TWH admitted NSTEMI / ACS Medical Officer approval: A1, A2, A3 to be attended ☐
Outpatient PCI/ Transfers directly to CDC Medical officer approval: A3 only ☐

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

Diagnosis:
____________________________________________________________________________________________________________________________________________________

A1. ADMITTING CARDIOLOGIST: Name: ____________________________
   Signature: ______________________________________________________
   Date: __________________________________________________________
   Time: __________________________________________________________

☐ This patient is suitable for Criteria Led Discharge. ☐ Please do not discharge until medical team review for the following reason(s):
____________________________________________________________________________________________________________________________________________________

A2. CARDIO ADVANCED TRAINEE/BASIC PHYSICIAN TRAINEE: Name: __________
   Signature: ____________________________
   Date: __________________________________________________________
   Time: __________________________________________________________

☐ This patient remains eligible for Criteria Led Discharge. ☐ Please do not discharge until medical team review for the following reason(s):
____________________________________________________________________________________________________________________________________________________

A3. INTERVENTIONALIST/ CARDIOLOGY ADVANCED TRAINEE: Name: __________
   Signature: ____________________________
   Date: __________________________________________________________
   Time: __________________________________________________________

☐ I agree for this patient to be discharged post PCI once the milestones in part B and C are met.
☐ Please do not discharge until medical team review for the following reason(s):
__________________________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nil Chest Pain overnight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. High Sensitivity troponin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
  • Post PCI level <150 or
  • If pre PCI peak troponin level >150:
    < 20% increase from peak level |   |           |
| 3. Dual antiplatelet therapy charted |   |           |
| 4. Access site haematoma: <5cm diameter groin OR < 2cm radial |   |           |
| 5. Hb within 10% of baseline |   |           |
| 6. Nil new or acute ECG changes |   |           |

PART C: PATIENT CRITERIA

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>All observations Between the Flags or within acceptable limits for this patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has not required a rapid response for the patient in last 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Discharge checklist completed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________
   Designation: ____________________________
   Signature: ____________________________
   Date: ____________________________
   Time: ____________________________

If patient not Criteria Led Discharged please document reason why:
Name: ____________________________
   Signature: ____________________________