health
Department:
Health
REPUBLIC OF SOUTH AFRICA

# Maternity Care
# Peri-operative record

**This record must be completed for all person's requiring surgery during pregnancy or the puerperium. Once completed, it must be placed within the Maternity Case Record to be filed at the hospital where the delivery took place. Procedures done at a facility where delivery did not occur must be filed in the patient records. Use a new record for every operation.**

Name and ID number of patient or place large patient sticker here

Name of medical practitioner booking the procedure

**Procedure:** ☐ Caesarean section ☐ Tubal ligation ☐ Laparotomy ☐ Emergency hysterectomy

☐ Other _____

**URGENCY OF PROCEDURE (select only 1)**

☐ RED: Immediate delivery (life threatening to mother and/or fetus)

☐ YELLOW: Urgent delivery (Maternal/fetal compromise not immediate life threatening)

☐ GREEN: Scheduled urgent delivery (need early delivery but no maternal/fetal compromise)

☐ ELECTIVE Scheduled at a time to suit mother/staff

Best describe the reason/indication for the caesarean section/ procedure:

| **Booking arrangements** |
|---|
| Discussed case with senior colleague/consultant (name and time): |
| Discussed with anaesthetic doctor (name and time): |
| Discussed with neonatal staff (name and time): |
| Date and time procedure scheduled: |

| URGENCY OF CAESAREAN DELIVERY (examples) | | | |
|---|---|---|---|
| | RED<br>Emergency- immediate threat to life of person or her fetus | YELLOW<br>Maternal or fetal compromise which is not immediately life threatening | GREEN<br>Needing early delivery, but no maternal or fetal compromise) |
| Target time (decision to incision) | Ideally within 30 minutes | Ideally within 60 minutes | Ideally within 3 hours |
| Fetal condition (examples) | Fetal distress (pathological CTG) | Suspicious CTG | Fetal anomaly or compromise that need daytime delivery for paediatric management (arrange necessary skilled team as needed) |
| | Cord prolapse | Cord presentation; patient in labour | |
| | Footling breech- with ruptured membranes | Footling breech, membranes still intact, patient in labour | |
| Clinical presentation (examples) | Abruptio placentae; baby alive and viable | Poor progress in labour | Eclampsia, failed induction of labour or vaginal delivery not possible |
| | Placenta praevia- massive bleeding | Unsuccessful attempt at VBAC | Failed induction of labour: urgent indication for delivery |
| | Uterine rupture/dehiscence | Cephalo-pelvic disproportion | 2 or more previous CS/previous classical CS in early labour |
| | Transverse lie, in labour | Prolonged second stage | One previous CS, patient not for VBAC, in early labour |
| | Abandoned instrumental delivery | Twin pregnancy; delivery of second twin | Any GREEN indication presenting In active labour |
| Maternal condition | Severe maternal disease | | |

**IMPORTANT INFORMATION FOR ANAESTHETIC TEAM:**

| | | |
|---|---|---|
| Haemoglobin: | NPO since: | Latest platelet count if pre-eclampsia: |

<u>Maternal medical condition (select all that is applicable)</u>

☐ Healthy
☐ Severe pre-operative blood loss (antepartum haemorrhage)
☐ Abruptio placentae
☐ Placenta praevia
☐ Morbidly adherent placenta
☐ Pre-eclampsia
☐ Decreased level of consciousness
☐ Acute severe hypertension
☐ Maternal diabetes
☐ BMI 40-50
☐ BMI >50
☐ Cardiac disease
☐ Active respiratory disease
☐ Currently on $MgSO_4$
☐ Currently on anti-coagulative drugs
☐ Allergies: _____
☐ Medical history _____
☐ Surgical history_____
☐ Other _____

# WARD PREPARATION FOR THEATRE AND TRANSFER

**Planned procedure**

**Procedure date/time** **Pickup date/time**

**Known allergies**

| | WARD | | | Theatre | | |
|---|---|---|---|---|---|---|
| | Yes | No | N/A | Yes | No | N/A |
| Informed consent signed | | | | | | |
| Medical alert band/ chain in situ | | | | | | |
| Make-up/varnish removed | | | | | | |
| Artificial nails removed | | | | | | |
| Jewelry removed | | | | | | |
| Dentures removed | | | | | | |
| Contact lenses removed | | | | | | |
| Patient is nil per mouth since ___h__ | | | | | | |
| Dressed in theatre garment | | | | | | |
| Urine catheter in-situ | | | | | | |
| List pre-medication drugs: | | | | | | |
| Premed administered by | | | | | | |
| Signature | | | | | | |
| Patient prepared by | | | | | | |
| Signature | | | | | | |
| Date /time | Left ward | | | Arrive OT | | |
| Received in theatre by | | | | | | |
| Signature | | | | | | |

| Vital signs on arrival OT | | Documents received OT | |
|---|---|---|---|
| Blood pressure | | | Maternity case record book |
| Pulse | | | Prescription chart |
| Respiration rate | | | Laboratory results |
| Urine disptix | | | X-Rays |
| Catheter | | | |
| Fetal heart | | | |

# CONSENT TO MEDICAL OR SURGICAL PROCEDURE

**I, Dr _____ have explained the nature, risks & possible consequences of the medical /surgical procedure to the undersigned patient or her legal guardian.**

**Signature** _____ **Date** _____

**Circle whichever is applicable**

| | | |
|---|---|---|
| **Procedure explained:** | Personally | Via Interpreter |

**NATURE OF PROCEDURE:**

_____

_____

**Where applicable indicate side of procedure (Right or Left)**

**Circle whichever is applicable**

| | | | | |
|---|---|---|---|---|
| **Type of anaesthetic:** | Local | Spinal | General | Procedural Sedation |

**CONSENT TO USE OF BLOOD and/or blood products if necessary during the course of the procedure**

**Consent granted by Patient/Guardian :** _____ **Signature**

**Consent withheld by Patient/Guardian:** _____ **Signature**

**I consent to a sample of my blood being taken and tested for Hepatitis B and the Human Immunodeficiency Virus (HIV) should contamination of a health care worker by my bodily fluids occur during the procedure.**

**Patient's / Guardian's Signature** _____

| | |
|---|---|
| **Full Name of Patient** | |
| **Signature/Thumb** **Date**<br>**Print of patient** | **I, the undersigned, hereby consent to the performance of, and understand the nature, risks and possible outcomes of the above procedure. The doctors who perform the above may carry out additional or alternative measures (including general anaesthesia) if considered necessary. In the case of a sterilisation procedure, I understand that pregnancy may occur in exceptional cases, in which case I shall not hold the Department of Health and/or its personnel responsible. I also accept that alternative methods of birth control are still available to me.** |

**COMPLETE THIS SECTION IF CONSENT IS GIVEN BY A PERSON ON BEHALF OF THE PATIENT**

**Print Name** _____

**Signature** _____ **Date** _____

**Relationship to patient** _____

**Means by which consent was given:** **Personally** **Telephonically**

**NAMES AND SIGNATURES OF WITNESSES TO THE PATIENT'S / GUARDIAN'S SIGNATURE ON THIS DOCUMENT**

| **Witness 1** | **Witness 2** |
|---|---|
| **Print Name** _____ | **Print Name** _____ |
| **Signature** | **Signature** |

# CONSENT TO CAESAREAN DELIVERY

**NATURE OF PROCEDURE: CAESAREAN SECTION***

Contact details (if patient wishes to discuss options later) .....

| | | | |
|---|---|---|---|
| I have introduced myself by name and explained the nature, risks and possible consequences of a caesarean delivery to the undersigned patient or person legally competent to give consent. In particular, I have explained the following: | Print name | | NAME OF DOCTOR (To be filled in by a registered health professional with appropriate knowledge of the proposed procedure) |
| | Signature | Date | |

**Intended benefit:**
Delivery of her baby (or babies) through a cut in the tummy and the uterus (womb) in a situation where the risks of the baby being born through the vagina is more than the risk of the delivery by Caesarean section.
**Frequent risks:**
Bleeding during or after the operation, infection in the wound or in the womb (sepsis), persistent pain and discomfort over the scar, risk of repeat caesarean delivery in following pregnancies, re-admission to hospital, minor cuts to the baby during delivery.
**Serious risks (uncommon):**
Emergency requiring removal of the womb (hysterectomy), increased risk of a tear in the womb in future pregnancies, development of a blood clot in the legs or lungs, injury to the bladder or bowel.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

| | | | |
|---|---|---|---|
| THE PROCEDURE WILL INVOLVE (one or more): | General anaesthesia ☐ | Regional anaesthesia (epidural or spinal) ☐ | Local anaesthesia ☐ |

| | |
|---|---|
| CONSENT TO USE OF BLOOD and/or BLOOD PRODUCTS<br>I grant consent ☐ I withhold consent ☐ Signature_____ | I have counselled the patient on the use and dangers of blood products and the undersigned patient hereby Grants or Withholds consent for the use of blood and/or blood products should it become necessary during the procedure.<br>TICK the appropriate box |

I, the undersigned patient hereby agree that a sample of my blood can be taken and tested and tested for Hepatitis B and Human Immunodeficiency Virus (HIV) should an incident of contamination of a health care worker by bodily fluids occur during the procedure.
TICK whichever is applicable. I agree ☐ I do not agree ☐

| | | |
|---|---|---|
| FULL NAME OF PATIENT ..... | | I, the undersigned, hereby consent to the performance of, and understand the nature, risks and possible consequences of the above procedure. The doctors who perform the procedure may increase the reasonable scope thereof or carry out additional or alternative measures (including general anaesthesia) if considered necessary. |
| SIGNATURE or THUMB PRINT OF PATIENT | Date | |

| | | | | | |
|---|---|---|---|---|---|
| PERSON LEGALLY COMPETENT TO GIVE CONSENT | Print name | | | | This section to be filled in if a person other than the patient gives consent. |
| | Signature | | | Date | |
| | Capacity or relationship to patient | | | | |
| | Means by which consent was given | Personally ☐ | Telephonically ☐ | Other: | |

| | | |
|---|---|---|
| WITNESS 1 | Print name | Names and signatures of witness to the signing of this document by the patient or a person legally competent to give consent on behalf of the patient. |
| | Signature | |
| WITNESS 2 | Print name | |
| | Signature | |

*A separate consent form should be used for sterilisation procedures.
*A separate consent form should be used if any additional procedures are planned during the time of the Caesarean section (e.g. hysterectomy).

**OBSTETRIC ANAESTHETIC RECORD**

Proposed Operation:

Surgeon: Grade:

Details of Anaesthetist

Name and

HPCSA nr and highest qualification

Date Consent obtained

Grade: Intern ☐ Comm. Service MO ☐ GP/MO < 2 years ☐ GP/MO ≥ 2 years ☐ Registrar ☐ Specialist ☐

Nil by mouth since (Time): What was eaten/drunk?

**History:**

Previous Anaesthetic History:

Medication: Allergies:

**General Examination:** Height (m) ☐ Mass (kg) ☐ BP ☐ Pulse ☐

Heart:

Chest:

**Airway Examination:** **Mallampati Score:** ☐

Jaw mobility ☐ Loose/awkward teeth: Yes ☐ No ☐ Pharynx: Neck:

ASA rating **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **E** ☐

**Investigations:**

Hb ☐ Platelets ☐ Urea & Electrolytes:

Chest X-Ray: Normal ☐ Abnormal ☐

Details:

Urine:

Other:

| **Premedication:** | | To be given at: | Ordered by | Given at: | By |
|---|---|---|---|---|---|
| 0.3 Molar sodium citrate 30 mL per os | ☐ | | | | |
| Metoclopramide 10 mg iv | ☐ | | | | |
| Ranitidine 150 mg per os | ☐ | | | | |
| Other: | | | | | |

Pre-anaesthesia check: Freely running iv ☐ Suction ☐ Machine check ☐

Technique: Spinal ☐ Epidural ☐ CSE ☐ General ☐ Sedation ☐ Standby ☐

**Regional anaesthesia:**

Spinal interspace:

Number of attempts

Position of patient: Lateral ☐ Sitting ☐

Spinal needle: Type: ☐ Atraumatic ☐

Size (gauge) ☐

Epidural needle: Type: Tuohy ☐ Other ☐

Size (gauge) ☐

Epidural space location:

Loss of resistance: To air ☐ To saline ☐

Other (describe) ☐

Epidural catheter: Size (gauge) ☐

Length within epidural space (cm) ☐

Sensory height (to cold) of block pre-incision:

**General anaesthesia:** Induction sequence: Preoxygenation ☐ Cricoid pressure ☐

Laryngoscopy and rapid tracheal intubation with a cuffed tube ☐

Check stomach ☐ Size of tracheal tube (mm) ☐

Air Entry: L ☐ R ☐ Length inserted (cm) ☐

**Alternative airway management:**

Face mask ☐

Laryngeal mask ☐

Awake intubation** ☐

Surgical airway ☐

Combitube Other ☐

(specify) ☐

**Ventilation:**

Spontaneous ☐

Controlled ☐

Circuit:

Ventilator:

$FiO_2$:

$O_2$/Air ☐

$O_2$/Nitrous Oxide ☐

** Details:

Remarks and Complications

**OBSTETRIC ANAESTHETIC RECORD**

| Time: | | | | | Times: | |
|---|---|---|---|---|---|---|
| **Drugs:** | | | | | Induction (I) | |
| Prophylactic antibiotics: | | | | | Uterine incision (U) | |
| Oxytocin | | | | | Cord clamp (D) | |
| Other uterotonics | | | | | I-D (min.) | |
| | | | | | U-D (sec.) | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Agent % (Inspired) | | | | | | Totals: |
| **IV Fluids:** | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **Blood Loss:** | | | | | | |
| **Urine output:** | | | | | | |

**Monitoring** every 5 mins:

- ECG
- Oximetry
- Capnograph
- NIBP
- CVP
- Arterial line
- N-M block
- Urine
- Temp
- $PIP_{(AW)}$
- $O_2$ Analyser

**Position:**

- Supine tilt
- Wedge
- Other
- Lithotomy
- Trendel.

SBP v Sat %
DBP ^ $ET_{CO2}$
HR • CVP
CVP × T °C
$FiO_2$

210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

**Recovery Room Record**

| Time | BP | Pulse | Respiratory pattern and rate | Output | | | Drugs & iv therapy | State of con-sciousness | Signature |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Urine | Vomitus | Wound | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Bromage score at admission to recovery room: _____

Bromage score on discharge from recovery room: _____

1 = Complete block (unable to move feet or knees)
2 = Almost complete block (able to move feet only)
3 = Partial block (just able to move knees)
4 = Detectable weakness of hip flexion (between scores 3 and 5)
5 = No detectable weakness of hip flexion while supine (full flexion of knees)
6 = Able to perform partial knee bend

| | |
|---|---|
| Complications in recovery room | |
| Transfer from recovery room authorised by | Time |
| Transferred to ward | Time |
| Received by | Time |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| OPERATION | **INTRA-OPERATIVE RECORD** | | | | | | | |
| | **NB: Complete or mark in space given** | | | | **THEATRE NR:** | | | |
| | Operation Time: | | From: | | To: | | Duration: | |
| | Type of Anaesthesia: | | | | Anaesthetist: | | | |
| | Surgeon: | | | Assistant: | | | | |
| | **SECTION: B - SURGEON COMPLETES THIS SECTION** | | | | | | | |
| | **Nature of Operation:** | | | | | | | |
| | Surgeon: | Name in Print: | | Signature: | | | Qualification: | |
| | Procedure code: | | | | | | | |
| | **SECTION C: PROFESSIONAL NURSE COMPLETES THIS SECTION** | | | | | | | |
| INTRAOPERATIVE PATIENT CARE | **PATIENT POSITION:** | **(MARK x)** | Supine | | Prone | | Lithotomy | |
| | Left Lateral | | Right Lateral | | Trendellen-burg | | Oher | |
| | **BONY PROMINENCES** | Checked: | YES: | NO: | Padded: | | YES: | NO: |
| | **WARMING BLANKET** | YES: | NO: | | | | | |
| | **ANY ABNORMALITIES OBSERVED** (Describe shortly) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | **DIATHERMY:** | **Diathermy used** | | YES: | NO: | **Checked** | YES: | NO: |
| | **Plate site:** | **ARM:** | **LEG:** | **OTHER:** | LEFT: | | RIGHT: | |
| | **WOUND CLASSIFICATION:** | | | | CLEAN: | | | |
| | INFECTED: | | CONTAMINATED: | | | CLEAN CONTAMINATED: | | |
| | **SKIN PREPARATION** | | | | | Chlorhexidine in Water | | |
| | Chlorhexidine in Alcohol | | Povidone-iodine | | | Other: | | |
| | **INFILTRATION** | YES: | NO | Type: | | | | |
| | **X-RAYS USED:** | YES: | NO | C-Arm used | | YES: | NO | |
| | | | | Contrast used | | YES: | NO | |
| | **SWAB/INSTRUMENT/SHARP CONTROL**<br>We, the undersigned, hereby declare that the instruments, needles and swabs in respect of the above-mentioned operation were counted before, during and after the operation and that the totals were found correct. | | | | | | | |
| | | **COMPLETE** | | **TOTAL:** | **N.A.** | **PLUGS:** | | |
| | | **YES** | **NO** | | | | YES: | NO: |
| | Abdominal | | | | | Type: | | |
| | Raytec | | | | | Size: | | |
| | Dissecting | | | | | **Tapes/Other** | YES: | NO: |
| | Other | | | | | Type: | | |
| | | | | | | **Clips** | YES: | NO: |
| | | | | | | **SKIN SUTURE** | | |
| | | | | | | | | |
| | **CATHETERS/ DRAINS** | | | **YES:** | **NO:** | **SIZE:** | | |
| | Urine | | | | | | | |
| | Nasal tube | | | | | | | |
| | Thoracic drain | | | | | | | |
| | Pensil drain | | | | | | | |
| | Other | | | | | | | |

## INTRA-OPERATIVE RECORD CONTINUED

**NB: Mark applicable given spaces**

### Unplanned events

| | | | | | |
|---|---|---|---|---|---|
| **UNUSUAL INCIDENT REPORT WRITTEN?** | | **YES:** | | **NO:** | |

**Intraoperative bleeding**

| Source of bleeding | Blood Loss |
|---|---|
| | |
| | |

| | | | | | |
|---|---|---|---|---|---|
| **ROUTE CHART COMPLETED:** | | **YES** | | **NO** | |

### INTRA-OPERATIVE

| | | | | | |
|---|---|---|---|---|---|
| **SPECIMEN OBTAINED** | YES: | NO: | | NUMBER: | |

| | |
|---|---|
| TYPE: | |

| **OPERATING TEAM MEMBERS:** | **NAME IN PRINT** | **SIGNATURE** |
|---|---|---|
| **REGISTERED SCRUB NURSE:** | | |
| **SUPERVISOR: (If theatre student/ new PN)** | | |
| **CO-CHECKER/ CIRCULATING NURSE:** | | |
| **ANAESTHETIC NURSE:** | | |

### POST-OPERATIVE

**POST OPERATIVE CHECKLIST**

| | | | | |
|---|---|---|---|---|
| Post-operative skin/pressure areas check: | Intact | | Skin Lesion: | |

| | |
|---|---|
| Short description of skin lesion: | |

**PATIENT TRANSFERRED TO: (Date/Time)**

| | | | |
|---|---|---|---|
| RECOVERY ROOM | | | |
| | | | |
| | | | |
| | | | |

Professional authorising release of patient from theatre

| Date/Time | Name | Signature |
|---|---|---|

Professional receiving patient from Theatre

| | Date/Time | Name | Signature |
|---|---|---|---|
| WARD: | | | |
| CRITICAL CARE: | | | |
| HIGH CARE: | | | |

**COUNSELLING CHECKLIST PRIOR TO POST PARTUM TUBAL LIGATION**

For persons capable of signing their own consent

**I have discussed the following with this person:**

- Her reason for choosing sterilization.
- Alternative long acting effective contraceptive methods.
- Sterilisation is a permanent and irreversible method of contraception.
- Stability of relationship and possibility of regret due to change in circumstances, such as possible loss of child/children/partner or remarriage.
- Consider option of male or female sterilization. (Male procedure is smaller, safer and more effective).
- The sterilization procedure. Local or general anaesthetic, surgical approach, type of tubal closure.
- Risk of anaesthesia/surgery and possibility of additional surgery if complications occur.
- The risk of failure: 1 in 200 lifetime risk of pregnancy in a female
- If pregnancy occurs after sterilisation, there is a slight risk of ectopic pregnancy and the symptoms to report are lower abdominal pain, missed period and irregular bleeding.
- The menstrual cycle will revert to what it was before pregnancy.
- No effect on long term health.
- Sterilisation does not protect against STI/HIV transmission.
- I have answered the person's questions and given a pamphlet

Date _____ Counselled by _____

I, (patient name) .....

with ID/Passport/other number.....

Hereby states that I have requested a sterilisation (permanent family planning).
This was my own choice and I was not forced to make this decision.
I understand that I will not be able to have any pregnancies in the future and that the operation is permanent.

Signed (patient).....

Witness 1.....

Witness 2

Page intentionally left blank

# CAESAREAN DELIVERY SAFETY CHECKLIST

| SIGN IN (To be said out loud before induction of anaesthesia) | TIME OUT (To be said out loud before skin incision) | SIGN OUT (To be said out loud before patient leaves the operation room) |
|---|---|---|
| Patient has confirmed<br>☐ Identity<br>☐ Procedure<br>☐ Consent | ☐ Confirm all team members have introduced themselves by name and role | Practitioner verbally confirms with the team:<br>☐ Name of the procedure and any additional procedure has been recorded?<br>☐ Instruments, swabs and sharp counts are correct?<br>☐ Specimens have been labelled?<br>☐ Blood loss has been recorded? |
| ☐ Anaesthesia safety check completed (Equipment and medication) | To Surgeon<br>Are there any potential problems the team should be aware of?<br>☐ No ☐ Yes<br>☐ Mothers rhesus status known<br>Does cord blood need to be taken?<br>☐ No ☐ Yes | |
| ☐ Neonatal safety check completed (Equipment and medication) | | |
| ☐ Pulse oximeter on patient and functioning | | |
| Is a difficult airway anticipated?<br>☐ No ☐ Yes and equipment and assistance is available | | |
| Does patient have a known allergy<br>☐ No ☐ Yes | To Anaesthetist:<br>☐ Wedge placed?<br>☐ Any patient specific concerns? | Obstetrician, Anaesthetist and Scrub Nurse have discussed:<br>☐ Concerns for recovery and further management?<br>☐ Need for post-operative VTE prophylaxis?<br>☐ Need for postoperative antibiotics?<br>☐ Equipment problems that have been identified?<br>☐ Oxytocin 20 IU in 1000mls IVI ready to be administered |
| Assess bleeding risk (Pre op Hb ……..…g/dl)<br>Risk factors for PPH. ☐ No ☐ Yes<br>(i.e. prolonged labour, multiple pregnancy, big baby, polyhydramnios, grand multiparity, clotting dysfunction, PPH in the past). If yes,<br>☐ There is adequate IV access?<br>Is emergency blood available? ☐ No ☐ Yes<br>Are there any concerns about the placental site<br>☐ No ☐ Yes | To Scrub Sister<br>☐ Sterility of instruments confirmed<br>☐ Any equipment issues / concerns<br>☐ Diathermy and suction functional | |
| ☐ Antibiotic prophylaxis give in the last hour?<br>☐ Appropriate / recent antacid prophylaxis given?<br>☐ Urinary catheter is draining | Patient Name: _____<br>Patient Surname:_____<br>Date of Birth:_____<br>Hospital number:_____<br>Date of Surgery:_____ | Midwife has confirmed that<br>☐ Baby/ies been correctly labelled?<br>☐ Relevant cord bloods have been taken? |
| Are any additional procedures planned?<br>☐ IUCD<br>☐ BTL<br>☐ N/A | | |
| Is the foetal heart present?<br>☐ No ☐ Yes | | |
| NAME AND SIGNATURE OF HEALTHCARE WORKER | NAME AND SIGNATURE OF HEALTHCARE WORKER | NAME AND SIGNATURE OF HEALTHCARE WORKER |