CRITERIA LED DISCHARGE
RESPIRATORY

PART A: MEDICAL REVIEW (to be completed by Consultant/Medical Fellow)

Estimated Date of Discharge (EDD) on admission

Diagnosis: ________________________________________________________________

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Do not discharge without medical team review (add reason):
   _______________________________________________________________________

☐ Patient informed and consented to Criteria Led Discharge

Name: ___________________________ Signature: ___________________________ Time/date: ____________

PART B: PATIENT DISCHARGE CRITERIA (to be completed by interdisciplinary team)

<table>
<thead>
<tr>
<th>IDT agreed specific milestones</th>
<th>Comments</th>
<th>Name</th>
<th>Designation</th>
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<tbody>
<tr>
<td>1. Off IV medications</td>
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<tr>
<td>2. Temp between ______ and ______</td>
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<td>3. Oxygen saturation on room air</td>
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<tr>
<td>Oxygen saturation ______ LPM</td>
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<td>4. Independent with ADLs, signed off by IDT. Support organised, if required.</td>
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<td>5. Referrals made (Y, in progress - IP, not needed - NA) and completed (C)</td>
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<td>6. Follow up needs documented</td>
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<td>7. Medication(s) / Script(s) completed</td>
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Responsible person: CLD competent staff member

PART C: REVOKE MEDICAL APPROVAL

Name: ___________________________ Signature: ___________________________ Date: ____________

I revoke medical approval for CLD (add reason)

PART D: PATIENT CRITERIA

Y/N | Name | Date/Time
--- | --- | ---

All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient

Transfer of care: nursing discharge checklist completed

Patient not discharged using CLD protocol (add reason & draw two oblique lines on form):

I confirm that the criteria I parts B and D have been met and are achieved:

Name: ___________________________ Designation: ___________________________ 
Signature: ___________________________ Date/time: ___________________________