STONNINGTON day surgery

PRE-ADMISSION ASSESSMENT

Unit Record Number: ☐☐☐☐☐☐☐☐☐☐

Surname: _____

Given Names: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Age: ☐☐ Sex: ☐

Medical Officer: _____

Affix Patients Identification Label

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
Diabetes (Type 1)	☐	☐
Diabetes (Type 2)	☐	☐
Thyroid Problems	☐	☐
Asthma (Please Bring Puffer)	☐	☐
Emphysema/COPD	☐	☐
Sleep Apnoea/Use CPAP	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
Chest Pain	☐	☐
Atrial Fibrillation	☐	☐
Pacemaker	☐	☐
Heart Valve Replaced	☐	☐
Blood Clot (Leg / Lungs)	☐	☐

	Yes	No
Do you take blood thinners	☐	☐
Anaemia	☐	☐
Heart Surgery	☐	☐
Rheumatic Fever	☐	☐
Reflux	☐	☐
Kidney Disease	☐	☐
Arthritis	☐	☐
Back / Neck Problems	☐	☐
Liver Disease / Hepatitis	☐	☐
Joint Replacement	☐	☐
_____		
_____		
_____		
Steroids / Cortisone	☐	☐

	Yes	No
Are you pregnant	☐	☐
Current mental health conditions	☐	☐
Dementia / history of delerium	☐	☐
Cognitive impairment	☐	☐
Do you suffer from Epilepsy, Seizures, Blackouts	☐	☐
Do you currently have any Skin Wounds, Pressure Sores or Skin Ulcers	☐	☐
Head cold or flu in the last 2 weeks	☐	☐
Have you or your family ever had a reaction to an Anaesthetic	☐	☐
Date: ____ / ____ /_____		
Have you ever had a Blood Transfusion	☐	☐
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: _____

PRE - ADMISSION Assessment FORM

MR001

SEE REVERSE

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 been infected or colonised with a multi-resistant organism such as MRSA, VRE or CRE ? ☐ YES ☐ NO

Details: _____

Are you currently experiencing any type of infection or have you been exposed to a person that is suffering a communicable (infectious) disease in the past 2 weeks, ie Chickenpox, Measles etc. ? ☐ YES ☐ NO

Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B? ☐ YES ☐ NO

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

Have you been overseas in past 4 weeks? ☐ YES ☐ NO

COVID 19

Have you ever been diagnosed with COVID 19? ☐ **YES** ☐ **NO**

Did you require hospitalisation? Details _____

Have you been vaccinated against COVID 19 ? If so which one and when ? _____

Dose 1 ☐ ...../...../..... Dose 2 ☐ ...../...../.....

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 and be cared for overnight by a family member or friend.

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

_____

Also please be advised for some surgeries you may need to have someone drive you into the consulting rooms for post-operative appointment the following day.

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 ☐ Other

Outcome:_____

_____

_____

Name:_____ Signature: _____

Date: _____ / _____ / _____