PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

LIFESTYLE

LIFESTYLE	YES (Please Tick)	NO		Staff use
Do you smoke?			Daily amount: ____________	Consider Nicotine patches
Have you ever smoked regularly?			Date ceased: ___ / ___ / ___	
Have you discussed nicotine replacement therapy or cessation with your Doctor?				
Alcohol intake			Amount: Frequency:	
Recreational drug use?			Type:	

NUTRITIONAL ASSESSMENT

Staff use

Height ____________cms Weight: ____________kgs

Have you lost weight recently without trying? ☐ Yes ☐ No = 0 ☐ Unsure = 2

If yes to weight loss: ☐ 1-5kg = 1 ☐ 6-10kg = 2 ☐ 11-15kg = 3 ☐ >15kg = 4

Have you been eating poorly due to a decrease in appetite? ☐ Yes = 1 ☐ No = 0

Food intolerance or allergies ☐ Yes ☐ No Describe exact food and response

Special dietary needs ☐ Yes ☐ No

Please specify:

Do you require assistance with meals ☐ Yes ☐ No

☐ Cut up ☐ Packets opened ☐ Special utensils ☐ Assistance with eating

Staff use: BMI= Hovermat in IBA ☐ __ / __ / __ Nutritional Assessment Score of 2 or above – refer to dietician ☐ __ / __ / __

Day Surgery Patients Discharge Plan

ALL PATIENTS UNDERGOING DAY PROCEDURES MUST HAVE AN ESCORT HOME AND A CARER OVERNIGHT

Who is taking you home? Name: ____________________ Phone No: ____________

Who is staying with you overnight? Name: ____________________ Phone No: ____________

Overnight Patient Discharge Plan (NOTE – DISCHARGE TIME IS 9.30AM)

Staff use

Living arrangements ☐ Alone ☐ Spouse/Partner with Carer ☐ With Family ☐ Other, specify

Home environment ☐ House/flat/apartment ☐ SRS ☐ Nursing Home ☐ Retirement Village ☐ Hostel ☐ Other, specify

At home there are ☐ Steps ☐ Ramps/rails ☐ External toilet ☐ Shower chair ☐ Separate shower ☐ Shower over bath ☐ Toilet Frame ☐ Bathroom handrails ☐ Toilet handrails ☐ Stairs Are the stairs available ☐ Yes ☐ No

Activity assessment – Do you cope independently with daily living activities eg showering, dressing?

☐ Yes ☐ No, specify assistance required ______________________________

Support services at home ☐ No services ☐ Family / Friends ☐ Personal carer ☐ Delivered meals ☐ Shopping ☐ Home Nursing ☐ Home Help ☐ Personal alarm ☐ Care package Case Manager ____________ Phone No: ________

Name of GP: ____________________ **Phone No:** __________ **Fax No:** __________

Do you plan to return to your current accommodation directly from hospital? ☐ Yes ☐ No

If No, specify plans:

Are you a carer for others at home? ☐ Yes ☐ No Specify:

Any additional patient information:

Signature ______________________________ Date ___ / ___ / ___ Time ________

Staff use: Issues identified Referred ☐ Home Health ☐ Social Work __ / __ / __ ☐ O.T. ☐ N/A

Pre-Admission Form Sighted / Triage ☐ Green No - Further Action Required ☐ Orange ☐ Red

☐ Refer to MR2B Signed: ____________________ Date: ___ / ___ / ___

Unit Nurses Signature: ______________________ Date: ___ / ___ / ___ Time: ________

ST VINCENT'S HEALTH AUSTRALIA

PATIENT REGISTRATION FORM

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: ____________ ADM No: ____________

SURNAME: ______________________

GIVEN NAMES: ______________________ SEX: ______

DATE OF BIRTH: ____________ PHONE No: ____________

ADDRESS: ______________________

TO BE COMPLETED BY PATIENT PRIOR TO YOUR ADMISSION

Interpreter required ☐ No ☐ Yes Language ____________________

Form completed by ☐ Patient ☐ Parent ☐ Relative/Carer, specify ____________ ☐ Staff member

☐ I understand that the hospital is a teaching hospital & I have read the section titled "Teaching & Learning" in the Patient Information Booklet

Have you been in hospital in the last 2 months? ☐ Yes ☐ No

Reason? ______________________ How long? ______________________

Reason for this admission and history or presenting illness:

If reason for admission is the result of an accident, please state:

When injury occured: ______________ Where injury occured (eg. Football field): ______________

How injury occured: ______________________________

Medical/Surgical History: List the medical conditions/operations performed and date (attach list if insufficient space)

CURRENT MEDICATIONS

Current medications – please list ALL medications including complementary medications and bring these to hospital in their original containers (attach a list if insufficient space)

DRUG NAME	DOSE	FREQUENCY / TIME	Staff use

MEDICATIONS

Staff use

Do you take or have you recently taken blood thinning medication or natural blood thinning medication? ☐ Yes ☐ No

Is your admitting doctor aware of this ☐ Yes ☐ No

Have you been told to cease this? ☐ Yes ☐ No

Date to cease ____ / ____ / _____ Date last taken ____ / ____ / _____

Have you been told to start any other treatment eg clexane? ☐ Yes ☐ No

Have you taken any steroids or cortisone tablets/injections in the last 6 months? ☐ Yes ☐ No

If yes. specify Date last taken ____ / ____ / _____

Staff use: Patient aware of management plan ☐ Notified required and completed ☐ Surgeon ☐ Anaesthetist ☐ Theatre ☐ Ward ☐ DPU

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ALLERGIES

ALLERGIES		Staff use
Do you have any allergies? ☐ Yes ☐ No (If yes please tick appropriate box and name allergies and give details)		Entered on IBA ☐ ___/___/___
☐ Drug or Natural Remedy Allergy	☐ Latex / Rubber Allergy	
☐ Adhesive Tapes Allergy	☐ Food Allergy	
☐ Lotions Allergy	☐ Other Allergy	

PATHOLOGY / X-RAYS OR OTHER TEST RESULTS

PATHOLOGY / X-RAYS OR OTHER TEST RESULTS	Staff use
Has your surgeon ordered blood tests / pathology / autologous blood for **THIS admission** ☐ Yes ☐ No Name of Pathology Service: ______________________ Date of test __________ Have you had a recent ECG / Echocardiogram? ☐ Yes ☐ No Have X-rays been taken for this admission? ☐ Yes ☐ No If Yes – please make sure you bring them with you	Results available? ☐ In File ☐ Online ☐ Not available ☐ With Patient ☐ With Doctor

GENERAL MEDICAL HISTORY

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO	Comments & Further Information	
Heart Disease including Heart Attack / Angina			Details/Date:	
(Please Circle) High Blood Pressure High Cholesterol			Details: Name of treating Dr:	
(Please Circle) Peripheral Vascular Disease palpitation, irregular heart beat / heart murmur				
(Please Circle) Implanted devices / prosthesis (eg joint / heart valve / lapband / stents / stimulators/ shunts/eye lens/other Pacemaker – last checked ___ / ___ / ___			Type & brand of implant: Is surgeon aware? ☐ Yes ☐ No Bring ID information if applicable	Ward / Theatre Notified ☐ __ / __ / __
Diagnosed Sleep Apnoea CPAP ☐ Mouth Guard ☐			Bring CPAP Machine to hospital Mouth Guard ☐	
(Please Circle) Asthma / bronchitis / emphysema / shortness of breath / hay fever / pneumonia / TB			Treatment (Please Tick) ☐ Oral Steroids ☐ Puffers ☐ Nebulisers ☐ Home Oxygen Please bring all Asthma medications	
Anaesthetic Reactions			Details	Anaesthetic referral ☐ __ / __ / __
Family history of anaesthetic reactions				
Problems with extending neck fully?				
Diabetes Type 1 ☐ Type 2 ☐			Controlled by ☐ Diet ☐ Tablet ☐ Insulin ☐ Pump	
Do you have instructions how to manage your diabetes on the day of surgery?			Specialist details:	
(Please Circle) Blood Disorders / bleeding problems / bruise easily / anaemia			Details	
Blood clots in legs			Specify	VTE Assessment ☐ PAC ☐ On Admission
Blood clots in lungs			Is Surgeon aware? ☐ Yes ☐ No	
Blood Transfusion Blood Transfusion reaction			Date of last transfusion ___ / ___ / ___ Type of reaction	
Arthritis			Details:	
Infectious diseases: HIV / sexual / hepatitis or other infections			Specify Treatment:	Infection Control ☐ __ / __ / __
Elimination issues: bowel or bladder problems / incontinence / stoma therapy			Specify	
(Please Circle) Skin conditions – existing wounds / fistula / pressure areas / ulcers / broken skin or reddened due to friction or pressure			Details and current treatment:	Pressure Ulcer Assessment ☐ By PAC ☐ On Admission

Name: ______________________________

Date of Birth: ______ / ______ / ______

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO	Comments & Further Information	Staff use
(Please Circle) Epilepsy / fits / seizure			Last Seizure: Treatment:	
(Please Circle) Strokes / mini strokes / MS / Motor Neurone Disease / brain surgery			Any residual weakness or symptoms?	
Parkinson's Disease			Treatment:	
(Please Circle) Short Term Memory loss / confusion / dementia			Details:	
(Please Circle) Mental illness / nervous breakdown / anxiety attacks / depression / psychosis			Details:	
Have you ever experienced drug or alcohol withdrawl?			Specify:	
Have you been diagnosed with chronic pain?			Specify:	
Faints / Black outs / dizzy spells / Migraine			Details:	
Fall in the past 12 months			Details:	Falls Risk Assessment ☐ By PAC ☐ On Admission
Physical Disability – Mobility aids			Specify: Please bring to hospital	
Reflux / hiatus hernia / gastric ulcers Renal impairment eg. dialysis				
Cancer			Location: Date diagnosed ___ / ___ / ___ ☐ Chemotherapy ☐ Radiotherapy	
Pregnant N/A			Due date ____ / ____ / ____	If yes, advise anaesthetist
Last menstrual period			Date ____ / ____ / ____	
Breastfeeding N/A				
Impairment ☐ Vision ☐ Hearing			Aids used:	
Do you have glaucoma?			Treatment:	
Dental problems			Specify:	
Do you have dentures			Specify:	
Limited jaw movement			☐ Caps ☐ Crowns ☐ Loose teeth	

INFECTION CONTROL ASSESSMENT

INFECTION CONTROL ASSESSMENT	YES	NO		Staff use
(Please Circle) Have you had a cough/cold/ chest infection recently?			Currently taking antibiotics? ☐ Yes ☐ No Surgeon aware? ☐ Yes ☐ No	Infection Control notified ☐ Yes ☐ No __ / __ / __
Have you had any illnesses such as gastroenteritis, or been in contact with someone who has had chicken pox within the last 14 days			Specify:	
Do you have a FAMILY HISTORY of Creutzfelt Jacob Disease (CJD) or progressive neurological disorder of less than 12 months duration?				**Staff use** Infection Control notified ☐ Yes ☐ No __ / __ / __
Do YOU have acute dementia or progressive neurological disorder of less than 12 months duration?				
Were you a recipient of a dura mater graft prior to 1990?				Infection Control to manage ☐ Yes ☐ No __ / __ / __
Have you been a recipient of human pituitary-derived hormones for infertility or short stature prior to 1985?				
Have you been involved in a *"Look Back"* study for CJD or are in the possession of a *"Medical in Confidence Letter"* regarding risk of CJD?				No further action required as per plan ☐ Yes ☐ No __ / __ / __

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