STONNINGTON day surgery

PRE-ADMISSION ASSESSMENT

Unit Record Number: ☐☐☐☐☐☐☐☐☐☐

Surname: _____

Given Names: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Age: ☐☐ Sex: ☐

Medical Officer: _____

Affix Patients Identification Label

PRE - ADMISSION Assessment FORM

PATIENT HEALTH HISTORY (Please complete all sections of this form and tick the appropriate answer in the appropriate box)

Admitting Surgeon: _____ Admission Date: _____ /_____ /_____ Time: _____AM / PM

Procedure / Reason for Admission: _____

What is your weight: _____kg Height: _____cm **BMI: > 35** ☐

HAVE YOU NOW, OR EVER BEFORE HAD (Please ✔ tick your answer)

	Yes	No		Yes	No		Yes	No
Diabetes (Type 1)	☐	☐	Do you take Warfarin	☐	☐	Are you pregnant	☐	☐
Diabetes (Type 2)	☐	☐	Anaemia	☐	☐	Mental Illness	☐	☐
Thyroid Problems	☐	☐	Heart Surgery	☐	☐	Dementia	☐	☐
Asthma (Please Bring Puffer)	☐	☐	Rheumatic Fever	☐	☐	Do you suffer from Epilepsy, Seizures, Blackouts	☐	☐
Emphysema/COPD	☐	☐	Reflux	☐	☐			
Sleep Apnoea	☐	☐	Kidney Disease	☐	☐	Do you currently have any Skin Wounds, Pressure Sores or Skin Ulcers	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐			
Heart Attack	☐	☐	Back / Neck Problems	☐	☐	Head cold or flu in the last 2 weeks	☐	☐
Angina	☐	☐	Liver Disease / Hepatitis	☐	☐	Have you or your family ever had a reaction to an Anaesthetic	☐	☐
Chest Pain	☐	☐	Joint Replacement	☐	☐			
Atrial Fibrillation	☐	☐	_____			Date: ____ / ____ /_____		
Pacemaker	☐	☐	_____			Have you ever had a Blood Transfusion	☐	☐
Heart Valve Replaced	☐	☐	_____					
Blood Clot (Leg / Lungs)	☐	☐	Steroids / Cortisone	☐	☐	Date: ____ / ____ /_____		

DO YOU HAVE ANY ALLERGIES ☐ YES ☐ NO (If yes. please give details below)

☐ Drugs ☐ Tapes ☐ Latex ☐ Rubber ☐ Food

_____

LIST OF MEDICATIONS INCLUDING PRESCRIBED & UNPRESCRIBED, HERBAL & RECREATIONAL DRUGS

Name of Medicine	How Much (dose)	How often (day)	Name of Medicine	How Much (dose)	How often (day)

LIST DETAILS OF ANY PREVIOUS OPERATIONS

Year:_____ Details: _____

Year:_____ Details: _____

Year:_____ Details: _____

Year:_____ Details: _____

SEE REVERSE

MR001

OTHER IMPORTANT INFORMATION

Do you have any special needs ☐ YES ☐ NO _____

Do you smoke ☐ YES ☐ NO Amount: _____ Date Ceased: _____ / ____ /_____

Do you drink alcohol ☐ YES ☐ NO Amount: _____

Do you have any special dietary needs ☐ YES ☐ NO Details: _____

Have you ever had a test to show that you had Hepatitis B, Hepatitis C, HIV, MRSA, VRE or CRE ☐ YES ☐ NO

Details: _____

Do you or your family have Creutzfeldt Jakob Disease (CJD) **Classical** ☐ YES ☐ NO **Variant** ☐ YES ☐ NO

Have you been admitted to an overseas hospital in the past 12 months ? ☐ YES ☐ NO Country: _____

Have you been identified as a CRE contact ? ☐ YES ☐ NO

ADMISSION FOR TREATMENT OF INJURY

Are you having treatment for an injury?" ☐ **YES** ☐ **NO**

If **"YES"**, Date of the Injury _____ / ____ /_____

Please Describe:

How ? (eg. cut with a knife). _____

Where ? (eg. kitchen, factory). _____

Activity ? (eg. cooking, building). _____

DISCHARGE If you are having a general anaesthetic or sedation **you will need to be escorted home** by a family member or friend.

Who will drive you home on day of surgery ? _____ Contact Phone No:_____

Who will be staying with you on the night of surgery ? _____

SIGNATURE PATIENT / CARER

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature:_____ Date: _____ / _____ / _____

Form completed by: _____

Patient Signature: _____ Carer: _____

DATE REVIEWED BY REGISTERED NURSE

Further review required ☐ **YES** ☐ **NO**

By whom ? ☐ Anaesthetist ☐ Surgeon ☐ Nurse

Outcome:_____

_____

_____

Name:_____ Signature: _____

Date: _____ / _____ / _____