Criteria Led Discharge
Total Shoulder Replacement (TSR)

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 Shoulder Replacement

☐ I agree for this patient to be discharged post TSR 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. Wound & wound dressing clean & dry
3. Cleared by Physiotherapy
4. Cleared by Occupational Therapy
5. 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: ___________________________