

Clinical Criteria for Discharge (CCD)

Patient's name: Hospital No:

Consultant:

Date CCD agreed:/...../..... Time::..... hrs

CCD completed by Dr (print name) Signature:

The patient will be clinically ready for discharge if the following criteria are met. If there has been no change to their condition, they can safely be discharged with no further medical review required:

1.
2.
3.

Follow up plan and any other comments:

If criteria are not met or results are outside agreed parameters, further medical review must be sought.

eDAN completed by (Print):

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Date:/...../..... Time::..... hrs

CCD met: Date:/...../..... Time::..... hrs

Discharged by (assessing nurse name and signature):

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