Criteria Led Discharge
Transient Ischaemic Attack (TIA)

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: ___________________________ Transient Ischaemic Attack

☐ I agree for this patient to be discharged post TIA 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 Name: ___________________________

Signature: ___________________________ Date: ___________________________ Time: ___________________________

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

MDT agreed specific milestones YES NO SIGNATURE

1. TIA symptoms resolved

2. Nil new acute changes on Magnetic Resonance Imaging (MRI)

3. Nil new acute changes on Carotid Doppler Ultrasound

PART C: PATIENT CRITERIA

YES NO SIGNATURE

All observations Between the Flags or within acceptable limits for this patient

All neurological observations Between the Flags

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: ___________________________