AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Assessment to Discharge (Part B)

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

ASSESSMENT TO DISCHARGE - PART B

ADMISSION CHECKLIST

		Intial when complete			
Health Passport ☐ Yes ☐ No Yellow Envelope ☐ Yes ☐ No		**Ward:**	**Ward:**	**Ward:**	**Ward:**
Alerts checked and actioned					
Patient admitted on CHiPS Whiteboard and handover sheet updated					
Patient labels printed + door name tags in place					
Patient wristband applied					
Team notified of patient arrival					
Meal card completed and meal type completed in CHiPS					
Patient orientated to ward and room					
Call bell given + explained					
PSAG at bedside updated with patient					
Patient welcome booklet + code of rights given + explained					
Patient registration details checked and signed with pt/family including email address					
Pain assessed and intervention provided if required					
Baseline observations EWS completed **(CR form)**					
Falls Risk Assessment completed **(CR form)**					
Pressure Risk Assessment completed **(CR form)**					
Smoking assessment form completed **(CR form)**					
Behaviours of concern assessment completed as appropriate **(CR form)**					
Infection control: Multi-Drug Resistant Organisms (MROs)					
Known MRO carriage	☐ Yes ☐ No ☐ Type: _____	Transmission precautions as per ADHB guidelines			
Overnight admission in a NZ healthcare facility (other than ADHB) or residential care facility in the previous 6 months	☐ Yes ☐ No ☐ Swabs/ samples taken				
Direct transfer from, admission, or outpatient haemodialysis in an overseas hospital in previous 12 months	☐ Yes ☐ No ☐ Swabs/ samples taken				
Travel (without hospitalisation) to listed South or South-East Asian country in previous 6 months (see policy / MRO form)	☐ Yes ☐ No ☐ Swabs/ samples taken				

VALUABLES / PROPERTY SIGHTED ON ADMISSION

Patient informed of valuables policy ☐ Yes ☐ No

Does the Patient want any valuables secured? ☐ Yes ☐ No

Cash amount $ _____ Cards, specify: _____

☐ Cell Ph ☐ Smart Ph

☐ Computer,

Type: _____

☐ Watch ☐ Necklace

☐ Earrings ☐ Bracelets

☐ Ring/s

Kept with patient at their request ☐ Yes ☐ No

Sent to security ☐ Yes ☐ No

Home with other ☐ Yes ☐ No

Whom: _____

☐ Dentures: ☐ Top ☐ Bottom ☐ Partial

☐ Glasses

☐ Contact lenses

☐ Prosthetic type: _____

☐ Hearing aids: ☐ Left ☐ Right

Signed by patient or family:

Initial: | **Date:**

VALUABLES / PROPERTY SIGHTED ON TRANSFER

Patient informed of valuables policy ☐ Yes ☐ No

Does the Patient want any valuables secured? ☐ Yes ☐ No

Cash amount $ _____ Cards, specify: _____

☐ Cell Ph ☐ Smart Ph

☐ Computer,

Type: _____

☐ Watch ☐ Necklace

☐ Earrings ☐ Bracelets

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☐ Contact lenses

☐ Prosthetic type: _____

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Signed by patient or family:

Initial: | **Date:**

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AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

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Responder: ☐ **Patient** ☐ **Other, specify:** _____

Sample Signatures			
NAME (family & given)	DESIGNATION	DATE	INITIAL

Sample Signatures			
NAME (family & given)	DESIGNATION	DATE	INITIAL

PATIENT'S MEDICATION

Has patient brought in their own medication?	☐ Yes ☐ No
Has the medication been sighted by the house surgeon?	☐ Yes ☐ No ☐ N / A
Has the medication been sent home?	☐ Yes ☐ No ☐ N / A
Medication stored in the medication room green bag?	☐ Yes ☐ No ☐ N / A
Controlled drugs signed into CD book and stored in CD cupboard?	☐ Yes ☐ No ☐ N / A
Restricted medications locked in cupboard	☐ Yes ☐ No ☐ N / A

PAIN ASSESSMENT

Do you have any pain or discomfort? ☐ No, If no move onto next section.
☐ Yes, If yes is it ☐ new ☐ longstanding?

Where is the pain? _____

Describe the pain (e.g. dull, sharp, localised, radiating, burning, tingling): _____

Is your pain ☐ Constant? ☐ Intermittent?

Is it worse at any particular time of day? ☐ No ☐ Yes, Describe: _ _____

How severe is your pain? *No pain* 0 1 2 3 4 5 6 7 8 9 10 *Worst pain imaginable*

Moderate pain

Do you normally use pain medication? ☐ No ☐ Yes, Describe: _____

How often? _____ Time last taken? _____

Discuss with medical staff to ensure appropriate medication charted and commenced

Initial:

NUTRITION ASSESSMENT

Weight: _____ **Usual Weight:** _____ **Height:** _____

Have you unintentionally lost weight in the last 3-6 months? ☐ No ☐ Yes How much? _____ kg

and / or

Is the patient likely to have a limited intake in the next 5 days? ☐ No ☐ Yes

If yes to either question, complete Malnutrition Screening Tool (CR form) and commence food chart (CR form)

Do you have any special dietary requirements? (puree, soft, thickened fluids, diabetic, dairy, religious)

☐ No ☐ Yes, describe: _____

Do you take any dietary/ nutritional supplements? ☐ No ☐ Yes, specify: _____

Have you (or family/clinician) noticed any new problems with swallowing (e.g coughing on food or fluids)?

☐ No ☐ Yes, ensure nurse dysphagia screen completed **(CR form)**

Initial:

GENITOURINARY ASSESSMENT:

Do you have problems passing urine? ☐ No ☐ Yes, describe: _____

Do you frequently go to the toilet at night? ☐ No ☐ Yes, how many times in a night? _____

IDC insitu? ☐ No ☐ Yes, date inserted: _____

Do you have any urinary incontinence? ☐ No ☐ Yes product normally used: Day: _____ Night: _____

Do you need any sanitary items ☐ No ☐ Yes

Discuss with patient toileting plan, product type / use Day: _____ ***Night:*** _____

Initial:

For additional space please use pages 6 and 7 of this form

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Responder: ☐ **Patient** ☐ **Other, specify:** _____

BOWEL ASSESSMENT

Do you have any issues with your bowels? ☐ Yes ☐ No, If no move to next section.
Do your bowels move every day? ☐ Yes ☐ No, how often? _____
Date of last bowel motion: _____
Do you have problems with:
Constipation? ☐ No ☐ Yes, describe: _____
Loose bowels? ☐ No ☐ Yes, describe: _____
Do you have a stoma? ☐ No ☐ Yes, describe: _____
Do you take any remedies or prescribed laxatives? ☐ No ☐ Yes, specify: _____
Do you have any faecal incontinence? ☐ No ☐ Yes, describe: _____
Do you have haemorrhoids? ☐ No ☐ Yes, treatment: _____

Discuss with medical staff, medication charted as required

Initial:

SPIRITUAL / CULTURAL NEEDS

Do you have any spiritual or cultural needs whilst in hospital? ☐ No ☐ Yes
Describe: _____

If yes, refer to chaplaincy, Kai Atawhai, Pacific Family Support Unit as appropriate.

Initial:

COMMUNICATION (assessor to answer for patient)

Have you noticed any communication difficulties while completing this assessment? ☐ No ☐ Yes
If yes, describe: _____
Is this ☐ new ☐ longstanding? (confirm with patient or carer)_____

If new issue, consider discussion with or referral to Speech Language Therapist.

Initial:

ENABLERS (To provide independance, comfort and safety in 'consenting' patient)

Decision to implement enabler following falls and / or behaviour of concern assessment **(CR forms)**

☐ **Bedrails** used for support in positioning or on request by 'competent' patient

☐ **Safety belts / lapbelt** to assist in positioning in chairs

☐ **Harness** to assist in positioning in chairs

☐ **Chair with attachable tray in place** for meals and activities of daily living

☐ **Other** _____

Verbal Consent Gained

Patient / Family / Whanau name: _____

Patient / Family / Whanau Signature: _____ **Date:** _____

Initial:

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Responder: ☐ **Patient** ☐ **Other, specify:** _____

SOCIAL ASSESSMENT

Occupation: _____

Are you a main caregiver? ☐ No ☐ Yes, for whom: _____

☐ Lives alone ☐ Lives with other/s, who? _____

☐ Independent Unit ☐ Serviced apartment ☐ Rest home ☐ Private hospital

☐ Other: _____

Meals on wheels ☐ No ☐ Yes, how often? _____

Personal cares ☐ No ☐ Yes, how often? _____

Home help ☐ No ☐ Yes, how often? _____

Personal Alarm ☐ No ☐ Yes

Other (e.g. carer relief): _____

Initial:

MOBILITY

Usually independent unaided? ☐ Yes ☐ No

If no, specify (walking aid, assistance) _____

Initial:

ACTIVITIES OF DAILY LIVING ASSESSMENT

	Pre-admission baseline function (what the patient could do before this admission)				**Current function** (what the patient is doing now)			
	Independent	Supervision	Assistance	Unable	Independent	Supervision	Assistance	Unable
Chair transfers								
Bed transfers								
Toilet transfers								
Showering								
Walking indoors								
Walking outdoors								
Stairs								
Cooking								
Shopping								

Do you have stairs or steps at home? ☐ No ☐ Yes

How many, internal / external, rails? _____

_____

Do you currently have any equipment at home (e.g. shower stool, walking frame)? ☐ No ☐ Yes

Specify: _____

_____

Do you have any modifications to your home? (e.g. bathroom rails, stair lift): ☐ No ☐ Yes

Describe: _____

_____

If patients ability has changed, consider discussion with or referral to Physiotherapist and / or Occupational Therapist.

For additional space please use pages 6 and 7 of this form

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Responder: ☐ Patient ☐ Other, specify: _____

SOCIAL ASSESSMENT CONTINUED

Do you feel you were managing at home before coming to hospital? ☐ Yes ☐ No

Describe concerns: _____

Is there anything worrying or upsetting you, or causing stress? ☐ Yes ☐ No

Describe: _____

When you leave hospital, where do you plan to live? _____

Have you got any concerns about leaving hospital? ☐ Yes ☐ No

Describe: _____

When you leave hospital, who will be available to support you during the day and overnight?

Describe: _____

Complete referrals to Allied Health and / or support services based on information obtained. **Initial:**

ROUTINE ENQUIRY

Response ☐ Yes ☐ No ☐ Declined to answer CR0018 Complete ☐ Yes ☐ No

Name _____ Signature _____ Date _____

ENDURING POWER OF ATTORNEY
For patients ≥65 yrs

Do you have an Enduring Power of Attorney for property and finance? ☐ Yes ☐ No

Contact details: _____

Do you have an Enduring Power of Attorney for personal care & welfare? ☐ Yes ☐ No

Contact details: _____

INPATIENT REFERRALS

Referral made	Referral mode	Referrer	Referral Date
	☐ Fax ☐ Phone ☐ Verbal ☐ CHiPS		
	☐ Fax ☐ Phone ☐ Verbal ☐ CHiPS		
	☐ Fax ☐ Phone ☐ Verbal ☐ CHiPS		
	☐ Fax ☐ Phone ☐ Verbal ☐ CHiPS		
	☐ Fax ☐ Phone ☐ Verbal ☐ CHiPS		
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DATE	ADDITIONAL NOTES	INITIAL

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DISTRICT HEALTH BOARD
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DATE	ADDITIONAL NOTES CONTINUED	INITIAL

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For additional pages, please use CR3009 Clinical Notes

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DISCHARGE REFERRALS

Referral made	Referral mode	Referrer	Referral Date
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		
	☐ Fax ☐ Phone ☐ Verbal		

DISCHARGE CHECKLIST

Sign if completed:	Initial	Date
Allied Health clearance checked on whiteboard		
Home equipment supplied / organised		
Written handover completed if patient being transferred to other care facility		
Verbal handover given if patient being transferred to other care facility		
Yellow envelope handed over		
Transit Nurse required		
Transport booked / organised, specify:		
Yellow medication card checked against prescription		
Prescription given		
Medication education given to patient		
Own medication returned to patient		
Advice to collect hospital only medication from hospital pharmacy (Level 5)		
IV cannula/s removed		
Discharge blood test forms given to patient		
Electronic Discharge summary provided and discussed with patient		
Wound care discussed with patient, specify:		
Health passport returned		
Valuables returned		
ACC / medical certificate given		
Health education/pamphlets, specify:		

FOLLOW UP APPOINTMENTS

	☐ GP	☐ Outpatient clinic	☐ Other specialty	☐ Nil

Describe: _____

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