Nelson Marlborough District Health Board

Given Name: _____ Gender: _____

Family Name: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

BOOKING FORM - ADULT

Date of assessment:

Diagnosis:

Procedure:

ICU bed required? ☐ YES ☐ NO Day Stay? ☐ YES ☐ NO ☐ Suitable for Registrar ☐ Suitable for Wairau

Estimated Theatre time (mins) Estimated Nights in Hospital

Surgery time + routine anaesthetic time

Additional Anaesthetic time (mins) Completed by Anaesthetist

Total Operation Time Planned Date

Operation Code: Procedure Code: Grade: CPAC Score:

Clinical Override ☐ Comment: _____

Please book for surgery ☐ Urgent ☐ Semi-urgent ☐ Routine ☐ **ACC Elective**

STOP WARFARIN ☐ YES ☐ NO ☐ N/A Special Instructions

STOP ASPIRIN? ☐ YES ☐ NO ☐ N/A

Yes

☐ Pre-op outpatient appointment required?

☐ Frozen section required? (Instructions loaded to Oracare comments)

☐ X – ray or image intensifier required

☐ Particular instruments/ implants required

Instructions loaded to Oracare comments

Pre-admission Risks Identified (State)

Surgical requirements coordinated by Surgical Secretaries ☐ JW

Estimated time off work (if applicable)

Patient available at short notice? ☐ Yes ☐ No

Surgical Consent Signed ☐

Direct patient to Preadmissions hub when complete.

Interpreter Required ☐ Yes ☐ No Language

Office Use Only

☐ CERTAINTY Date entered on to Concerto _____ Surgery in ☐ Wairau ☐ Nelson

☐ NOT MET THRESHOLD Waitlisted? ☐ YES ☐ NO By _____ Date _____

Total operation time entered ☐ YES

CONSENT

Nelson Marlborough District Health Board

TE WAI ORA

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 apply

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 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 to blood samples being taken and tested. These samples will be tested only to identify such contagious diseases as are considered of considerable risk e.g. hepatitis and HIV. I understand I will be informed of results if I request them, and any need for further medical 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 me 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.

CONSENT

Nelson Marlborough District Health Board

Given Name: _____ Gender: _____

Family Name: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

BY SIGNING THIS CONSENT FORM I GIVE MY AUTHORITY TO (TICK YES OR NO)

	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 me	☐	☐	☐
NMDHB taking and holding procedural images	☐	☐	☐

I AGREE THAT I HAD OPPORTUNITY TO DISCUSS

	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/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 asked I have answered them appropriately and to the best of my ability.

Signed _____ Date _____

Patient/person legally entitled to consent - print surname

Signed _____ Date _____

Interpreter (if applicable) - print surname

Signed _____ Date _____

Health Professional - print surname

ANAESTHETIC

I agree to a local /general /regional block (cross out that which does not apply) anaesthetic being given.

I have read or had explained, and understand, the risks and benefits of the proposed anaesthetic. I have had adequate opportunity to ask questions about the anaesthetic, alternative procedures and risks.

I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcoholic beverages or make important decisions for 24 hours after the procedure.

I have discussed this with _____ _____

Health Professional Designation

Discussion/comments:

_____

_____

_____

Signed _____ Date _____

Patient/person legally entitled to consent - print surname

Signed _____ Date _____

Health Professional - print surname

CONSENT

Nelson Marlborough
District Health Board

TE WAI ORA

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.

FILE AROUND HERE

Nelson Marlborough District Health Board

TE WAI ORA

Given Name: _____ Gender: _____

Family Name: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

ADULT PATIENT HEALTH QUESTIONNAIRE

Please complete the following questions. They will help to provide our staff with necessary information to assess your health and plan your care. The information will remain confidential and form part of your medical records.

MEDICATIONS

List all medications you take. This includes tablets like aspirin, inhalers, eye drops and skin ointment.

Drug	Amount	How Often

COMPLIMENTARY & ALTERNATIVE MEDICINES

List all complementary and alternative medicines or Rongoa Maori you take.

DRUG AND NON-DRUG ALLERGIES

List all allergies including drugs, lotions, sticking plaster, latex, food, etc...

Medication/Other	Please describe your reaction, e.g. wheeze, rash, vomiting

PRIMARY HEALTH QUESTIONNAIRE

Nelson Marlborough District Health Board

TE WAI ORA

HEALTH QUESTIONNAIRE

ANAESTHETIC

	Yes	No	Comment
Have you had a general anaesthetic before?	☐	☐	
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?	☐	☐	
Artificial Heart valves?	☐	☐	
Rheumatic heart disease?	☐	☐	
Abnormal heart rhythms?	☐	☐	
Lung problems e.g asthma, emphysema?	☐	☐	
Diabetes?	☐	☐	
Stroke or transient ischaemic attack (TIA)?	☐	☐	
Epilepsy or seizures?	☐	☐	
Kidney problems?	☐	☐	
Blood clots in legs or lungs?	☐	☐	
Blood disorders (State)?	☐	☐	
Muscle/nerve disease?	☐	☐	
Rheumatoid arthritis	☐	☐	
Thyroid/pituitary Problems?	☐	☐	
Ankylosing spondylitis	☐	☐	
Surgery to neck or back	☐	☐	

	Yes	No	Comment
Hepatitis – if yes was it related to an anaesthetic?	☐	☐	
Are there any other conditions not mentioned above?	☐	☐	

DO YOU HAVE?

	Yes	No	Comment
Angina. If yes, what starts it and how often.	☐	☐	
1. Do you get angina with everyday living activities?	☐	☐	
2. Do you get angina at rest?	☐	☐	
3. Do you get angina walking 20 – 100 metres?	☐	☐	
Shortness of breath			
1. I can perform all physical activity without limitation – **If Yes do not answer 2,3,4,5 below.**	☐	☐	
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	☐	☐	
5. I get short of breath at rest and am mostly housebound. I cannot carry out any physical activity without getting short of breath.	☐	☐	
Unusual thumping in the chest or palpitations	☐	☐	
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?	☐	☐	
Blackouts or fainting. If yes, state reason.	☐	☐	
Frequent indigestion or heartburn.	☐	☐	
If yes, is it well controlled with medication?	☐	☐	
Severe snoring or stopping breathing at night	☐	☐	
1. If yes, do you feel tired/fatigued/sleepy during the day?	☐	☐	
2. Has anyone observed you stop breathing during sleep?	☐	☐	

Nelson Marlborough District Health Board

TE WAI ORA

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	☐	☐	
Climbing a flight of stairs without resting	☐	☐	
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	☐		
Once per week	☐		
One to three times per month	☐		
Hardly 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

STOP HERE!

Please give this pack back to the staff at the Pre Admissions reception desk.
Please do not leave until the staff inform you all necessary preparation has been completed.
Thank you for your help.

FRAILTY

Not frail ☐ Pre-frail ☐ Frail ☐

Office Use Only - Triage Codes

DC FFS	☐	IPFT (N A)	☐	IPS (N A)	☐
DC (N)	☐	IPFT (N)	☐	IPS (N RMO A)	☐
DC (N A)	☐	IPS (N)	☐		
IP FFS	☐	IPS (N RMO)	☐		

Comments _____

_____

_____

HEALTH QUESTIONNAIRE

Nelson Marlborough District Health Board

FSA HUB

Baseline Observations *(not required for paediatric patients)*

Weight	(kg)	Pulse	
Height	(cm)	BP	
BMI = Kg/m^2		SpO_2 (Air)	%
HbA_1C		GP Letter ☐	

SMOKEFREE PRE-OPERATIVE ASSESSMENT Date ____________

A Smokefree Status NO YES	Brief Advice - Cessation Offer 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 ____________

A Smokefree Status NO YES	Brief Advice - Cessation Offer 1st 2nd 3rd	Referral? YES NO (declined)		
Smoked in the last 30 days (Z720)	Nurse		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	0800 778 778	
NRT charted NRT used	Other	NRT card/script		
Zyban/Champix used	Leaflet given			

MULTI-DRUG RESISTANT ORGANISM (MDRO) - ANTIBIOTIC-RESISTANT 'SUPER BUGS'

	Yes	No
1) Has the patient been in an <u>overseas</u> health-care facility in the last 12 months for at least one overnight admission or as a staff member? *If yes, screen for MRSA, VRE and CR-GNR. Use contact isolation precautions until results negative.*	☐	☐
2) Does the patient have an alert dated within the last 3 years for VRE, MRSA or CR-GNR? *If yes, use contact isolation precautions.*	☐	☐

KEY

VRE = vancomycin-resistant enterococci

MRSA = methicillin-resistant *Staphylococcus aureus*

CR-GNR = carbapenem-resistant gram-negative rods

PRE ADMISSION CHECKLIST

Code of rights pamphlet issued Yes ☐

Do you have someone to stay with you overnight following surgery? Yes ☐ No ☐ TBA ☐ N/A ☐

Pre Admissions Hub Signature

Nelson Marlborough
District Health Board

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
FBC	Date Date			LapChol Breast Surgery	LFT Date Amylase Date		
NA, K Creatine, GFR	Date Date			Thyroid Surgery	Ca/PO4 Date T4/TSH Date		
LFT's	Date Date			Gynae Obstetrics	PTH Date Pregancy test Date		
HbA1c	Date Date			Urology	Renal Stones KUB within 48 hours of surgery Biopsy result		
Coagulation	Date				MSU Date PSA		
NT BNP	Date			ENT	Audiogram		
Troponin	Date				CT Scan		
G&H/Cross Match				Other			
ECG							
CXR							
Urinalysis/MSU							
Swabs							
Echo Cardiogram							
Lung Function Test							
Other							

DOCUMENT ACTION TAKEN IF TESTS ABNORMAL

_____

_____

Nelson Marlborough District Health Board

Given Name: _____ Gender: _____

Family Name: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

FAST TRACK BOOKING FORM (ELECTIVE) - ADULT INPATIENT

Any new issues since completing Health Questionnaire? ☐Y ☐N ☐N/A

Any new prescribed medications since completing Health Questionnaire? ☐Y ☐N ☐N/A

Patient's understanding of Operation/Procedure

NURSING ASSESSMENT

COMMUNICATION

Any problems ☐Y ☐N

IMPACT OF HOSPITALISATION

Cultural needs ☐Y ☐N
Advised of Te Pukenga Hauora Service ☐Y ☐N
Religious/spiritual needs ☐Y ☐N
Advised of hospital chaplaincy service ☐Y ☐N

COGNITIVE

Impairment ☐Y ☐N

TEETH

Dentures ☐Y ☐N
Upper full plate ☐Y ☐N
Upper partial plate ☐Y ☐N
Crown/bridge ☐Y ☐N
Lower full plate ☐Y ☐N
Lower partial plate ☐Y ☐N
Crown/bridge ☐Y ☐N
CAPS ☐Y ☐N

DIETARY

Normal diet ☐Y ☐N
Alcohol ☐Y ☐N
Alternative remedies ☐Y ☐N
Recreational drugs ☐Y ☐N

ELIMINATION

Continent ☐Y ☐N
IDC ☐Y ☐N
Stoma ☐Y ☐N

MOBILITY

Independent ☐Y ☐N
Walking aid ☐Y ☐N
Prosthesis ☐Y ☐N
Previous trips/falls ☐Y ☐N
Other _____ ☐Y ☐N

CNS

Hearing impairment ☐Y ☐N
Visual impairment ☐Y ☐N
Contact lenses ☐Y ☐N
Hearing aid ☐Y ☐N
Spectacles ☐Y ☐N
Artificial eye ☐Y ☐N

SELF CARE

Independent ☐Y ☐N
Caregiver required ☐Y ☐N
Caregiver organised ☐Y ☐N

SUPPORT

Health services currently used ☐Y ☐N ☐N/A
Services advised of admission ☐Y ☐N ☐N/A

PATIENT NEEDS, ISSUES, CONCERNS

MRSA TESTING (METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS)

MRSA Y ☐ N ☐
GP Contacted Y ☐ N ☐
Swab results +ve ☐ -ve ☐
Treatment Y ☐ N ☐

Additional Transmission Precautions

Contact ☐ Droplet ☐
Airborne ☐ Other _____ ☐

REFERRALS SENT (SPECIFY)

PRE-ADMISSION

Nelson Marlborough District Health Board

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 Score
41 - 60 years			
Minor surgery			
Major surgery < 1 month			
Varicose veins			
Inflammatory bowel disease			
Swollen			
BMI > 25			
Acute myocardial infarction			
Congestive heart failure			
Sepsis			
Serious lung disease			
COPD			
Medical patient on bed rest			
Each Risk Factor = 2 Points		**Score 2**	
60 - 74 years			
Arthroscopic surgery			
Malignancy (past or present)			
Surgery > 45 mins			
Laparoscopic surgery > 45 mins			
Patient confined to bed > 72 hrs			
Immobilising plaster cast			
Central venous access			
Each Risk Factor = 3 Points		**Score 3**	**Risk Level**
≥ 75 yrs			
History DVT/PE			
FH thrombosis (1st degree relative)			
+ve factor V Leiden			
+ve prothrombin 20210A			
Elevated homocysteine			
+ve lupus anticoagulant			
Elevated anticardiolipin antibodies			
Heparin induced thrombocytopnia			
Thrombophilia			
Each Risk Factor = 5 Point		**Score 4**	
Lower extremity arthroplasty			
Hip, pelvis, leg fracture (<1 month)			
Stroke (<1 month)			
Acute spinal cord injury (1< month, paralysis)			
Women Only, Each = 1 Point		**Score 5**	
OCP or HRT			
Pregnancy, post partum (<1 month)			
History unexplained stillborn, recurrent abortion			
History eclampsia or growth restricted infant			

Total score	Risk level
0	Very low
1 - 2	Low
3 - 4	Moderate
≥ 5	High

GFR =

Not for SCD

PVD

CHF

Acute DVT (superficial)

Limb oedema

Skin graft

Neuropathy

Cellulitis

NMDHB-2141

HISTORY AND EXAMINATION

BACKGROUND

PAST MEDICAL HISTORY

Medical

Surgical

MEDICATIONS

Medications

Antiplatelet/Anticoagulants Y☐ N☐

Bleeding Risk Y☐ N☐

Plan:

Allergies and Sensitivities

Medic Alert Bracelet Y☐ N☐

EXAMINATION

Cardiovascular

Respiratory

Other

I understand and have participated in the planning of my care for this admission.

I understand it is my right to accept or decline treatment.

Patient signature Date

Staff signature Date

Nelson Marlborough
District Health Board

TE WAI ORA

OPERATION/PROCEDURE

PROCEDURE NOTES

Date: _____

Surgeon: _____

Anaesthetist: _____

Radiologist: _____

Operation/Procedure: _____

Post-Operative/Post-Procedure Instructions: _____

Nelson Marlborough
District Health Board

WARD ADMISSION

Orientation	Patient oriented to ward ☐ Yes ☐ No	Date: _____	Time: _____

VALUABLES/TAONGA

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

Nelson Marlborough
District Health Board

CLINICAL NOTES	
Date/Time	

SURGERY

Nelson Marlborough
District Health Board

CLINICAL NOTES	
Date/Time	

SURGERY

Nelson Marlborough District Health Board

TE WAI ORA

SURGERY

CLINICAL NOTES

Date/Time	

CLINICAL NOTES	
Date/Time	

Nelson Marlborough District Health Board

TE WAI ORA

NURSING CARE PLAN

Date: _____ Commenced by: _____

Review patient and plan each shift, update by ruling out previous entry and signing below each shift

Expected outcomes	Interventions to consider		Individual patient nursing interventions		
Neurological/Cognition/LOC Neurological status monitored Variances noted and actioned	GCS Neuro obs/AVPU BSL				
Airway/Breathing Maintain adequate Oxygenaction	RR/02 Sats/EWS O2 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 regime, Stoma Catheter, Dialysis PV loss FBC				
IV Therapy/Medication Pain assessed and controlled Medication administered safely	IV fluids, CVC, PICC, TPN, Epidural, Regional, PCA, IV Meds				
Eating & Drinking Maintain/restore nutritional status	FBC, NBM, Fluids, Diet, Special Diet				
Mobility/Activity/Safety Potential complications identified/ minimised	Fall Risk Score Assess Daily: Falls Prevention, ABCDEF, Supervise, Enablers, Restraint, Bedrest, Mobility, DVT risk - TEDS				
No Lift Policy Assessment/Equipment	On bed	I S A N			
	Off bed	I S A N			
	Mobilising	I S A N			
Activities of Daily Living Usual functional level maintained/ restored	Personal cares				
Skin/Wound Care Potential complications identified/ minimised/appropriately treated	Waterlow score Pressure ulcer prevention Strategies Wound care assessment/plan				
Patient Education/Discharge Planning Prepared and informed to be discharged	Discharge checklist commenced information handouts - list				
Cultural, Spiritual and/or Social Plan of care meets individual patient need	Family involvement with care planning Offer Chaplaincy support				
Review each shift			**Date and sign notce**	**Date and sign AM**	**Date and sign PM**
Day/post op day					

Individual Goals should be discussed with patient daily and evaluated in progress notes each shift

Nelson Marlborough District Health Board

TE WAI ORA

NURSING CARE PLAN

Date: _____ Commenced by: _____

Review patient and plan each shift, update by ruling out previous entry and signing below each shift

Individual patient nursing interventions	Individual patient nursing interventions	Individual patient nursing interventions	Individual patient nursing interventions

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	Date/Sign notce	Date/Sign AM	Date/Sign PM

Individual Goals should be discussed with patient daily and evaluated in progress notes each shift

SURGERY

Nelson Marlborough District Health Board

PATIENT DISCHARGE CHECKLIST

DISCHARGE PLANNING

HOME	Y	N	SUPPORT	Y	N	DISCHARGE TO
Stated NOK Current	☐	☐	Further assistance needed on discharge			Person to discuss care & discharge plan with:
Lives alone	☐	☐	Detail: _____	☐	☐	Name: _____
Dependents at home	☐	☐	_____			Contact: _____
Arrangements for dependents	☐	☐	_____			Transport arranged
Care giver at home	☐	☐	_____			Name: _____
Name: _____			_____			Contact: _____
Contact: _____			_____			_____
Organised to attend to patient	☐	☐	_____			

COMPLETE 24 HOURS PRIOR TO DISCHARGE

MEDICAL	Y	N	N/A	NURSING	Y	N	N/A	ALLIED HEALTH	Y	N	N/A	CLERICAL	Y	N	N/A
Ordered for discharge	☐	☐	☐	Risks to discharge identified with family/whanau	☐	☐	☐	Discharge equipment organised	☐	☐	☐	Patient transfer requirements organised	☐	☐	☐
Pending results	☐	☐	☐	Community support available and appropriate	☐	☐	☐	Physio	☐	☐	☐	Travel arrangements confirmed with patient/ whanau	☐	☐	☐
Specify:								OT							
Discharge tests (lab xray required)	☐	☐	☐	Discharge time expectations communicated to family/ whanau	☐	☐	☐	Discharge education for family/whanau	☐	☐	☐				

COMPLETE MORNING OF DISCHARGE

MEDICAL	Y	N	N/A	NURSING	Y	N	N/A	ALLIED HEALTH	Y	N	N/A
Discharge summary complete and copy to patient	☐	☐	☐	Alert & oriented	☐	☐	☐	Check patient has follow-up appointment	☐	☐	☐
				EWSS = 0	☐	☐	☐				
ACC & medical certificate issued	☐	☐	☐	Tolerating food and fluids	☐	☐	☐	Copy of discharge letter sent to GP	☐	☐	☐
Prescription and explanation given	☐	☐	☐	Pain controlled	☐	☐	☐				
Prescription faxed to community pharmacy	☐	☐	☐	Nausea controlled	☐	☐	☐	Discharge off computer	☐	☐	☐
				Wound satisfactory	☐	☐	☐				
Discharge advice sheet given	☐	☐	☐	UTT/Catheter removed and HPU	☐	☐	☐	**CLERICAL**	**Y**	**N**	**N/A**
Education given:				Mobilising safely	☐	☐	☐	Follow up on OPD appointments made and given to patient	☐	☐	☐
Catheters	☐	☐	☐	IV cannula removed	☐	☐	☐				
Wounds	☐	☐	☐	Medications returned to patient	☐	☐	☐	Copy of discharge letter sent to GP	☐	☐	☐
Drains	☐	☐	☐	Community support available and appropriate	☐	☐	☐				
Packing	☐	☐	☐	Discharge time expectations communicated to family/whanau	☐	☐	☐	Discharge off computer	☐	☐	☐
POP	☐	☐	☐								
Discharge blood forms given to patient	☐	☐	☐								

Discharging Doctor (Please Print)	Discharging Nurse/Midwife (Please Print)	Role Signature Print Name	Discharging Clerical Staff (Please Print)
_____	_____	PT _____	_____
		OT _____	
		SW _____	
Signature	Signature	DT _____	Signature
_____	_____	SLT _____	_____
		Other _____	

DISCHARGE