Criteria Led Discharge
Total Hip Replacement (THR)

GP: [GP PHONE:]
WARD: [DATE OF ADMISSION:]

THIS FORM IS TO BE COMPLETED FOR EVERY PATIENT

PART A: MEDICAL REVIEW (to be completed by Consultant or Advanced Trainee or Registrar)

Estimated Discharge Date: ___/___/_____

Diagnosis: ____________________
Total Hip Replacement ___________________________

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

☐ Please do not discharge until medical team review for the following reason (s):

_________________________________________________________________

Consultant/Advanced Trainee/Registrar Name: ___________________________

Signature: ___________________________ Date: ___________________ Time: ___________

PART B: Specific patient interdisciplinary discharge criteria (AGREED SPECIFIC MILESTONES)

MDT agreed specific milestones

1. Hb≥ 90
2. Wound & wound dressing clean & dry.
3. Cleared by Physiotherapy
4. Cleared by Occupational Therapy
5. Post discharge anticoagulation
6. Discharge analgesia

PART C: PATIENT CRITERIA

All observations Between the Flags or within acceptable limits for this patient
Has not required a rapid response for the patient in the last 24 hours
Nursing Discharge checklist complete

Responsible person: JMO or Criteria Led Discharge competent Registered Nurse

I confirm that the criteria/parts B and C have been met and are achieved: Name: ___________________________

Signature: ___________________________ Date: ___________________ Time: ___________

If patient not Criteria Led Discharged please document reason why: _______________________

Name: ___________________________ Signature: ___________________________