Placenta Praevia and Suspected Accreta / Percreta Checklist

MUST ATTACH PATIENT LABEL HERE
SURNAME: ___________________ NHI: __________
FIRST NAMES: _______________ DOB: __________
Please ensure you attach the correct visit patient label

CLINICAL DETAILS
Date: ___ / ___ / ______ Time: ______________ Theatre: _________________________
Proposed Procedure/Plan: ___________________________________________________________________
_________________________________________________________________________________________
Primary Surgeon: _______________ Primary Anaesthetist: _______________________

PRE-OP CHECKLIST
Placental Imaging Reviewed: □ YES □ NO
Uterine Artery Balloons In Situ: □ YES □ NO
Image Intensifier Operating Table Tble: □ 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: ______ Phone: 021 471 618
L9 Theatre Co-ordinator Name: _______________ Date: ______ Phone: ______________
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