Cambridge English for
Nursing
TEACHER'S NOTES

Sample medical charts and forms

Title	*Page*	*Use*
Discharge Form	2	A summary of patient's care while an inpatient. It is sent to the local doctor and/or district nurse to ensure continuity of care (Unit 10).
ECG request form	3	This is ordered if a patient complains of chest pain (Unit 1) and used in the pre-operative check list as part of anaesthetic work-up (Unit 8).
Biochemistry Non-blood request form	4	A request for screening of body fluids other than blood e.g. urine, faeces, semen, cerebrospinal fluid (CSF) and sweat. Various substances are tested in the body fluids. (Unit 5).
Biochemistry and Haematology Request form	5	A Full Blood Count as a general indicator of the patient's health (Unit 2), as an INR (International Normalised Ratio) check when taking warfarin (Unit 8) and to check cholesterol and triglyceride levels when taking cholesterol-lowering medication (Unit 6).
Clinical Microbiology	6	Testing urine specimens for infection (Unit 5).
Laboratory Request Form (UK)	7	A request for particular tests from Pathology (Unit 5).
Laboratory Request Form (Aus)	8	
Cardiac Care Unit	9	Combination of Glasgow Coma Scale chart (Unit 9), Diabetic Chart (unit 4) and Vascular obs. chart - used to assess blood circulation in vascular ulcers (Unit 3). It also notes specialised IV lines, IV cannulas (Unit 7), drains (Unit 9) and catheters (Unit 5).
Day Surgery Follow-up	10	This is used to check on patients after day surgery. A phone call is made to check on pain level, wound status and mobility (Unit 10).
Patient Preparation	11	Information on special preparation needed for certain tests, e.g. bowel prep (Unit 8).

Discharge Form

GP.....

Address.....

.....

GP phone.....

DHA .....

Dear Doctor.....

Your patient identified below was discharged today from Ward .....

Spec.

Surname:	Forename:	Consultant 1	
Casenote No:	District No:	Consultant 2	
DOB:		Date on W List / /	
Address:		Date of Admission / /	
Post code:		Date of Discharge / /	
Home phone:	Work phone:		

Reason for admission	Operation/investigation	Date
.....	.....	.....
.....	.....	.....
.....	.....	.....

TREATMENT AND MANAGEMENT	DIAGNOSIS (1 then 2 etc)
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

DRUG REGIMEN ON DISCHARGE	Child resistant container YES/NO	Inpatient prescription checked .....(pharm. sig.)

Drug (generic name unless brand formulation req.	*Dose*	*Frequency*	*Days supply/ indefinite*	*Pharmacy dispense*
1.....				
2.....				
3.....				
4.....				
5.....				
6.....				
7.....				
8.....				
9.....				

Discharged to: Home/other	If you wish to discuss this patient Please contact Dr .....Bleep..... Signed .....Date .....
Outpatient appointment / / Future planned admission / /	Further summary to be dictated YES/NO

ECG Request Form

HEART AND LUNG UNIT

E.C.G.

Unit No.	S. M. W.	M/F
Name & Address (Surname first)		
Date of Birth	Family Dr.	

Hospital ..... Ward/Department .....

Consultant ..... Results to .....

Diagnosis/Clinical information .....

.....

.....

Drug therapy .....

.....

.....

BP /

Leads requested .....

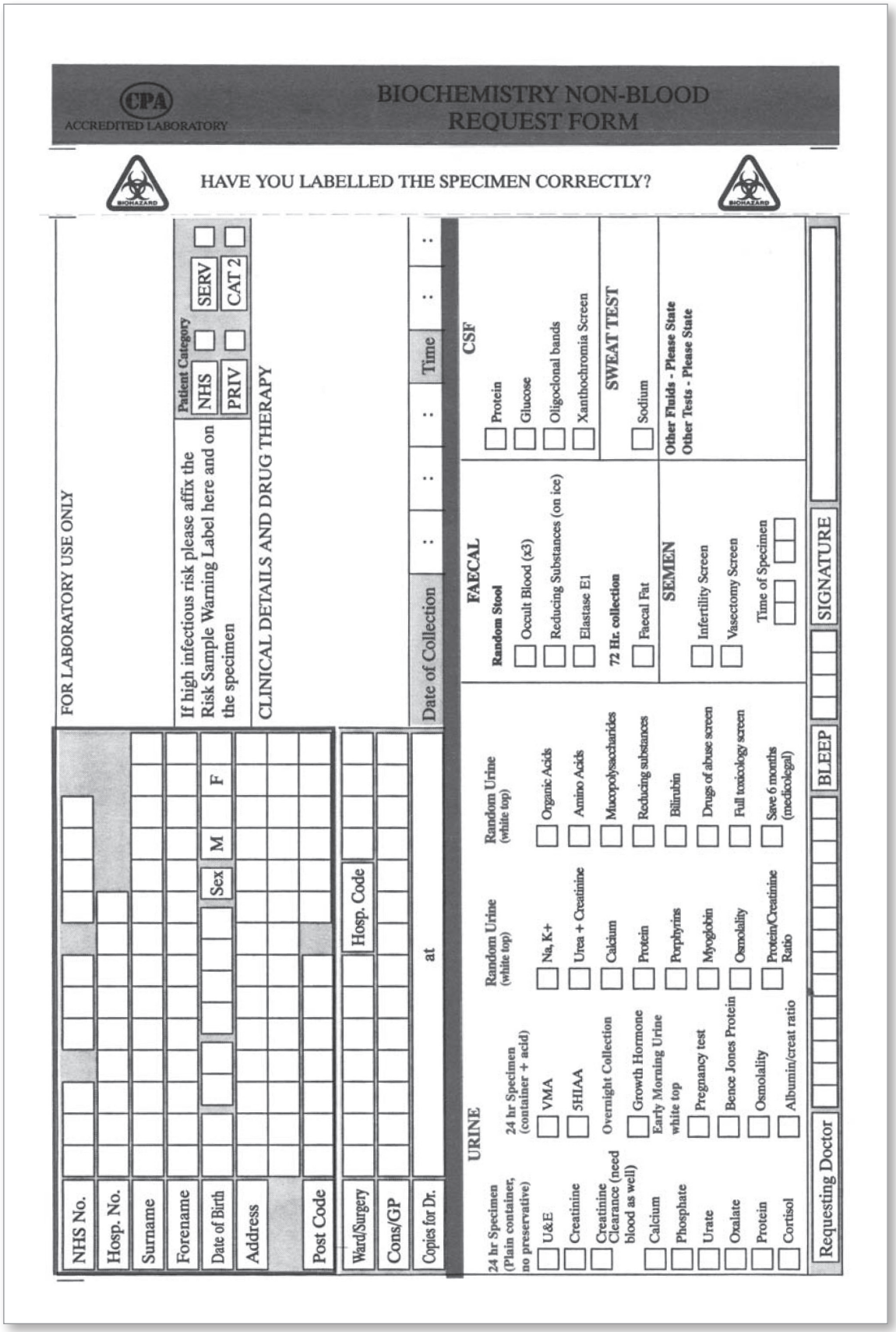
Pacemaker check ☐

Other instructions .....

.....

.....

Date of request ..... Signed .....



CPA ACCREDITED LABORATORY

BIOCHEMISTRY NON-BLOOD REQUEST FORM

HAVE YOU LABELLED THE SPECIMEN CORRECTLY?

BIOHAZARD

FOR LABORATORY USE ONLY

If high infectious risk please affix the Risk Sample Warning Label here and on the specimen

Patient Category: NHS ☐ PRIV ☐ SERV ☐ CAT 2 ☐

CLINICAL DETAILS AND DRUG THERAPY

NHS No.
Hosp. No.
Surname
Forename
Date of Birth
Sex M F
Address
Post Code
Ward/Surgery
Hosp. Code
Cons/GP
Copies for Dr.
at
Date of Collection : : : : Time : :

URINE

24 hr Specimen (Plain container, no preservative)
☐ U&E
☐ Creatinine
☐ Creatinine Clearance (need blood as well)
☐ Calcium
☐ Phosphate
☐ Urate
☐ Oxalate
☐ Protein
☐ Cortisol

24 hr Specimen (container + acid)
☐ VMA
☐ 5HIAA
Overnight Collection
☐ Growth Hormone
Early Morning Urine white top
☐ Pregnancy test
☐ Bence Jones Protein
☐ Osmolality
☐ Albumin/creat ratio

Random Urine (white top)
☐ Na, K+
☐ Urea + Creatinine
☐ Calcium
☐ Protein
☐ Porphyrins
☐ Myoglobin
☐ Osmolality
☐ Protein/Creatinine Ratio

Random Urine (white top)
☐ Organic Acids
☐ Amino Acids
☐ Mucopolysaccharides
☐ Reducing substances
☐ Bilirubin
☐ Drugs of abuse screen
☐ Full toxicology screen
☐ Save 6 months (medicolegal)

FAECAL

Random Stool
☐ Occult Blood (x3)
☐ Reducing Substances (on ice)
☐ Elastase E1

72 Hr. collection
☐ Faecal Fat

SEMEN
☐ Infertility Screen
☐ Vasectomy Screen
Time of Specimen ☐☐ ☐☐

CSF
☐ Protein
☐ Glucose
☐ Oligoclonal bands
☐ Xanthochromia Screen

SWEAT TEST
☐ Sodium

Other Fluids - Please State
Other Tests - Please State

Requesting Doctor | BLEEP | SIGNATURE

CPA
ACCREDITED LABORATORY

BIOCHEMISTRY & HAEMATOLOGY REQUEST FORM

PLEASE ENSURE BOTH COPIES ARE LABELLED
HAVE YOU LABELLED THE SPECIMEN CORRECTLY?

FOR LABORATORY USE ONLY

NHS No.
Hosp. No.
Surname
Forename
Date of Birth
Sex M F
Address
Post Code

If high infectious risk please affix the Risk Sample Warning Label here and on the specimen

Patient Category
NHS PRIV
SERV CAT2

CLINICAL DETAILS AND DRUG THERAPY

Ward/Surgery
Cons/GP
Copies for Dr.
Hosp. Code
at

Date of Collection : : : : Time : :

HAEMATOLOGY (Urgent request 'phone ext. 6492 [QAH] 3243 [SMGH])

- FULL BLOOD COUNT (F)
- ESR (E)
- I.M. SCREEN (GF) (M)
- MALARIA (MALS)
  Please state travel destination & prophylaxis
- INR (on anticoagulants) (I)
  Anticoag Clinic Y N
- INR (OTHER) (I)
- APTR (HEPARIN) (A)
- COAG SCREEN (CS)
- B12 (SB12)
- FOLATE (RF)
- FERRITIN (FER)
- ANTENATAL BOOKING EDD=
- ANTENATAL OTHER VISIT EDD=
- KLEIHAUER TEST

OTHER TESTS

BIOCHEMISTRY (Urgent request 'phone ext. 6348)

- U & E, CREATININE
- LIVER
- BONE
- GLUCOSE (RANDOM)
- GLUCOSE (FASTING) (minimum 12 hours)
- HbA1c
- CREATINE KINASE
- CRP
- THYROID (FT4, TSH)
- CHOLESTEROL
- TRIGLYCERIDE (minimum 12 hours fast)
- HDL-CHOLESTEROL
- URATE
- PROSTATE SPECIFIC ANTIGEN
- IMMUNOGLOBULINS
- PROTEIN ELECTROPHORESIS

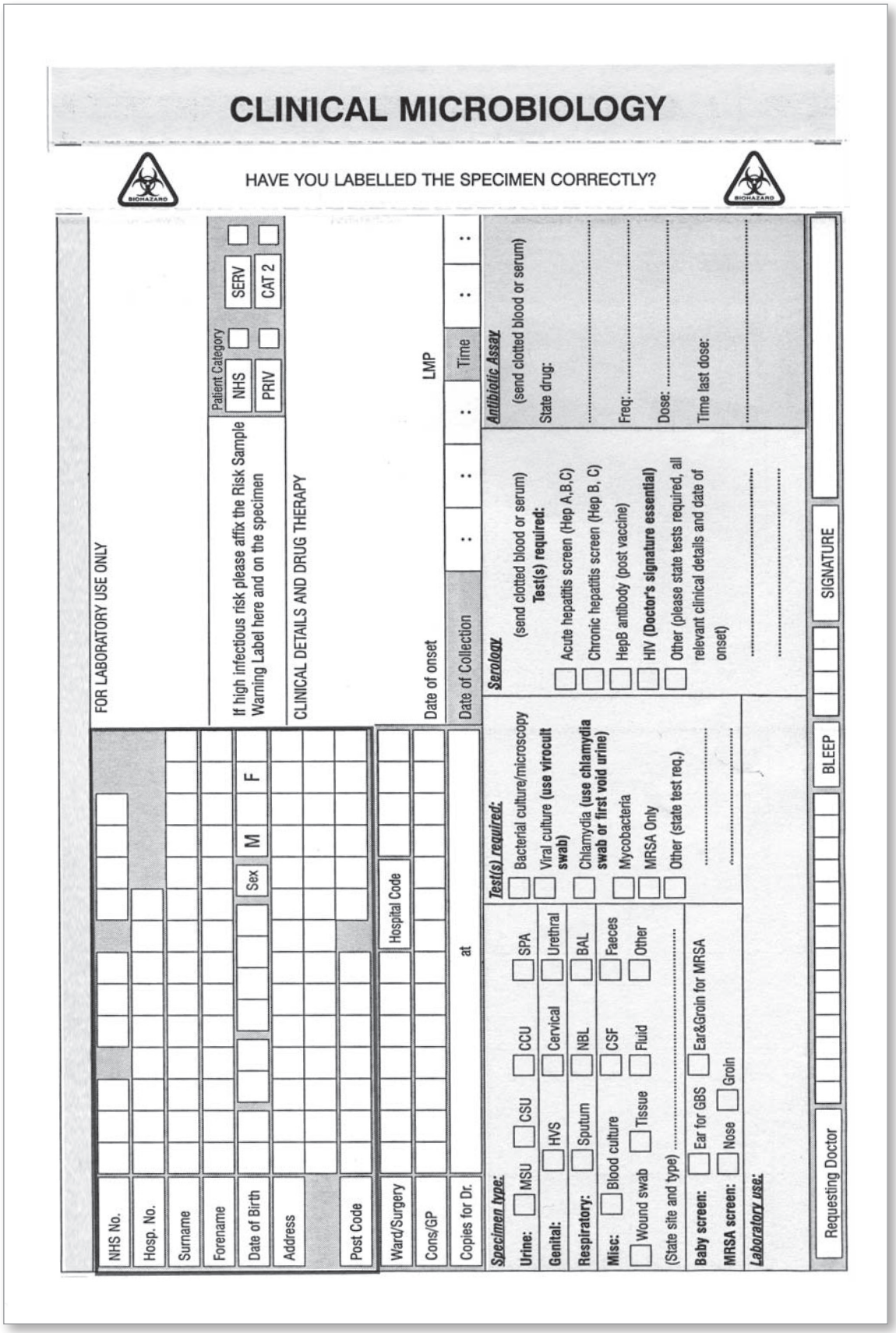
AUTOIMMUNE PANELS

- RHEUMATOID
- LUPUS
- LIVER
- GUT
- VASCULITIS

SPECIFIC TESTS

- Ds DNA ANTIBODIES
- ENAs
- CARDIOLIPIN ANTIBODIES
- ANCA
- COMPLEMENT C3/C4
- THYROID ANTIBODIES

Requesting Doctor BLEEP SIGNATURE



CLINICAL MICROBIOLOGY

HAVE YOU LABELLED THE SPECIMEN CORRECTLY?

FOR LABORATORY USE ONLY

NHS No.
Hosp. No.
Surname
Forename
Date of Birth
Sex M F
Address
Post Code
Ward/Surgery
Hospital Code
Cons/GP
Copies for Dr.
at

If high infectious risk please affix the Risk Sample Warning Label here and on the specimen

Patient Category: NHS PRIV SERV CAT 2

CLINICAL DETAILS AND DRUG THERAPY

Date of onset LMP

Date of Collection : : Time : :

Specimen type:

Urine: MSU CSU CCU SPA

Genital: HVS Cervical Urethral

Respiratory: Sputum NBL BAL

Misc: Blood culture CSF Faeces
Wound swab Tissue Fluid Other
(State site and type) .....

Baby screen: Ear for GBS Ear&Groin for MRSA

MRSA screen: Nose Groin

Laboratory use:

Test(s) required:
Bacterial culture/microscopy
Viral culture **(use virocult swab)**
Chlamydia **(use chlamydia swab or first void urine)**
Mycobacteria
MRSA Only
Other (state test req.) .....
.....
.....

Serology
(send clotted blood or serum)
Test(s) required:
Acute hepatitis screen (Hep A,B,C)
Chronic hepatitis screen (Hep B, C)
HepB antibody (post vaccine)
HIV **(Doctor's signature essential)**
Other (please state tests required, all relevant clinical details and date of onset)
.....
.....

Antibiotic Assay
(send clotted blood or serum)
State drug:
.....
Freq: .....
Dose: .....
Time last dose:
.....

Requesting Doctor BLEEP SIGNATURE

Laboratory Request Form (UK)

Laboratory Request Form

Nature of Specimen and Investigation Required:

Relevant Clinical Data:

Date: Signature

FOR LABORATORY USE ONLY

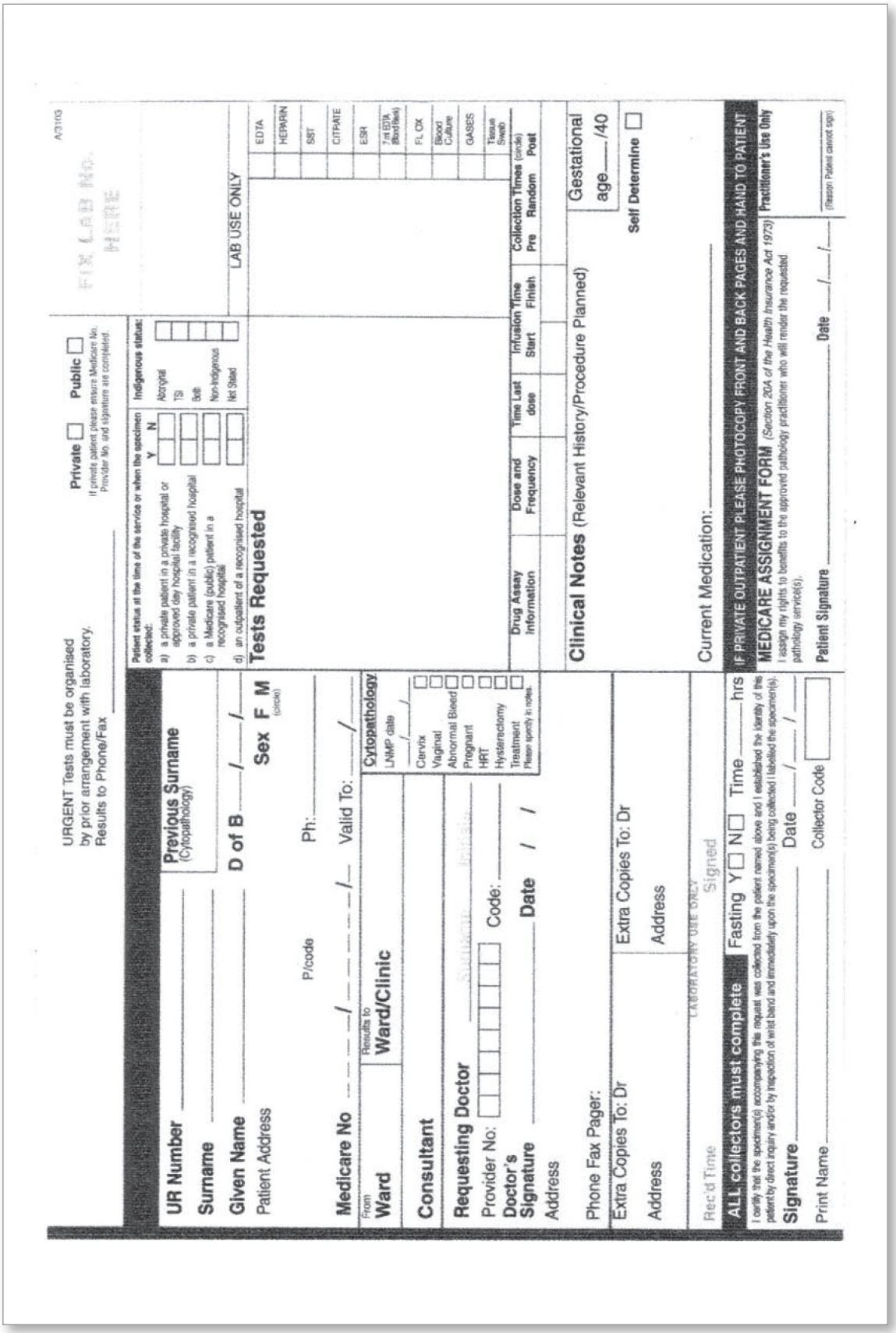
HOSPITALS USE RENADDRESS BELOW

Hospital	Ward, Address or Dept. **Postcode**		SURNAME Block Letters
Sex: M/F	Prev. Tests Yes/No	Dr. or Mr.	First Names
TICK STATUS OF PATIENT	Private		Date of Birth / Hospital No
	N.H.S.		

FOR LABORATORY USE ONLY

Date: Signature: Harlow W10887

Laboratory Request Form (Australia)



URGENT Tests must be organised by prior arrangement with laboratory.
Results to Phone/Fax _____

Private ☐ Public ☐
If private patient please ensure Medicare No. Provider No. and signature are completed.

A/3103

FOR LAB USE

UR Number _____
Surname _____
Given Name _____
Patient Address _____
P/code Ph: _____
Medicare No __ __ __ __ __/__ __ __ __ __ __/__ Valid To: __/__/__

Previous Surname (Cytopathology) _____

D of B __/__/__ Sex F M (circle)

From Ward _____ Results to Ward/Clinic _____

Consultant _____

Requesting Doctor _____ Signature _____
Provider No: ☐☐☐☐☐☐ Code: _____
Doctor's Signature _____ Date / /
Address _____

Phone Fax Pager: _____

Extra Copies To: Dr _____
Address _____

LABORATORY USE ONLY
Recd Time _____ Signed _____

ALL collectors must complete Fasting Y☐ N☐ Time ____ hrs

I certify that the specimen(s) accompanying this request was collected from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band and immediately upon the specimen(s) being collected I labelled the specimen(s).

Signature _____ Date __/__/__
Print Name _____ Collector Code ☐☐☐☐

Patient status at the time of the service or when the specimen collected:

	Y	N
a) a private patient in a private hospital or approved day hospital facility	☐	☐
b) a private patient in a recognised hospital	☐	☐
c) a Medicare (public) patient in a recognised hospital	☐	☐
d) an outpatient of a recognised hospital	☐	☐

Indigenous status:
Aboriginal ☐
TSI ☐
Both ☐
Non-Indigenous ☐
Not Stated ☐

LAB USE ONLY

Tests Requested

Drug Assay Information	Dose and Frequency	Time Last dose	Infusion Time Start	Infusion Time Finish	Collection Times (circle) Pre	Collection Times (circle) Random	Collection Times (circle) Post

Cytopathology
LNMP date __/__/__
Cervix ☐
Vaginal ☐
Abnormal Bleed ☐
Pregnant ☐
HRT ☐
Hysterectomy ☐
Treatment ☐
Please specify in notes.

Clinical Notes (Relevant History/Procedure Planned)

Gestational age ___/40

Self Determine ☐

Current Medication: _____

IF PRIVATE OUTPATIENT PLEASE PHOTOCOPY FRONT AND BACK PAGES AND HAND TO PATIENT

MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973)

I assign my rights to benefits to the approved pathology practitioner who will render the requested pathology service(s).

Patient Signature _____ Date __/__/__

Practitioner's Use Only

EDTA ☐
HEPARIN ☐
SST ☐
CITPATE ☐
ESR ☐
7ml EDTA (Blood Bank) ☐
FL OX ☐
Blood Culture ☐
GASES ☐
Tissue Swab ☐

_____ (Reason Patient cannot sign)

Cardiac Care OBS Chart

Pupils: Reacts / Sluggish / No Reaction	RIGHT	Size	
		Reaction	
	LEFT	Size	
		Reaction	
Record As: R - Right, L - Left	ARMS	Normal Power / Weakness / No Response	
	LEGS	Normal Power / Weakness / No Response	
Eyes	Open Spontaneously 4; Verbal Command 3; Pain 2; No Response 1		
Best Motor Response	Verbal Command Obeys 6; Localises Pain 5; Flexion with Pain 4; Flexion Abnormal 3; Extension 2; No Response 1		
Best Verbal Response	Orientated and Converse 5; Disorientated and Converse 4; Inappropriate Words 3; Incomprehensible Sounds 2; No Response 1		

Date		Urinalysis	
Time		Time	
Blood Glucose		P.H.	
Insulin		Ketones	
Date		Blood	
Time		Glucose	
Blood Glucose		Protein	
Insulin			

Vascular	
Date	
Time	
Colour	
Movement	
Sensitivity	
Pedal Pulse (L)	
Pedal Pulse (R)	
Groin	
Flap	

Plan _____

Tracheostomy
Size:
Date
Arterial Line
Date Inserted
Location
Tranducer
Change date
C.V.P.
Date Inserted
Location
Transducer
Change Date
Venflons
Site
Date
Site
Date
Site
Date
Drains
Site
Date
Site
Date
Site
Date
N.G. Tube
Date
Size
Catheter
Date
Size

Surname: _____

First Names: _____

Age: _____ Sex: _____

Ward: _____ Doctor: _____

Medical Record Number: _____

DAY SURGERY
DAY PROCEDURE
Follow-Up Phone Call Form

1. Instructions for Use:

- Prior to discharge Patients are offered a post-discharge follow-up telephone call to ensure they are experience a satisfactory post-op recovery. The nurse will discuss their recovery progress, including pain management strategies, and assist them with their concerns, providing support and information as required.
- If the patient agrees to the call they should be contacted preferably within 24 hours after discharge but at least within 72 hours post-discharge.
- Allocate a Score of 1 if outcome achieved, if not a variance must be recorded. Enter N/A if the intervention or outcome is not applicable.
- Where relevant any ongoing problems related to the operation/procedure must be referred to the Treating Doctor and in addition the patient may require a 2nd Follow-Up Phone Call.

PROCEDURE / OPERATION: _____

KNOWN ALLERGIES: _____

2. Discharge Details: Date: _____ Time: _____

Follow-Up Phone Call Approved by Patient? **YES / NO** Contact Number: _____

3. Follow-Up Phone Call: Date: _____ Time: _____

Key Criteria	Statement	1st Phone Call	Initial	2nd Phone Call	Initial
Mobility	• Patient ambulates at pre-operative level or has the ability to use aides, (crutches, etc) and has no dizziness				
Hydration/ Elimination	• Patient has no vomiting and minimal nausea, has normal / expected bowel/bladder function and is tolerating diet and fluids				
Pain Management/ Comfort	• Patient states they have minimal or no pain - Score <3/10. Level of pain should be acceptable to the patient, controlled by oral analgesics and consistent with anticipated post-operative discomfort.				
Wounds / Drains	• Wound dressings are dry and intact / minimal ooze.				
	• Patient states there are no signs of inflammation or discharge				
	• Bleeding • P.V. loss minimal / expected				
	• Rectal minimal / as expected				
	• Oral Surgery minimal				
	• No Signs of Fever				
TOTAL SCORE					
VARIANCE / ACTION / OUTCOME					

Nurse responsible for 1st Follow-Up Phone: _____

Signature Print Designation Initials Date & Time (hrs)

Nurse responsible for 2nd Follow-Up Phone Call (if required): _____

Signature Print Designation Initials Date & Time (hrs)

05/07

DAY PROCEDURE FOLLOW-UP PHONE CALL FORM

MR 4.7F

PATIENT PREPARATION

The following are for adult studies. For children, or for patients who you may feel may not cope with the particular preparation, please contact our staff. For any particular diagnostic or clinical problem, please consult one of our radiologists.

If you have a history of significant allergic responses, asthma or diabetes, please tell our reception staff when making your appointment. Medication (to reduce the small risk of an allergic reaction), may be required, which can be picked up from our offices. This will be organised on an individual basis.

X-RAY EXAMINATIONS

PLAIN X-RAYS: No preparation required.

BARIUM MEAL / SWALLOW / SMALL BOWEL STUDY: Nothing by mouth for four hours prior to the examination.

BARIUM ENEMA: Preparation kit and instructions available from our offices. Clear fluid as required.

HYSTEROSALPINGOGRAM: Ideally should be done between the 5th and 10th day of the menstrual cycle.

I.V.P. (I.V.U.): Preparation kit and instructions available from our offices. Nothing by mouth for four hours prior to the examination.

MAMMOGRAPHY: Please do not use talcum powder or deodorant on day of the examination.

MYELOGRAPHY: Clear fluids only for four hours prior to the examination. Overnight stay in hospital is generally required.

ULTRASOUND

ABDOMEN: Fast for 6 hours. Please do not smoke during this period. Take normal medications with a sip of water. *(Note – no milk or soft drinks please).*

RENAL: Clear Fluids only for 6 hours prior to appointment. Drink 500mls finishing at least 30 minutes prior to appointment. Then do not empty your bladder until after the examination.

PELVIS: It is important that you have a full bladder at the time of the examination. Drink 1 litre of clear fluid one hour prior to the appointment time. Then do not empty your bladder until after the ultrasound examination. (Note: Male pelvis – drink 500mls only)

OBSTETRIC ULTRASOUND: A full bladder will be required. Empty bladder one hour prior to the appointment. Drink 500mls of clear fluid over the next half hour. For obstetric ultrasound greater than 20 weeks, a full bladder is not needed.

BREAST, THYROID ULTRASOUND, DUPLEX CAROTID, LEG VEINS, PENILE DOPPLER: No preparation required.

RENAL ARTERIES, ABDOMINAL AORTA DOPPLER: Please fast for 6 hours prior to the examination, with no smoking during this time.

C.T. SCANNING

CT ABDOMEN, CT PELVIS, CT CHEST, CT HEAD: Nothing by mouth for four hours prior to your appointment.

CT LUMBAR SPINE, CT SINUSES: No preparation is required.

MAGNETIC RESONANCE IMAGING

No preparation required. Please inform our receptionist if you have a pacemaker, intracranial aneurysm clip, or inner ear implant, when making your appointment.

NUCLEAR MEDICINE

Please contact either Pindara, Wesley or John Flynn locations for specific preparation.

ANGIOGRAPHY

Clear fluids only for four hours prior to the examination. Patients will need to stay for approximately four hours after the examination.

LIVER BIOPSY, UNDER ULTRASOUND OR CT

Clear fluids only for four hours prior to the examination. Note that you will need to stay in our department for approximately four hours after the procedure.

BONE MINERAL DENSITY

No preparation required.