PENINSULA HEALTH

PRE ADMISSION SERVICE QUESTIONNAIRE

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
Please fill in if no Patient Label available

15/8/13 - Print Code: 10562

OFFICE USE ONLY

HEALTH QUESTIONNAIRE TRIAGE:

Ready for care at: ☐ Rosebud ☐ Frankston

Further assessment required from:

☐ Patient ☐ GP ☐ Specialist ☐ Medical Record ☐ Other.....

Comments: .....

.....

.....

.....

.....

.....

.....

☐ PAC attendance required surgical preparation

☐ Anaesthetic assessment required

Screened by: ..... Date .....

If > 3 months since completion, phone patient to update information

Phone triage completed by:..... Date .....

ALERTS

☐ HDU / ICU
☐ Anticoagulant Plan
☐ HITH
☐ Insulin Requiring Diabetes (IDDM)
☐ Pacemaker
☐ Sleep Apnoea
☐ CPAP
☐ Latex Allergy
☐ Anaesthetic Risk
☐ Interpreter needed
☐ Bariatric - BMI = ... Weight =.....
☐ No blood products
☐ MRSA / VRE +ve
☐ Methadone Program (notify Pharmacy

Planned Procedure / Operation:.....

.....

Category: 1 ☐ 2 ☐ 3 ☐ Surgeon:.....

Proposed date of operation:	Admission Date	Admission Time	Frankston	Rosebud
...../ ..... /.....	...../ ..... /.....	..... :.....		

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PLEASE COMPLETE FOLLOWING 3 PAGES OF THIS QUESTIONNAIRE ACCURATELY.
Incomplete or unreturned forms will cause your surgery to be delayed.

You may wish to ask a family member, friend or carer to help you. If you require further information, your local Doctor may be able to assist. To contact the Pre Admission Service - phone 9784 7340, during business hours.

HEIGHT/WEIGHT/AGE

Please complete this section carefully. It is important to give an ACCURATE weight and height to avoid unnecessary cancellation.

How old are you? ..... **What is your weight**.....kgs or ..... stone

What is your height .....cms or ..... feet and inches

Has your weight changed much in the last 3 months ☐ No ☐ Yes - increase / decrease

OFFICE USE ONLY

BMI .....
(BMI > 35 not suitable for Rosebud)

MEDICATIONS

MEDICATIONS: Please list all medications you are taking including any drugs or medicine not prescribed by a doctor:

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

ALLERGIES

ALLERGIES			Medicine or Product	What reaction
Are you allergic to any Medications?	☐ No	☐ Yes	.....	.....
Are you allergic to Latex or rubber products?	☐ No	☐ Yes	.....	.....
Are you allergic to anything else? e.g. bandaids, tapes, food etc.	☐ No	☐ Yes	.....	.....

SURGICAL HISTORY

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

Please ✓ boxes as appropriate. ***If you answer Yes to any questions,*** *please give as much information as possible. You may attach a separate piece of paper if you need to write more information.*

CARDIAC

Do you have or have you ever had any of the following

	No	Yes	
1. High blood pressure	☐	☐	When ....
2. Angina or chest pain,	☐	☐	If no go to Question 3
(a) How often do you get angina?			.....
(b) Do you get angina during activity or exercise?			.....
(c) Do you get angina when resting or at night?			.....
3. Heart attack	☐	☐	When .....
4. Palpitations or irregular heart beat	☐	☐	When .....
5. Insertion of heart valve, coronary stent or pacemaker (*specify*)	☐	☐	When .....
6. Rheumatic fever	☐	☐	When .....
7. Heart Murmur	☐	☐	
8. (a) Are you being treated by a Cardiologist / Heart Specialist	☐	☐	Last Visit ..... /..... /.....
(b) What is the Specialist's name/Phone no.....			

- FOR COMPLETION BY PATIENT -

PENINSULA HEALTH

Pre Admission Service Questionnaire (cont.)

Patient to Complete

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
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PHF5548850"

- FOR COMPLETION BY PATIENT -

Do you have or have you ever had any of the following

		No	Yes	
RESPIRATORY				
9.	Are you being treated by a Lung / Respiratory Specialist	☐	☐	Last Visit ...../...../.....
	(b) What is the Specialist's name / Phone No			
10.	Do you smoke	☐	☐	How many per day
11.	Are you an ex-smoker	☐	☐	When did you stop
12.	Asthma or shortness of breath (*please circle*)	☐	☐	When
13.	Bronchitis or emphysema (*please circle*)	☐	☐	When
14.	Pneumonia or tuberculosis (T.B.) (*please circle*)	☐	☐	When
15.	Obstructive sleep apnoea as diagnosed by your doctor	☐	☐	CPAP Machine ☐ No ☐ Yes
16.	Shortness of breath that prevents you from climbing one flight of stairs	☐	☐	
17.	Home Oxygen therapy	☐	☐	
GENERAL				
18.	Do you drink alcohol	☐	☐	How much per week
19.	Problem with alcohol or drug use	☐	☐	
20.	Hepatitis, jaundice, cirrhosis or pancreatitis (*please circle*)	☐	☐	What and When
21.	Kidney disorder - stones, infection, failure, dialysis (*please circle*)	☐	☐	What and When
22.	Organ transplant (*please specify*)	☐	☐	When
23.	Diabetes	☐	☐	Treated by: ☐ diet ☐ tablets ☐ insulin
24.	Stroke	☐	☐	When
25.	Epilepsy, fits, fainting or "funny turns" (*please specify*)	☐	☐	What
26.	Significant back injury/disorder	☐	☐	What and When
27.	Significant neck injury/disorder	☐	☐	What and When
28.	Blood disorder (leukaemia, anaemia, haemophilia or other) (*please specify*)	☐	☐	What and When
29.	Blood transfusion	☐	☐	When
30.	Do you object to accepting blood products for a cultural / religious reason	☐	☐	
31.	Blood clot in legs or lungs (*please circle*)	☐	☐	When
ANAESTHETIC				
32.	Do you have any risk factors for Creutzfeldt Jakob Disease (CJD)	☐	☐	What
33.	Does any condition prevent you from undertaking normal daily activities	☐	☐	What
34.	Have you ever had any serious problems with anaesthetics or surgery before (e.g. prolonged nausea, high temperature, prolonged drowsiness)	☐	☐	What
35.	Have any blood relatives had serious problems with anaesthetics	☐	☐	What
36.	Female patients only: Could you be pregnant?	☐	☐	How many weeks
37.	List any serious illness or medical condition (eg.Cancer, HIV, Psychiatric condition)			
	.....			
38.	Have any of the above medical conditions become worse in the last 3 months	☐ No	☐ Yes	What .....

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Pre Admission Service Questionnaire (cont.)

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GENERAL HEALTH INFORMATION

Please ✓ boxes as appropriate

	No	Yes
39. Do you require an Interpreter - if yes, what language?	☐	☐
40. Do you have a problem with your speech? - if yes, what	☐	☐
41. Do you have impaired eyesight? - Glasses / Contact Lens / Eye prosthesis / Legally blind *(circle)*	☐	☐
42. Do you have impaired hearing? - Deaf / Hearing aid *(circle)*	☐	☐
43. Has your bowel pattern changed recently? - Constipation / Diarrhoea / Blood / Incontinence *(circle)*	☐	☐
44. Do you have any problems passing urine? - pain / odour / blood / incontinence, catheter *(circle)*	☐	☐
45. Do you have a stoma? - colostomy / ileostomy / ileal conduit, tracheostomy / laryngectomy *(circle)*	☐	☐
46. Have you had any falls in the past few months?	☐	☐
47. Do you use any mobility aids such as a stick, frame or wheelchair etc.?	☐	☐
48. Do you have any eating or swallowing difficulties or special eating/dietary needs?	☐	☐
49. In the last three months have you had a non-healing wound	☐	☐

DISCHARGE PLANNING

1. Do you live alone?	☐	☐
2. Do you live in a residential care facility? - nursing home / hostel / other supported accommodation *(circle)*	☐	☐
3. Do you have responsibility for the care of others at home? e.g. sole parent, care of disabled relative *(circle)*	☐	☐
4. Do you currently require assistance with toileting / showering / bathing / dressing / cooking / housework /shopping? *(circle)*	☐	☐
5. Will additional assistance be needed when you return home?	☐	☐
6. Do you currently receive any support services? e.g. home nursing / meals on wheels / home-help / personal care, respite care / Community Aged Care Packages - *(circle)*	☐	☐

7. We advise that you must have an adult escort you home and a carer overnight following discharge from day surgery.

   Who will stay with you? - Name:..... Phone No. .....

8. Who will escort you home from hospital - Name: ..... Phone No. .....

9. How long do you expect to be in hospital .....

Signature of Person Completing Form:..... Date Signed .....

Relationship to Patient (if not completed by the patient): .....

- FOR COMPLETION BY PATIENT -

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