

- | | |
|---|--|
| <input type="checkbox"/> Dandenong Hospital | <input type="checkbox"/> Monash Medical Centre - Clayton |
| <input type="checkbox"/> Kingston Centre | <input type="checkbox"/> Monash Medical Centre - Moorabbin |
| <input type="checkbox"/> Jessie McPherson | <input type="checkbox"/> Community Health Services |
| <input type="checkbox"/> Casey Hospital | <input type="checkbox"/> Cranbourne Integrated Care Centre |

Unit Record Number:

Surname

Given Name

D.O.B. Age Sex

Affix Patient Identification Label

ASTHMA CLINICAL PATH FOR CHILDREN AND ADOLESCENTS

NB: Not for use in patients who have Life Threatening Asthma

This Clinical Pathway is designed to assist clinicians by providing a framework of expected care, and should not replace clinical judgement.

ASSESSMENT OF SEVERITY

Mild	Moderate	Severe	Life threatening
<ul style="list-style-type: none"> • Normal mental state • Subtle or no accessory muscle use 	<ul style="list-style-type: none"> • Normal mental state • Minor accessory muscle use 	<ul style="list-style-type: none"> • Agitated • Moderate/marked accessory muscle use 	<ul style="list-style-type: none"> • Confused/drowsy • Maximal accessory muscle use/exhaustion
<ul style="list-style-type: none"> • SpO₂ >95% • Able to talk and/or feed 	<ul style="list-style-type: none"> • SpO₂ 92-95% • Some limitation of ability to talk and/or feed 	<ul style="list-style-type: none"> • SpO₂ <92% • Too breathless to talk and/or feed • Tachycardia[#] • Increased respiratory rate[#] 	<ul style="list-style-type: none"> • SpO₂ <92% • Silent chest • Poor respiratory effort • Altered consciousness • Cyanosis

NB. If a patient has signs and symptoms across categories always treat according to their most severe features

TREATMENT

<ul style="list-style-type: none"> • Salbutamol via MDI & spacer <ul style="list-style-type: none"> • 6 puffs <6 years • 12 puffs ≥6 years 	<ul style="list-style-type: none"> • Consider Oxygen (high-flow) via face mask • Salbutamol via MDI & spacer <ul style="list-style-type: none"> • 6 puffs <6 years • 12 puffs ≥6 years 	<ul style="list-style-type: none"> • Oxygen (high-flow) via face mask • Salbutamol via MDI & spacer <ul style="list-style-type: none"> • 6 puffs <6 years • 12 puffs ≥6 years • Ipratropium bromide <ul style="list-style-type: none"> • 2 puffs <6 years • 4 puffs ≥6 years OR • Salbutamol via nebuliser 5 mg • Ipratropium bromide 0.25 mg 	<ul style="list-style-type: none"> • Oxygen (high-flow) via face mask • Salbutamol via nebuliser 5 mg • Ipratropium bromide 0.25 mg
<ul style="list-style-type: none"> • Consider oral prednisolone 1 mg/kg if episode has persisted over several days 	<ul style="list-style-type: none"> • Oral prednisolone 1 mg/kg 	<ul style="list-style-type: none"> • Oral prednisolone 1 mg/kg OR • IV methylprednisolone 1 mg/kg if oral not tolerated 	<ul style="list-style-type: none"> • IV methylprednisolone 1 mg/kg
<p>Assess response to treatment 15 mins after β₂ agonist</p>	<p>Assess response to treatment 15 mins after β₂ agonist</p> <ul style="list-style-type: none"> • Repeat salbutamol up to every 20 minutes according to response 	<p>Assess response to treatment 15 mins after β₂ agonist</p> <ul style="list-style-type: none"> • Repeat salbutamol every 20-30 minutes including ipratropium bromide up to 3 times in the first hour 	<p>Discuss with a senior clinician, PICU team or paediatrician</p> <ul style="list-style-type: none"> • Repeat salbutamol every 20-30 minutes or continuously including ipratropium bromide up to 3 times in the first hour

Record severity of asthma, respiratory rate, heart rate, oxygen saturation

RESPONSE

<p>RESPONDING</p> <ul style="list-style-type: none"> • Continue bronchodilators as ordered • Discharge when stable on 3-4 hourly treatment • Continue oral prednisolone 1 mg/kg/day for up to 3 days <p>At discharge</p> <ul style="list-style-type: none"> • Ensure stable on 3-4 hourly inhaled treatment • Review the need for regular treatment & inhaled steroids • Review inhaler technique • Provide a written Asthma Action Plan for treating future attacks and letter for GP • Arrange follow up with GP and/or Specialist 	<p>NOT RESPONDING</p> <ul style="list-style-type: none"> • Reconsider diagnosis • Continue salbutamol every 20-30 minutes (or continuous) and arrange HDU/PICU transfer <p>In consultation with senior clinician, consider:</p> <ul style="list-style-type: none"> • Chest x-ray and blood gases • IV magnesium sulphate 40 mg/kg over 20 minutes • IV aminophylline 10 mg/kg loading dose over 60 minutes (maximum dose 500mg) (omit in those receiving oral theophyllines) followed by continuous infusion <9 years 1.1 mg/kg/hour, ≥9 years 0.7 mg/kg/hour • IV salbutamol 5 mcg/kg/min for 60 minutes followed by continuous infusion 1mcg/kg/min
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PEF measurements in children with acute asthma are often unreliable, and their clinical usefulness is unclear.

[#]Normal parameters for Paediatric Vital Signs are given in Annex 5 in the Guidelines.

Based on the Southern Health Evidence-Based Practice Guideline for the Management of Asthma in Children, 2004
Developed after consulting the Royal Children's Hospital Melbourne Clinical Paths for Asthma and The Northern Hospital Paediatric Asthma Clinical Pathway.



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DISCHARGE CRITERIA	Date	Time	Name/initial
• Salbutamol required 3 4 hourly (or more frequently with Specialist authorisation)			
• Parents/carer comfortable with child s condition, discharge instructions and time			

DISCHARGE CHECKLIST All sections must be completed prior to discharge

Medical	Date	Time	Name/initial
Education	• Explanation given about asthma		
	• Symptoms of asthma identified and discussed		
	• Asthma triggers identified and discussed		
	• Medications explained		
Discharge	• Immunisations up-to-date? <input type="checkbox"/> No ordered <input type="checkbox"/> Yes <input type="checkbox"/> No letter to GP <input type="checkbox"/> Other (specify)		
	• Pattern of asthma identified on page 3 as frequent episodic or chronic persistent <input type="checkbox"/> No, inhaled steroid not required <input type="checkbox"/> Yes, on adequate preventer medication <input type="checkbox"/> Yes, inadequate preventer → inhaled steroid commenced/increased		
	• Oral prednisolone commenced for this episode <input type="checkbox"/> No <input type="checkbox"/> Yes → prednisolone to complete 3 day course prescribed		
	• Discharge script sent to pharmacy <input type="checkbox"/> Yes <input type="checkbox"/> Not required		
	• Medical certificate completed <input type="checkbox"/> Yes <input type="checkbox"/> Not required		
	• QUIT information given <input type="checkbox"/> Yes <input type="checkbox"/> Not required		
	• Asthma Action Plan completed and explained		
	• GP identified for patient (online list www.healthforkids.net.au) <input type="checkbox"/> Yes <input type="checkbox"/> Not required		
	• Follow up arranged: <input type="checkbox"/> Paediatrician / Respiratory Physician <input type="checkbox"/> Outpatients <input type="checkbox"/> GP <input type="checkbox"/> Other (specify)		
	• Letter and copy of Action Plan to GP Name: _____ Fax No: _____ Address: _____		
	• Letter and copy of Action Plan to Paediatrician/Respiratory Physician Name: _____ Fax No: _____ Address: _____		
	Nursing		
Education	• Asthma information booklet given		
	• Asthma video viewed		
	• Spacer/delivery devices explained and demonstrated		
	• Patient/parent demonstrates correct spacer/delivery device technique		
Discharge	Peak flow device explained & demonstrated <input type="checkbox"/> Yes <input type="checkbox"/> Not required		
	• Discharge Risk Screen completed (ED Nursing Assessment Sheet)		
	• Discharge Checklist completed (MRE21)		
Referral to Asthma Educator <input type="checkbox"/> Yes <input type="checkbox"/> Not required			
Pharmacy			
	• Discharge medications explained		
	Discharge medications dispensed		
	• Spacer provided <input type="checkbox"/> Yes <input type="checkbox"/> Not required		

ADMISSION DETAILS Complete if patient requires admission to inpatient bed			
<input type="checkbox"/> Patient requires admission	Doctor s Name:	Signature	
<input type="checkbox"/> Bed Bureau, AO or NUM contacted	<input type="checkbox"/> Ward Contacted	Person spoken to:	
<input type="checkbox"/> Salbutamol required one hourly or less frequently	or	<input type="checkbox"/> Agreement with the ward if required more frequently	
Name	Signature	Date:	Time: am/pm

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Affix Patient Identification Label

INITIAL MEDICAL ASSESSMENT

Presenting problem	

Previous episodes	Number of courses of prednisolone in last 12 months:	Number of hospital admissions in last 12 months:
	Number of ED presentations in last 12 months:	Any ICU admissions for asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Trigger factors: <input type="checkbox"/> Infection <input type="checkbox"/> Exercise <input type="checkbox"/> Allergens/Irritants, specify:	

Pattern of asthma	<input type="checkbox"/> Attacks > 6 weeks apart <input type="checkbox"/> Attacks not usually severe <input type="checkbox"/> No nocturnal symptoms <input type="checkbox"/> No daytime symptoms Extra β_2 agonist use: none or sport only <input type="checkbox"/> Infrequent episodic	<input type="checkbox"/> Attacks < 6 weeks apart <input type="checkbox"/> Attacks more troublesome <input type="checkbox"/> Nocturnal symptoms 0-1 night/week <input type="checkbox"/> Daytime symptoms 0-2 days/week Extra β_2 agonist use 0-2 days/week <input type="checkbox"/> Frequent episodic	<input type="checkbox"/> Nocturnal symptoms >1 night/week <input type="checkbox"/> Daytime symptoms >2 days/week Extra β_2 agonist use >2 days/week <input type="checkbox"/> Multiple ED visits/admissions for asthma <input type="checkbox"/> Chronic persistent
	Currently prescribed preventer medication? <input type="checkbox"/> Yes → continue in hospital <input type="checkbox"/> No → commence inhaled steroid		
	Take special care managing children with co-morbid conditions such as chronic lung disease, cardiac conditions, CF etc		

Other relevant history	

Current medication	Drug/ Device	Dose and Frequency	Drug/ Device	Dose and Frequency

Assessment of Severity	<input type="checkbox"/> Normal mental state <input type="checkbox"/> Subtle or no accessory muscle use <input type="checkbox"/> SpO ₂ > 95% <input type="checkbox"/> Able to talk and/or feed <input type="checkbox"/> Mild	<input type="checkbox"/> Normal mental state <input type="checkbox"/> Minor accessory muscle use <input type="checkbox"/> SpO ₂ 92-95% <input type="checkbox"/> Some limitation of ability to talk and/or feed <input type="checkbox"/> Moderate	<input type="checkbox"/> Agitated <input type="checkbox"/> Moderate/marked accessory muscle use <input type="checkbox"/> SpO ₂ <92% <input type="checkbox"/> Too breathless to talk /feed <input type="checkbox"/> Tachycardia <input type="checkbox"/> Increased respiratory rate <input type="checkbox"/> Severe	<input type="checkbox"/> Confused/drowsy <input type="checkbox"/> Maximal accessory muscle use/ exhaustion <input type="checkbox"/> Silent chest <input type="checkbox"/> Poor respiratory effort <input type="checkbox"/> Altered consciousness <input type="checkbox"/> Cyanosis <input type="checkbox"/> Life threatening Remove from path, consult senior clinician, treat as per algorithm

General examination	

Summary	

Doctor's name (print)	Signature	Date	Time	am/pm
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ASTHMA CLINICAL PATH FOR CHILDREN & ADOLESCENTS MRJ21(I)

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INITIAL TREATMENT

If any step omitted (excluding those in italics), provide explanation in notes

	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE	
Medical	<input type="checkbox"/> Salbutamol via MDI & spacer <input type="checkbox"/> 6 puffs <6 years <input type="checkbox"/> 12 puffs ≥ 6 years <input type="checkbox"/> Oral prednisolone 1 mg/kg/day (consider if episode has persisted over several days) <input type="checkbox"/> Treatment explained to patient/parent <input type="checkbox"/> Review 15 mins after treatment Doctor s Name Signature Date Time am/pm	<input type="checkbox"/> Oxygen (high-flow) via face mask (consider if O ₂ saturations <95%) <input type="checkbox"/> Salbutamol via MDI & spacer <input type="checkbox"/> 6 puffs <6 years <input type="checkbox"/> 12 puffs ≥ 6 years <input type="checkbox"/> Oral prednisolone 1 mg/kg/day <input type="checkbox"/> Treatment explained to patient/ parent <input type="checkbox"/> Review 15 mins after treatment Doctor s Name Signature Date Time am/pm	<input type="checkbox"/> Oxygen (high-flow) via face mask <input type="checkbox"/> Salbutamol via MDI & spacer <input type="checkbox"/> 6 puffs <6 years <input type="checkbox"/> 12 puffs ≥ 6 years Ipratropium bromide via MDI & spacer <input type="checkbox"/> 2 puffs <6 years <input type="checkbox"/> 4 puffs ≥6 years OR <input type="checkbox"/> Salbutamol 5 mg and Ipratropium bromide 0.25mg via nebuliser <input type="checkbox"/> Oral prednisolone 1 mg/kg/day <input type="checkbox"/> Treatment explained to patient/parent <input type="checkbox"/> Review 15 mins after treatment Doctor s Name Signature Date Time am/pm	
	Medical	REVIEW AT 15 MINUTES <input type="checkbox"/> Good response <input type="checkbox"/> Observe and prepare for discharge <input type="checkbox"/> Asthma education as per checklist <input type="checkbox"/> Discharge Plan commenced as per checklist <input type="checkbox"/> Review within 1 hour at _____am/pm Doctor s Name Signature Date Time am/pm	REVIEW AT 15 MINUTES <input type="checkbox"/> Good response <input type="checkbox"/> Repeat β ₂ agonist up to every 20 minutes according to response <input type="checkbox"/> Review within 1 hour at _____am/pm Doctor s Name Signature Date Time am/pm	REVIEW AT 15 MINUTES <input type="checkbox"/> Good response <input type="checkbox"/> Repeat β ₂ agonist every 20-30 minutes <input type="checkbox"/> Ipratropium bromide up to 3 times in the first hour <input type="checkbox"/> Review within 1 hour at _____am/pm Doctor s Name Signature Date Time am/pm
		<input type="checkbox"/> Poor response <input type="checkbox"/> Review diagnosis <input type="checkbox"/> Consider O ₂ (high-flow) via face mask <input type="checkbox"/> Consider oral prednisolone 1 mg/kg/day <input type="checkbox"/> Repeat β ₂ agonist up to every 20 minutes <input type="checkbox"/> Review within 1 hour at _____am/pm	<input type="checkbox"/> Poor response <input type="checkbox"/> Review diagnosis <input type="checkbox"/> O ₂ (high-flow) via face mask <input type="checkbox"/> Repeat β ₂ agonist up to every 20 minutes PLUS Ipratropium bromide up to 3 times in first hour <input type="checkbox"/> Review within 1 hour at _____am/pm	<input type="checkbox"/> Poor response <input type="checkbox"/> 20-30 minute (or continuous) β ₂ agonist nebulisers <input type="checkbox"/> Ipratropium bromide up to 3 times in first hour <input type="checkbox"/> Discuss with senior clinician. <input type="checkbox"/> If Life Threatening, LEAVE PATH. Manage as per algorithm

Nursing	<input type="checkbox"/> Plan of care explained	<input type="checkbox"/> Hydration status assessed and managed
	<input type="checkbox"/> Medications given as ordered	<input type="checkbox"/> Fluid Balance Chart if patient <2 years or receiving IV fluids
	<input type="checkbox"/> Observations completed as per chart	<input type="checkbox"/> Other (specify)
	Nurse s name	
Signature	Date	Time am/pm

ADDITIONAL NOTES --Complete as required

	Name (print) & Initial

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Dear Doctor

Your patient presented on: _____ and was discharged on: _____

Clinical setting

- Monash Medical Centre
- Emergency Department
- Dandenong Hospital
- Ward _____
- Casey Hospital
- Intensive Care Unit

Consultant _____

Diagnosis

- Asthma
 - Exacerbation: Mild Moderate Severe
 - Pattern: Infrequent episodic Frequent episodic Chronic persistent
- Probable asthma (diagnosis and pattern not yet fully established)
- Other _____

Treatment

- Inhaled bronchodilator therapy
- Corticosteroids
- Other _____

Details of Discharge Medications are in attached Asthma Action Plan

- Other Discharge Medication prescribed _____

Follow up appointment

- With you in ____ weeks and/or if condition deteriorates or fails to improve significantly within 48 hours. Alternatively they can return to the Emergency Department.
- With Dr _____ in ____ weeks
- In Paediatric Outpatient Clinic in ____ weeks
- In Paediatric Rapid Review Service at Monash Medical Centre on _____
- With Paediatric Asthma Educator at
 - Central Bayside Community Health Service
 - Casey Community Health Service

Immunisation

- Up-to-date for age
- Not up-to-date for age. Immunisations due _____

Other Comments

Name (print) _____ Signature _____ Date _____



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|---|--|
| <input type="checkbox"/> Dandenong Hospital | <input type="checkbox"/> Monash Medical Centre - Clayton |
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Acute Asthma Action Plan for _____

Instructions for this episode of asthma

- Take your **reliever** as often as required until symptoms settle
- See your GP or return to hospital if symptoms are getting worse or not settling
- Remember to continue your usual dose of **preventer** if you have one
- If you have been given **prednisolone**, take the prescribed dose for the next ____ days

Make an appointment to see your GP in the next ____ days

It is important for your GP to see you when you are feeling better to plan your ongoing asthma care and arrange asthma education. Seeing your GP will help you to have fewer asthma symptoms and be in control of your asthma. Take this Action Plan when you go to see your GP.

Preventer treatment

- Not required
- | | | |
|---|-----------------|-----------------------|
| <input type="checkbox"/> Your preventer medication is | Dose (How much) | Frequency (How often) |
| <input type="checkbox"/> Fluticasone ____ mcg | _____ | _____ |
| <input type="checkbox"/> Other (specify) _____ | _____ | _____ |

- If you have been prescribed a preventer you should use it every day
- If your preventer comes in a puffer you should use a spacer when you take it
- You should rinse your mouth after using your preventer

Sport or exercise

- If this usually makes you wheezy, take 2 puffs of your reliever before starting
- You may need to repeat the dose if you also get symptoms during sport

What to do if you get symptoms of asthma in future

(Wheezing, chest tightness, shortness of breath)

- Your reliever medication (blue device) is _____
- For mild symptoms take 2 puffs of your reliever
- For more severe symptoms take up to ____ puffs of your reliever
- Use your spacer if you have one
- Repeat doses as often as you need to
- If you need your reliever more often than every 3 hours, then see your GP or go to hospital
- Don't stop taking your preventer
- If you have been prescribed prednisolone, and you think this is a more severe attack, take the prescribed dose and then see your GP or go to hospital
- If you are having a bad attack or you are worried
- If you need your reliever more than every 3 hours
- If you don't feel any better after using your reliever
- If wheezing lasts more than 24 hours and is not getting better
- **If you are having a very severe attack, call an ambulance and take up to ____ puffs of your reliever every 15-30 minutes**

Your Asthma Action Plan

Keep this plan readily available at all times. Please take this plan and your medications to all doctor's visits. Give copies to others who are involved in the care of your asthma (eg grandparents, crèche, kinder, school).

If you use a spacer, wash it in soapy water at least once a month and let it drip dry.

Written by _____ Signature _____ Date _____

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Revised Asthma Clinical Path Feedback

We want this clinical path to be as useful and easy to use as possible so please give us your feedback!

Compared to your previous practice, did using this clinical path:

- | | |
|---|---|
| 1. | 2. |
| <input type="checkbox"/> Save lots of time | <input type="checkbox"/> Substantially improve patient care |
| <input type="checkbox"/> Save a little bit of time | <input type="checkbox"/> Slightly improve patient care |
| <input type="checkbox"/> Take about the same amount of time | <input type="checkbox"/> Have no impact on patient care |
| <input type="checkbox"/> Take a little more time | <input type="checkbox"/> Slightly worsen patient care |
| <input type="checkbox"/> Take a lot more time | <input type="checkbox"/> Substantially worsen patient care |

Why? _____

Why? _____

Compared to your previous practice, did using this clinical path:

- | | |
|---|---|
| 3. | 4. |
| <input type="checkbox"/> Make your work a lot more straightforward | <input type="checkbox"/> Make it much easier to find the information you need |
| <input type="checkbox"/> Make your work a little more straightforward | <input type="checkbox"/> Make it slightly easier to find the information you need |
| <input type="checkbox"/> Have no effect on your work | <input type="checkbox"/> Have no impact on ease of finding information you need |
| <input type="checkbox"/> Make your work a little more difficult | <input type="checkbox"/> Make it slightly harder to find the information you need |
| <input type="checkbox"/> Make your work a lot more difficult | <input type="checkbox"/> Make it much harder to find the information you need |

Why? _____

Why? _____

5. What sections of this clinical path are not needed and could be removed?

Description of Section	Page Number

6. What could be added to this clinical path to make it easier or more effective to use?

Description	Page Number

Please use the back of this page for other comments about how we can improve this clinical path.

Southern Health

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|---|--|
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Other comments about this Revised Clinical Path

What did you like about it?

What didn't you like about it?

Other thoughts or suggestions?