the Mater

Patient Label

IMPORTANT
Complete in full and send to the Mater otherwise, it will be returned to you, which could delay your booking.

Endoscopy Pre - Admission Questionnaire

The patient must complete all of the Form

It is important that you return this document at least 3 days prior to your procedure.

Name: _____

Date of Admission: _____ **Date of procedure:** _____

Doctor: _____

Have you been in a hospital in the last 12 months?

☐ No ☐ Yes Where: .....

Length of Admission: .....

If you have, any queries ask your **doctor** or contact the Pre Admission Clinic: 9900 7494

MATER HOSPITAL
25 ROCKLANDS RD
NORTH SYDNEY NSW 2060
P.O. BOX 958
NORTH SYDNEY NSW 2059
TEL 9900 7300 FAX: 9959 4110

Fundraising:
The Mater Hospital has a mailing program that gives previous patients an opportunity to receive newsletters and to contribute to fundraising activities.
Please tick this box ☐ if you do not wish to receive fundraising communications from the Mater.
(Note: Only your name and address will be utilised for mailing purposes. All other personal details remain confidential).

Privacy Statement

This form document is CONFIDENTIAL
This form contains personal and health information in relation to the patient named on this document.
The information on this form is:
(a) kept and used in accordance with the Mater's privacy policy and collection statement
(b) not intended to be disclosed or used by any person other than the patient or health professionals involved in the patients care at the hospital without the patients consent.
If you have this form document and you are not the patient or a health professional involved in the patients care you should return this to a member of staff at the hospital immediately.

Instructions for completing this form

Pre Admission Questionnaire

1. It is very important that you complete this with as much information as possible.

2. This Questionnaire must be completed for each admission.

    - If the patient has been admitted within the last 3 months to the Mater the medical history does not need to be re done. If there has been no change in your medical history you will only need to complete the discharge section on page 4.

3. These details help us with your background information so that we can properly prepare for your admission.

4. Complete the pages with the blue headings, not the shaded green area.

Nursing Pre Admission Assessment – at the end of the Questionnaire

1. This section is for staff use only. Nursing staff are required to check the assessment and to complete the green shaded area where applicable.

2. Also, nursing staff must complete the Pre Admission Assessment Nursing Summary in the green section.

To be completed by the admitting Doctor

Relevant History or Specific Pre Operative Instructions:

.....

.....

.....

.....

.....

.....

.....

.....

.....

the Mater

Mater Hospital - Endoscopy Booking Form

Patient Details — Patient to Complete

Have you ever been a patient at the Mater before No ☐ Yes ☐ Year? _____

Mr. Mrs. Miss. Ms. Other _____ Are you an Aboriginal & Torres Straight Islanders descent ☐

Surname: _____ **Given Names:** _____

Date of Birth: _____ Age: _____ Male/Female Religion: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____ Country _____

Country of Birth: _____

Telephone: (H) _____ (W) _____ (M) _____

Email address _____

Family Doctor: _____ Phone: _____

Address: _____

Next of Kin or Person to Notify: _____ Relationship: _____

Address: _____

Suburb: _____ Postcode: _____

Telephone: (H) _____ (W) _____ (M) _____

Accommodation Preference: Single Room ☐ Shared Room ☐ **We will make every effort to provide you with your preference; however, rooms cannot be guaranteed and are allocated according to clinical need and availability.**

Hospital Booking Details — Doctor to Complete

Admitting Doctor _____

Admission Date: _____ Time: _____ Procedure Date _____

Transfer From: _____ MRSA Swabs taken date _____

☐ Day Only ☐ Overnight, No nights _____ If length of stay longer than DRG please give reason

_____

Diagnosis: _____

Surgery /Procedure: _____

_____

Estimated length of Surgery _____ ☐ Image Intensifier

Item No/s MBSN(s): _____

Prosthesis – Product Name/Code: _____

☐ **Level I ICU (HDU)** ☐ **ICU Post Op No days** _____ ☐ **Cardiac Cath Lab**

Health Insurance — Patient to Complete

Health Fund Name: _____ Member No: _____

DVA Number: _____ White / Gold DVA transport required: Yes / No / NA

Pension No: _____ Pharmacy Concession/Safety Net No: _____

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Number beside your name on the Medicare Card: ☐

Expiry Date: _____

Workers Comp Insurance Company: _____ Workers Comp Claim No: _____

Copy of Workers Compensation approval letter must be attached

the Mater Surgical Consent

Operation / Procedure

Patient Label

Patients 14 years and older are able to consent, and parents on behalf of their children.

Provision of information to the patient

I, Dr ..... have discussed with this patient / parent /guardian the various ways of treating the patient's present condition including the following proposed procedure/treatment

Patient's Name: .....
I have informed this patient of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

The proposed procedure / treatment is: **Do not use abbreviations** .....

.....

.....

Medical Officer's Signature: ..... Date: .....

Patient Consent:

I (Name).....

of (Address) .....

Consent to, and understand the following. The doctor has explained to me that:

- The administration of anaesthetics, medications, and/or other treatments which could be related to this procedure and their risks;
- I have had the opportunity to ask questions in relation to the above, and I am aware of the likely results, the risks and potential complications;
- other unexpected operations/procedures/treatments may be necessary and I request that these be undertaken as required;
- the operation/procedure/treatment may not give the expected result even though the operation/procedure/treatment is carried out with all due professional care.

Blood Transfusion / Products:

- I understand why I may require a blood transfusion / blood product and have discussed other relevant options with the doctor. I have been informed of the risks and benefits, alternatives to a blood transfusion / product. I was given a Consumer Brochure
- ☐ **Yes I consent to a blood transfusion /product**
- ☐ **No I do not consent to a blood transfusion /product**

Dr ..... has explained as above and I am satisfied with the explanation and answers to my questions.

.....	.....	.....
Name of patient /parent/guardian	Signature	Date
.....	.....	.....
Print Name of Interpreter	Signature:	Date

Medical History must be completed by the patient - before admission

Tick ✓ if you have or have had any of the following and circle any relevant medical history and make any comments you feel would assist in your care.

General Medical History	Yes	No	Comments & Further information
Diabetes - ☐ Diet ☐ Tablet ☐ Injection ☐ Insulin	☐	☐	
Chest Pain / Angina / Palpitations	☐	☐	
Heart attack(s) / Heart Surgery	☐	☐	
High blood pressure	☐	☐	
Any medical devices - Pacemaker / Stents / Pain Infusions	☐	☐	
Rheumatic fever / Heart murmur	☐	☐	
Stroke / limb paralysis / weakness	☐	☐	
Have you had problems with an anaesthetic	☐	☐	
Sleep apnoea / home CPAP	☐	☐	
Shortness of breath after mild exercise	☐	☐	
Have you had recent cold or respiratory illness	☐	☐	
Blood Disorders/ Anaemia	☐	☐	
Asthma/ bronchitis/Emphysema	☐	☐	
Reflux	☐	☐	
Blood Clots legs / lung	☐	☐	
Stress / Panic Attacks / Migraines	☐	☐	
Depression / Mental illness / Dementia/ Parkinsons Disease	☐	☐	
Epilepsy / Dizzy spells/fits / black outs	☐	☐	
Thyroid / Endocrine disorder	☐	☐	
Back Injury/Problems Congenital / Spinal Surgery / Neck surgery	☐	☐	
Previous Head Injury	☐	☐	
Cancer - where	☐	☐	
Bladder problems / Kidney Disorder - stones / Dialysis	☐	☐	
Arthritis Osteoarthritis Rheumatoid	☐	☐	
Glaucoma	☐	☐	
Hepatitis (specify Type A, B, C)	☐	☐	
Are you pregnant / weeks	☐	☐	

Infection Control Assessment	Yes	No	Comments & Further information
Do you have any chronic infections? If yes describe	☐	☐	
Do you currently have any form of infection? If yes describe	☐	☐	
Have you had any illness as such gastroenteritis or been in contact with someone who has Chicken Pox with in the last 14 days	☐	☐	
Intravenous Antibiotic treatment > 4 wks	☐	☐	
History of Intensive Care > 1 wk	☐	☐	
Transferred from an Overseas Hospital	☐	☐	

Have you ever been involved in a "look back" for Creutzeldt Jacob Disease (CJD) or alternatively received and "In Medical Confidence" letter notifying you of a potential exposure to CJD?

Have you been hospital within the last 12 months Yes ☐ ☐ **No**

Smoking: Do you Smoke: Yes ☐ No ☐
Have you ever smoked: Yes ☐ No ☐ Date Ceased:

Alcohol: How often do you consume alcohol? Daily/ Socially/ Rarely

Height: ..... Weight: .....

Allergies: Do you have any allergies? (medication/ food /latex /adhesive tape) No ☐ Yes ☐
If yes, specify what triggers the allergy & reaction you have.

Medications

Do you take or have recently taken blood-thinning medication eg. **Aspirin**, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix or natural blood thinning medication? ☐ Yes ☐ No - **if yes** contact your doctor for further instructions.

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

Date to cease: ..... Date last taken:.....

Have you been told to start any other blooding thinning treatment eg Clexane ☐ Yes ☐ No

Current Medications

Drug Name/ Dose/Frequency		

Surgical History - list and date previous surgery/or procedure where (attach list if insufficient space)

Day Surgery / Endoscopy Discharge Plan

All patients undergoing Day Procedures MUST have an Escort home & a Carer overnight

Do you have someone staying with you overnight Yes ☐ No ☐

Contact details of person collecting you from Hospital - **Phone**: .....

How are you getting home?.....

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

Do you care for others at home? ☐ Yes ☐ No: Specify: .....

Patient Signature: _____ Date: _____

Pre Admission Clinic Assessment – Nursing staff only to complete

Pre Admission Form sighted, Date _____ ☐ No further Action Required

Phone Consult ☐ Date ☐ Clinic Consult _____

Medical 2 Points Each	Score	Surgical 1 Point Each	Score
Insulin dependent diabetic		Major Abdominal Surgery	
Ischeamic heart disease AMI & Angina stents recent history of stents (contact specialist and obtain letter)		Major Vascular / Cardiac Surgery	
Anticoagulants Warfarin or Clopidogrel (antiplatelets) Aspirin		Major Cancer Surgery	
Obstructive Sleep Apnoea		Shared Airway Surgery	
Dementia / Parkinson's Disease		Joint Replacement	
> 85 yrs – both medical & surgical pts		Revision Joint Replacement	
Medical 1 Points Each			**Score**
> 70 yrs – both medical & surgical pts		COPD / Asthma / Smoker =1 point for each condition	
BMI >30 Obesity		Deep Venous Thrombosis or Pulmonary Embolism	
Heart Valve Replacement / Arrhythmias Anaemia		Non Insulin Dependent Diabetes Mellitus	
Hypertension		Epilepsy	
Pre Admission Triage Score **Add up total Score as per Pre Admission Protocol**		**Total Points**	

Reference - In addition use clinical judgment to triage patient accordingly if they do not fit the relevant criteria

Less than 4 Continue all Cardiac medications, cease smoking, review by Anaesthetist in Hospital

Anaesthetist Problems - Contact Anaesthetist

4-6 Contact Anaesthetist **6-8** Contact Surgeon re referral to Physician or seek report & contact Anaesthetist

8 or more Contact Surgeon re referral to Physician & ICU / HDU bed

Discharge Risk Assessment Tool

Discharge Risk Factors

Three or more medications & recently changed in last 2 wks ☐

Cognitive Impairment ☐

Multiple Chronic Conditions ☐

Falls History last 12 mths ☐ Mobility Impairment ☐

Psychosocial Concerns eg emotional, financial, legal ☐

Multiple Hospital Admissions ☐

Living Alone ☐

Are they a carer? ☐

Do they have difficulties with activities of daily living? ☐ Are they receiving or needing Community Services

Home Access and Safety Issues ☐

Lives Long Distance ☐ Accommodation Issues ☐ Requires Transport Services ☐

Contact Discharge Planner, Social Worker, Occupational Therapist- if any of the above risks are identified

Pre Admission Assessment Nursing & Allied Health Summary

☐ **Pathology as per surgeon protocol** State what pathology	☐ **Radiology as per surgeon protocol completed**
	☐ Request form ☐ Attended When
☐ Other	☐ Other

Outcome Referral	**Date**	**Signature**
Anaesthetist		
Physician		
Infection Control		
Dietician Score– (refer to dietician of **> 2** above)		
Referrals to Allied Health - Who and when?		
Nurse Unit Manager		
Clinical Pathway / Other		
Falls Risk commenced in Clinical Pathway		
VTE Risk assessment commenced in Clinical Pathway		

Date	**Comments**	**Signature**
	Note any Drugs to be ceased prior to surgery	