



Consultant's Name: Dr. Athale
Diagnosis: Appendicitis

UHID

PATIENT AND FAMILY EDUCATION RECORD

To be filled by concerned disciplines, Use Key below

Assessment

Barriers to Learning				Plan to Address Factors			
<input type="checkbox"/> None		<input type="checkbox"/> Vision / Hearing Limitations		<input type="checkbox"/> Use of interpreter			
<input type="checkbox"/> Limited Reading Abilities		<input type="checkbox"/> Physical barriers		<input type="checkbox"/> Educate family			
<input type="checkbox"/> Religious / Cultural Factors		<input type="checkbox"/> Language barriers		<input type="checkbox"/> Simple language			
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions		<input type="checkbox"/> Low motivation / desire to learning		<input type="checkbox"/> Written instructions			
<input type="checkbox"/> Completed By Date <u>7/11/01/21</u>		Time <u>9 AM</u>		Nurse Signature: <u>Kelbilen</u>			

Learning Record

Needs	Date	Day			Date	Day			Date	Day			Signature
		L	P	O		L	P	O		L	P	O	
Disease	<u>11/10</u>				<u>12/10</u>				<u>15/10</u>				Doctor
<input type="checkbox"/> Information on Disease / Diagnostics		S	M	W		S	M	T		S	U	N	()
Treatment		S	M	W		S	M	T		S	U	N	-
Medications													Doctor / Nurse
<input type="checkbox"/> Information on Safe and Effective use of medicines		S	M	W	<u>12/10</u>	S	M	W	<u>15/10</u>	G	A	B	()
<input type="checkbox"/> Information on Drug / Drug and Drug / Food interactions		S	M	W		S	M	W	<u>15/10</u>	S	O	N	-
<input type="checkbox"/> Discharge Medications													
Surgical Instructions													Nurse / Doctor
<input type="checkbox"/> Pre-Operative Instructions	<u>10/10</u>	S	O	N	<u>12/10</u>	S	O	N	<u>15/10</u>	S	O	N	<u>16/10</u>
<input type="checkbox"/> Post-Operative Instructions (Wound/Dressing Care)	<u>11/10</u>	S	C	H	<u>V</u>	<u>13/10</u>	C	H	<u>V</u>	<u>15/10</u>	S	O	<u>16/10</u>
Pain Management													Nurse / Doctor
<input type="checkbox"/> Reporting of pain													
<input type="checkbox"/> Pain Management													
Safe and Effective use of Medical Equipment (If required)													Doctor / Nurse
Name of Equipment													
Rehabilitation Techniques													Physiotherapist
<input type="checkbox"/> Home Exercises	<u>11/10</u>	O	D	V					<u>15/10</u>	P	O	V	<u>16/10</u>

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