Canterbury
District Health Board
Te Poari Hauora ō Waitaha

SURNAME ..... NHI .....
FIRST NAME ..... DOB .....
ADDRESS .....
..... POSTCODE .....
(or affix patient label)

Suppression of Patient Details

Reason for initiating name suppression process

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Hospital/Location: .....

Verbal consent received from patient: ☐ Yes ☐ No

Name of clinician responsible for initiating this process:

Name of department shift coordinator/team leader responsible:

Name of unit receptionist recording the name suppression:

Date name suppression recorded: …….. / …….. / ……..

Time name suppression recorded:

CHECKLIST

Patient name removed from patient details board in ED/Ward:		☐ Yes	☐ No	Time: .....
CDHB staff notified:	Duty Manager	☐ Yes	☐ No	Time: .....
	Security and Orderlies	☐ Yes	☐ No	Time: .....
	Switchboard	☐ Yes	☐ No	Time: .....
	Ward staff	☐ Yes	☐ No	Time: .....
	Social Work	☐ Yes	☐ No	Time: .....

Details of staff member completing this form

Name: .....

Signature: ..... Date: …….. / …….. / ……..

OUTCOME OF NAME SUPPRESSION

Patient discharged: ☐ Yes ☐ No Time: ..... Date: …….. / …….. / ……..

If no answered to question immediately above, state reason for reinstating suppression:

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Suppression reinstated by: .....

Time: ..... Date: …….. / …….. / ……..

SUPPRESSION OF PATIENT DETAILS