DISCHARGE CHECKLIST

NAME :
DATE OF BIRTH : SEX :
ADMIT DATE : ROOM NO.:
MRN : EPISODE NO.:

	Date of X-Ray	No. of Films	Reports Yes ✓	Reports No X	Remarks
X-RAY					
▲ Chest					
▲ Ultrasound					
▲ MRI					
▲ CT Scan					
▲ Pt Own X-Ray					
▲ Angiogram					
DIAGNOSTIC					
▲ Stress Test (original)					
▲ Holter (original)					
▲ CD/PTCA/OGDS/COLONOSCOPE					
▲ CD/Angio/OGDS/COLONOSCOPE					

HEALTH EDUCATION

☐ Diet
☐ Physio / Ambulation
☐ Wound Care / Episiotomy
☐ Urinary Catheter / Ryle's Tube Feeding
☐ Breast Feeding
☐ Medication

☐ Branula / Chemoport Needle / CVL removed

☐ ID Band removed

☐ Appointment / Date Time:

☐ Medical Certificate Issued:

From: To:

*Birth Notification Form given to:

Name:

Relationship:

Signature:

Others / Follow-up A & E

Acknowledge by:

(Signature)

Name in full

Relationship:

Discharge by:

(Name in full)

Date: