



MGM
NEW BOMBAY HOSPITAL, VASHI



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MRS LALITA RAVINDRA LOKHAND
UHID MGM16035596 IPD MGMIP2406662
Age/Sex : 68 Years F DOA 03/10/2024
BED : 806 WARD : SAUN
DR : DR K RAJMOHAN

Consultant's Name: Dr. K. Rajmohan.

Diagnosis: AED

UHID

PATIENT AND FAMILY EDUCATION RECORD

To be filled by concerned disciplines, Use Key below

Assessment

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Vision / Hearing Limitations	<input type="checkbox"/> Use of interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input checked="" type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input checked="" 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 checked="" type="checkbox"/> Completed By Date <u>31/10/24</u> Time <u>2pm</u> Nurse Signature: <u>Deepthi IN301</u>		

Learning Record

Needs	Date	Day <u>1</u>				Date	Day <u>2</u>				Date	Day <u>3</u>				Signature
		L	P	O			L	P	O			L	P	O		
Disease														Doctor		
<input checked="" type="checkbox"/> Information on Disease / Diagnostics	3/10/24	P	OD	V		3/10	P	OD	V					<u>[Signature]</u>		
<input checked="" type="checkbox"/> Treatment		P	OD	V		P	OD	V						<u>[Signature]</u>		
Medications														Doctor / Nurse		
<input checked="" type="checkbox"/> Information on Safe and Effective use of medicines	3/10	P	OD	V		3/10	P	OD	V					<u>[Signature]</u>		
<input checked="" type="checkbox"/> Information on Drug / Drug and Drug / Food interactions		P	OD	V		P	OD	V						<u>[Signature]</u>		
<input type="checkbox"/> Discharge Medications						5/10	P	OD	V					<u>[Signature]</u>		
Surgical Instructions														Nurse / Doctor		
<input type="checkbox"/> Pre-Operative Instructions																
<input type="checkbox"/> Post-Operative Instructions (Wound/Dressing Care)																
Pain Management														Nurse / Doctor		
<input checked="" type="checkbox"/> Reporting of pain		P	OD	V										<u>[Signature]</u>		
<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																