure					
Sepsis				• • • • • • • • • • • • • • • • • • • •	
Serious lung disease					
COPD		1975 (1974) 12. 1974			
Medical patient on bed rest					
Each Risk Factor = 2 Points		Score 2			
60 - 74 years					
Arthroscopic surgery		1.78 F 7.38 3.78	Ç. A		
Malignancy (past or present)					
Surgery > 45 mins		41.45.4 1.4.14.14.4	127g - 1	والماسيد و	
Laparoscopic surgery > 45 mins				···	
Patient confined to bed > 72 hrs					
Immobilising plaster cast					
Central venous access	streen and on	ense verske enskriver blev til serike foldste			(strackiego, kons
Each Risk Factor = 3 Points	4.00	Score 3	Risk Level		
≥ 75 yrs			Total score	Risk level	
History DVT/PE			0	Very low]
FH thrombosis (1st degree relative)			1 - 2	Low	
+ve factor V Leiden	······································	<u> </u>	3 - 4	Moderate	
+ve prothrombin 20210A		a la elementation de la companya	≥5	High	
Elevated homocysteine					_
+ve lupus anticoagulant			GFR =		
Elevated anticardiolipin antibodies			Not for SCD PVD		
Heparin induced thrombocytopnia		e i sa e e i de e	CHF		
Thrombophilia Each Risk Factor = 5 Point		Score 4	Acute DVT		
T	ense siste	Score 4	(superficial)		
Lower extremity arthroplasty		: :	Limb oedema		
Hip, pelvis, leg fracture (<1 month) Stroke (<1 month)			Skin graft		
			Neuropathy Cellulitis		
Acute spinal cord injury (1< month, paralysis) Women Only, Each = 1 Point		Score 5	OGHUHUS		
OCP or HRT					
Pregnancy, post partum (<1 month)					
History unexplained stillborn, recurrent abortion					
History eclampsia or growth restricted infant					

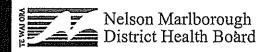
Date



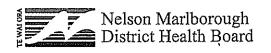
HISTORY AND EXAMINATION BACKGROUND		
PAST MEDICAL HISTORY Medical	VV	Surgical
MEDICATIONS Medications Antiplatelet/Anticoagulants Y \(\sum \text{N} \) Bleeding Risk Y \(\sum \text{N} \) Plan:	Allergi	es and Sensitivities
	Medic Alert Bracelet	Y N
EXAMINATION Cardiovascular R	espiratory	Other
•		
I understand and have participated in the planning of my continuous landerstand it is my right to accept or decline treatment.	are for this admission.	
Patient signature		Date

_12 _

Staff signature



OPERATION/PROCEDURE	
PROCEDURE/NOTES Date:	W25W
Date:Surgeon:	
Anaesthetist:	
Radiologist:	
Operation/Procedure:	
• الأنسي ر الر	
Post-Operative/Post-Procedure Instructions:	{
-	
•	



Orientation Patient oriented to ward			WARD) ADMIS	SION	
Description of valuables retained by patient: Taken into custody Yes No Receipt given Yes No Patient retains property Yes No Patient / support person advised that property and valuables are retained at their own risk Yes No Patient / care giver signature Nurse signature Date NOTES	Orientation	Patient oriented to ward	Yes	□No	Date:	Time:
Taken into custody Yes No Receipt given Yes No Patient retains property Yes No Patient / support person advised that property and valuables are retained at their own risk Yes No Patient / care giver signature Nurse signature Date NOTES	VALUABLESA	TAONGA				
Patient / support person advised that property and valuables are retained at their own risk	Description of	valuables retained by patien	t:			
Patient / support person advised that property and valuables are retained at their own risk			·			
Patient / support person advised that property and valuables are retained at their own risk					,	
Patient / support person advised that property and valuables are retained at their own risk	A					
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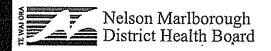
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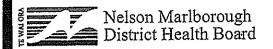
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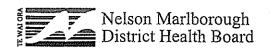


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NURSING CARE PLAN					
Date:		-		<u> </u>	
Review patient and plan each shift,	update by ruling ou	t previous entry a	nd signing below eac	h shift	
Expected outcomes	Interventions to	consider	Individual patient	nursing intervention	ins
Neurological/Cognition/LOC Neurological status monitored Variances noted and actioned	GCS Neuro obs/AVP BSL	U		1904	
Airway/Breathing Maintain adequate Oxygenaction	RR/02 Sats/EWS 02 therapy				
Circulation Haemodynamic status monitored Variances noted and actions	Temp/BP/HR ECG Daily/Weekly weight				
Elimination (including reproduction) Maintain/ restore normal bowel function	Bowel function Bowel management Catheter, Dialysis PV loss FBC				
IV Therapy/Medication Pain assessed and controlled Medication administered safely	IV fluids, CVC, PICC Regional, PCA, IV M				
Eating & Drinking Maintain/restore nutritional status	FBC, NBM, Fluids, D	Diet, Special Diet		~ 1	الاس
Mobility/Activity/Safety Potential complications identified/ minimised	Fall Risk Score Asse Falls Prevention, AB Enablers, Restraint, DVT risk - TEDS	CDEF, Supervise,			
No Lift Policy	On bed	ISAN			
Assessment/Equipment	Off bed	ISAN			
Activities of Daily Living Usual functional level maintained/ restored	Mobilising Personal cares	ISAN			
Skin/Wound Care Potential complications identified/ minimised/appropriately treated	Waterlow score Pressure ulcer prev Wound care assess				
Patient Education/Discharge Planning Prepared and informed to be discharged	Discharge checklist information handou				
Cultural, Spiritual and/or Social Plan of care meets individual patient need	Family involvement planning Offer Chaplaincy st				
Review each shift			Date and sign notce	Date and sign AM	Date and sign PM
Day/post op day					
Individual Goals should be discus	sed with patient da	nily and evaluated	in progress notes ea	ach shift	



NURSING CARE PLAN											
Date: Commenced by: Review patient and plan each shift, update by ruling out previous entry and signing below each shift											
Individual interventio	patient nurs ons	ing	Individual interventio	patient nurs ns	ing	Individual interventio	patient nursi ns	ing	Individual Interventio	patient nursi ns	ng

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ate/Sign notce	Date/Sign AM	Date/Sign PM	Date/Sign notce	Date/Sign AM	Date/Sign PM	Date/Sign notce	Date/Sign AM	Date/Sign PM	Date/Sign notce	Date/Sign AM	Date/Sign PM
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Individual	Goals shot	ıld be discu	issed with p	patient dail	y and evalu	ated in pro	gress notes	s each shift			

PATIENT DISCHARGE CHECKLIST						
DISCHARGE PLANNING						
HOME	Y N SUPPORT	Y N DIS	CHARGE TO			
Stated NOK Current Lives alone Dependents at home Arrangements for dependents Care giver at home Name: Contact: Organised to attend to patient	Further assistance need Detail:	plan Nan Con Trar Nan	son to discuss care & discharge i with: ne: tact: sport arranged ne: tact:			
COMPLETE 24 HOURS PRI	NR:TO DISCHARGE					
OUNIFICIE/24 NUUNƏ PKII	UN IU DISUNANGE					
Ordered for F	Y N N/A Risks to discharge identified [] [] vith family/whanau	Discharge	CLERICAL Y N N/A Patient transfer requirements organised			
	Community support available	Physio	Travel arrangements			
tests (lab xray c	Discharge time expectations Discharge time expectations Discharge time expectations Discharge Di	Discharge	No. 1 - Ambrella			
COMPLETE MORNING OF D	DISCHARGE					
MEDICAL Discharge summary complete and copy to patient	Y N N/A NURSING Alert & oriented EWSS = 0		ALLIED HEALTH Y N N/A neck patient has follow-up			
ACC & medical certificate issued	Tolerating food and fluids		opy of discharge letter sent			
Prescription and explanation given Prescription faxed to community pharmacy	Pain controlled Nausea controlled Wound satisfactory		ischarge off computer			
Discharge advice sheet given	UTT/Catheter removed and	d HPU	CLERICAL Y N N/A			
Education given:	Mobilising safely		Follow up on OPD appointments made and			
Catheters	IV cannula removed	gi	ven to patient			
Wounds	Medications returned to pa	to to	opy of discharge letter sent GP			
Drains Packing	Community support availal Discharge time expectation		ischarge off computer			
POP	family/whanau	no continuincated to	oonlarge on computer			
Discharge blood forms given to patient						
Discharging Doctor (Please Print)	(Please Print)	Role Signature Print Name PT OT SW	Discharging Clerical Staff (Please Print)			
Signature	Signature	DT SLT	Signature			