Patient-held OPAT Plan

NHS
Greater Glasgow and Clyde

Name: _____

Date of birth: _____

CHI number: _____

Diagnosis: _____

Antibiotic: _____

Type of venous access device e.g. cannula, PICC: _____

Date of discharge from hospital or starting OPAT: _____

Planned number of days of antibiotics via the vein: _____

On Monday to Friday appointments will be on Ward 1C, on Saturday and Sunday appointments will be on the Clinical Decision Unit (CDU).

Date and time of first OPAT appointment: _____

Date of next planned medical review and blood tests (if required): _____

Team looking after my child: _____

Consultant looking after my child: _____

Contact details for the team looking after my child: _____

9am to 5pm: _____

5pm to 9pm (and overnight): _____

For staff: Please give a copy to the parent or carer and scan and upload to Clinical Portal

Paediatric outpatient parenteral antibiotic therapy (pOPAT) Parent or carer declaration

I am happy to look after my child at home. ☐

I can bring my child to the hospital for their appointments, or at other times if needed. ☐

I know when and where to bring my child to for their appointments. ☐

I have read and understood the pOPAT patient information leaflet. ☐

I know how to look after the cannula, PICC or other venous access device. ☐

I understand what to look out for and what to do if I am worried about my child at home. ☐

I know how to contact the doctors looking after my child. ☐

I am happy that my questions about pOPAT have been fully answered. ☐

If you agree with the statements above, please initials the boxes and sign below.

Patient name: _____

Date of birth: _____ CHI Number: _____

Parent or guardian name: _____

Signature: _____

Date: _____

Doctor's name: _____

Signature: _____

Date: _____

For staff: Please scan and upload to Clinical Portal