Criteria Led Discharge
Total Knee Replacement (TKR)

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 Knee Replacement [ ]

☐ I agree for this patient to be discharged post TKR 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 [ ] YES [ ] NO SIGNATURE

1. Hb≥ 90 [ ]

2. ROM 10 to 80 degrees [ ]

3. Wound & wound dressing clean & dry [ ]

4. Cleared by Physiotherapy [ ]

5. Cleared by Occupational Therapy [ ]

6. Post discharge anticoagulation [ ]

7. Discharge analgesia [ ]

PART C: PATIENT CRITERIA [ ] YES [ ] NO SIGNATURE

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: [ ]