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

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

PRE-ADMISSION HEALTH QUESTIONNAIRE

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ALLERGIES — Staff use

Do you have any allergies? ☐ Yes ☐ No (If yes please tick appropriate box and name allergies and give details)

☐ Drug or Natural Remedy Allergy	☐ Latex / Rubber Allergy
☐ Adhesive Tapes Allergy	☐ Food Allergy
☐ Lotions Allergy	☐ Other Allergy

Staff use: Entered on IBA ☐ ___/___/___

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

Staff use: Results available?
☐ In File
☐ Online
☐ Not available
☐ With Patient
☐ With Doctor

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO (Please Tick)	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	NO (Please Tick)	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				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?				Infection Control to manage ☐ Yes ☐ No __ / __ / __
Were you a recipient of a dura mater graft prior to 1990?				
Have you been a recipient of human pituitary-derived hormones for infertility or short stature prior to 1985?				No further action required as per plan ☐ Yes ☐ No __ / __ / __
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?				

PRE-ADMISSION HEALTH QUESTIONNAIRE

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PRE-ADMISSION HEALTH QUESTIONNAIRE

LIFESTYLE	YES (Please Tick)	NO (Please Tick)		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:

Issues identified

Referred

☐ Home Health

☐ Social Work

__/__/__

☐ O.T.

☐ N/A

Any additional patient information:

_____

_____

_____

Signature _____ Date ___ / ___ / ___ Time _____

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

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

Unit Nurses Signature: _____ Date: ___ / ___ / ___ Time: _____

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