NAME NHI

DATE OF BIRTH PATIENT LABEL

WARD/UNIT

Placenta Praevia and Suspected Accreta / Percreta Checklist

CLINICAL DETAILS

Date: ____ /____ /____ Time:________________________ Theatre: ________________________________

Proposed Procedure/Plan: ____

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Primary Surgeon: __________________________ Primary Anaesthetist:______________________________

PRE-OP CHECKLIST

Placental Imaging Reviewed:	YES	NO
Uterine Artery Balloons In Situ:	YES	NO
Image Intensifier Operating Table:	YES	NO
Consent (including massive transfusion and hysterectomy):	YES	NO
Cross Matched Blood Available:	YES	NO
Anaesthetic Equipment Ready (cell saver, rapid infuser etc):	YES	NO

STAFF and SERVICES (strike out if not required)

Delivery Unit / HDU	Name: ______________________	Date: _______________	
L9 Theatre Co-ordinator	Name: ______________________	Date: _______________	Phone: 021 471 618
Anaesthesia Co-ordinator	Name: ______________________	Date: _______________	Phone: ________________
Interventional Radiologist	Name: ______________________	Date: _______________	Phone: ________________
Image Intensifier Booked	Name: ______________________	Date: _______________	Phone: ________________
Urologist	Name: ______________________	Date: _______________	Phone: ________________
Vascular Surgeon	Name: ______________________	Date: _______________	Phone: ________________
General Surgeon	Name: ______________________	Date: _______________	Phone: ________________
Gynae Oncologist	Name: ______________________	Date: _______________	Phone: ________________
Blood Bank	Name: ______________________	Date: _______________	Phone: 24015 or 24014
DCCM Informed	Name: ______________________	Date: _______________	Phone: 24800
NICU / Paeds Informed	Name: ______________________	Date: _______________	Phone: ________________
Level 8 Co-ordinator	Name: ______________________	Date: _______________	Phone: 021 492 086

NOTES

PLACENTA PRAEVIA and SUSPECTED ACCRETA / PERCRETA