

TCM ADMISSION CHECK LIST WARD

PHASE

Patient MRN

Time / Date Presented _____

Time / Date Seen _____

		Y	N	TCM INTERVENTION		
				Y	N	Time
Documentation of Management Plan						
General Surgery		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Orthopaedics		<input type="checkbox"/>	<input type="checkbox"/>			
Neurosurgery		<input type="checkbox"/>	<input type="checkbox"/>			
Other		<input type="checkbox"/>	<input type="checkbox"/>			
Nutritional Status (IV Fluids / NBM)						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Observations required Frequency						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Analgesia						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
				<input type="checkbox"/>	<input type="checkbox"/>	
				Pain Team	<input type="checkbox"/>	<input type="checkbox"/>
DVT prophylaxis						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Investigation results						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Admission correct ?						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Appropriate ward ?						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Pt / family aware of plan ?						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nursing staff aware of plan ?						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nursing care ?						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Referrals to:						
	Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	OT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	Social Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D/C planning						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Tertiary Survey						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Comments :				Total Time :		
				<input type="text"/>		
