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| **Name of document:** | | | | | | | | | | | | |
| Is this a new document? ☐ Yes ☐ No  Is this patient information?  Is this a policy/guideline? | | | | | Is this a review of a current document? ☐ Yes ☐ No  *If yes, please go to question 11.*  Is this document still required?  Yes  No  Is this for discontinuation of a current document? ☐ Yes ☐ No *Please go to question 12.* | | | | | | | |
| 1. What is the desired outcome when the document is introduced? | | | | | | | | | | | | |
| 2. What problem is the document addressing? | | | | | | | | | | | | |
| 3. What process will you employ to ensure it is effective (audit)? | | | | | | | | | | | | |
| 4. Area of Impact: | | | | | | | | | | | | |
| Maternity inpatients only  Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | All maternity clients  Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | DHB wide  (all locations, including rural and community) | | | | | External Provider  (e.g. Lab tests, Primary Health service) |
| **Due diligence** | | | | | | Please specify details: | | | | | | |
| 5. Who will be the main distributors of the pamphlet/handout/form? How are you intending to consult with them?  e.g. Midwives, LMCs, other Health practitioners, external providers (e.g. Primary health providers, Lab tests), etc. | | | | | |  | | | | | | |
| 6. Who will be the main audience? How are you intending to consult with them?  e.g., Maternity consumers | | | | | |  | | | | | | |
| ☐ 7. How will you undertake an unbiased pilot with maternity consumers? | | | | | |  | | | | | | |
| 8. What pamphlets/handouts/forms (electronic and paper), already exist that are similar, will be impacted or be replaced by this document? How will you consult with these document owners? | | | | | |  | | | | | | |
| 9. How will the document enhance workflow and communication? | | | | | |  | | | | | | |
| 10. What is your plan for socialising this document? | | | | | |  | | | | | | |
| 11. Information has been updated to reflect current research and practice.  *For reviews only* | | | | | |  | | | | | | |
| 12. If this document is to be discontinued, what alternative ways will this information be given to women.  *For discontinuations only* | | | | | |  | | | | | | |
| **Document Management** | | | | | | | | Today’s date | | | dd/mm/yyy | |
| Document author | |  | | | | | | | Signed | |  | |
| Document Owner | |  | | | | | | | Position | |  | |
| Department | |  | | | | | | | | | | |
| Cost Code Manager  (consumer information only) | |  | | | | | | | Signed | |  | |
| Existing forms affected  *Please list all codes and indicate replacement or removal e.g. A1234HWF* | | | | Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  To be removed  To be replaced  Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  To be removed  To be replaced  Confirmed above with department owner(s):  Yes  No | | | | | | | | |
| Review Date and Frequency | | | | New Document review date \_\_\_\_\_\_\_\_\_\_ (dd/mm/yy)  Ongoing review:  3 years  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Specifications | | | | Expected document usage per month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Approvals** | | | | **Approved to proceed** | | | | | | **Final sign-off** | | | |
| Maternity client Information Committee | | | | *Name dd/mm/yy* | | | | | | *Name dd/mm/yy* | | | |
| ☐ Midwifery Director | | | |  | | | | | | *Name dd/mm/yy* | | | |
| Director Women’s Health | | | |  | | | | | | *Name dd/mm/yy* | | | |
| Other | | | |  | | | | | |  | | | |
| Has this been placed on the agenda for the Maternity Governance Group? | | | | *dd/mm/yy* | | | | | | | | | |
| Discontinuation | Title: Confirmed with department owner:  Yes  No  Reason: | | | | | | | | | | | | |
|  | *Master copy to be kept by NWH Information Officer* | | | | | | | | | | | | |