

Needs	Date	Day			Date	Day			Date	Day			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
<input type="checkbox"/> Diet instructions for patients at Nutritional risk	4/11	O	OD	✓	6/11	O	OD	✓	8/11	O	OD	✓	<i>[Signature]</i>
<input type="checkbox"/> Diet advice for home													
Discharge Planning													Nurse / Doctor
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting concerns													
<input type="checkbox"/> Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													Nurse / Doctor
<input type="checkbox"/> Smoking cessation													
<input type="checkbox"/> Weight control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other risks													

LEARNER (L) - P - Patient, M - Mother, F - Father, S - Spouse other _____ (State Relationship)

PROCESS (P) - OD - Oral Discussion, D - Demonstration, W - Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written material given and explained (if any):

Reports Given:

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	_____	_____	_____	Diet Advice	_____	_____	_____
ECG Report	_____	_____	_____	CT Scan Report	_____	_____	_____
Doppler Report	_____	_____	_____	CT Scan Film	_____	_____	_____
X-Ray Report	_____	_____	_____	ECHO Report	_____	_____	_____
X-Ray Film	_____	_____	_____	Ultrasound Report	_____	_____	_____
Compact Disc	_____	_____	_____	Any other report	_____	_____	_____

Name of Attendant / Patient Pamela Tawau Signature *[Signature]*

Name of Discharge Nurse: *[Signature]* Emp ID: 13458 Signature *[Signature]*

Name of Doctor _____ Emp ID: _____ Signature _____