



Consultant's Name: Dr. Prashant Athale

Diagnosis: Sepsis

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 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>29/10/24</u>	Time <u>10:00</u>	Nurse Signature: <u>Utm</u>	

Learning Record

Needs	Date	Day__			Date	Day__			Date	Day__			Signature
		L	P	O		L	P	O		L	P	O	
Disease													Doctor
<input type="checkbox"/> Information on Disease / Diagnostics	<u>29/10/24</u>	<u>P</u>	<u>OD</u>	<u>A</u>	<u>31/10/24</u>	<u>P</u>	<u>OD</u>	<u>A</u>	<u>01/11/24</u>	<u>P</u>	<u>OD</u>	<u>Y</u>	<u>Mr. At</u>
Treatment													
Medications													Doctor / Nurse
<input type="checkbox"/> Information on Safe and Effective use of medicines	<u>29/10/24</u>	<u>P</u>	<u>OD</u>	<u>V</u>	<u>31/10/24</u>	<u>S</u>	<u>OD</u>	<u>V</u>	<u>01/11/24</u>	<u>S</u>	<u>OD</u>	<u>V</u>	<u>Mr. At</u>
<input checked="" type="checkbox"/> Information on Drug / Drug and Drug / Food interactions		<u>S</u>	<u>OD</u>	<u>V</u>		<u>S</u>	<u>OD</u>	<u>V</u>		<u>S</u>	<u>OD</u>	<u>V</u>	<u>Mr. At</u>
<input type="checkbox"/> Discharge Medications													
Surgical Instructions													Nurse / Doctor
<input type="checkbox"/> Pre-Operative Instructions	<u>29/10/24</u>	<u>C</u>	<u>ch</u>	<u>V</u>									<u>Mr. At</u>
<input type="checkbox"/> Post-Operative Instructions (Wound/Dressing Care)	<u>30/10/24</u>	<u>S</u>	<u>OD</u>	<u>V</u>	<u>31/10/24</u>	<u>S</u>	<u>OD</u>	<u>V</u>	<u>01/11/24</u>	<u>S</u>	<u>OD</u>	<u>V</u>	<u>Mr. At</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	<u>29/10/24</u>				<u>31/10/24</u>				<u>01/11/24</u>				Physiotherapist
<input type="checkbox"/> Home Exercises		<u>P</u>	<u>OD</u>	<u>V</u>		<u>P</u>	<u>OD</u>	<u>V</u>		<u>P</u>	<u>OD</u>	<u>V</u>	<u>Mr. At</u>