

**SALISBURY DAY SURGERY UNIT**

**ADMISSION**

Sticky Label
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NAME PERSON COLLECTING  
CONTACT No

NAME EMERGENCY CONTACT  
CONTACT No

**PHONE/CLINIC ASSESSMENT**

DRUGS	HEIGHT	BASELINE MEASUREMENTS
ALLERGIES	WEIGHT	B/P mm/Hg T °C HR BPM

**CARE PLAN**

PROCEDURE	PLAN	INITIALS	
ADMISSION DATE	PRE-OP ASSESSMENT COMPLETED		
TIME	CONSENT FORM SIGNED  SEEN BY ANAESTHETIST  SEEN BY SURGEON		
SPECIFIC CARE (i.e. mobility, hearing, sight, menstruation)			
PROCEDURE	THEATRE CHECKLIST  SKIN SUTURES LA  DRESSING	scrub	handover
RECOVERY	SPECIFIC POST-OP INFORMATION		

