



Urology Prostate Biopsy Service

Date:

NEXT OF KIN: (relationship)		URINALYSIS
Name:		
Contact Number:		

Allergies

Once Only Medications

Date	Time	Drug	Dose	Route	Prescriber's Signature	Time Given	Given By	Pharmacy
	STAT	Ciprofloxacin	500mg	PO				
	STAT	Metronidazole	400mg	PO				

Initial Observations

Pulse:	RR:	Height:
Blood Pressure:	O ₂ Sats:	Weight:
Temperature:	NEWS Score:	BMI:

Past Medical History

Current Medications

Name	Dose	Frequency	Name	Dose	Frequency

Admitting nurse signature:

Admitting nurse name:

Designation:

PATIENT NAME:

DIS NUMBER:

Date:

Post-Operative Nursing Record

Pulse:
 Blood Pressure:
 Temp:
 O₂ sats:
 RR:
 NEWS Score:

Comments:

Discharge Criteria

Urine has been voided	Yes	No
Any Haematuria	Yes	No
Observations stable	Yes	No
GP Discharge letter given to patient	Yes	No
Discharge medication given to patient	Yes	No
Written/verbal discharge instructions given	Yes	No
Patient happy to go home	Yes	No
Signature:	Print name:	Discharge time:

Accountability Register

Date	Print name	Sign	Designation	Initials	Role