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.

Patient Pre - Admission Questionnaire

The patient must complete front page and pages 1- 4

It is important that you return this document at least 5 days prior to your surgery.

Name: _____

Day of Admission: _____ **Day of Surgery:** _____

Surgeon: _____

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

☐ No ☐ Yes Where: .....

How long where you admitted: .....

If you have, any queries ask your doctor or contact the

Pre Admission Clinic 9900 7494

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 & Day Surgery 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 _____

Surname: _____ **Given Names:** _____

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

Address: _____

Suburb: _____ State: _____ Postcode: _____ Country _____

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

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 to 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 is: **Do not use abbreviations** .....

.....

.....

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

Patient Consent:

I .....

of .....

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.

Orthopaedic Patients only - if having Bone Graft consent to:

1. Bone (allograft and non-irradiated allograft) from a TGA licensed approved Bone Bank may be necessary to fill defects in the bone during the procedure.
2. Bone tissue and (in the case of revision surgery) implants that are removed at the time of surgery may be used by researchers approved by the St Vincents & Mater Health Ethics Committee for investigating the cause of success or failure of joint replacement surgery.
3. As an additional precaution for myself, and the hospital, blood testing for Human Immunodeficiency Virus "HIV" and Hepatitis B&C prior to receiving a bone graft e is recommended /suggested.

☐ **Bone graft information given to patient if having a Bone graft.**

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

Interpreter Required ☐ No ☐ Yes Language: .....

Reason for Admission, Procedure or Presenting Illness: .....

.....

.....

.....

Do you see any other Specialist for any other conditions ☐ No ☐ Yes if yes List any Names and details:

(eg Cardiologist) .....

.....

.....

..... Phone: .....

Allergies: Do you have any allergies? No ☐ Yes ☐ If yes, specify what triggers the allergy & what reaction you have.	**Staff Use**
	☐ Allergies documented on Med Chart & Theatre Alert Form completed

Pathology / X-Rays or Other Test Results	**Staff Use**
Have blood tests/ pathology/ autologous blood been taken for this admission ☐ Yes ☐ No	Results available
Which Company? ..... When?	☐ In file
Have you had a recent ECG/ Echocardiogram? ☐ Yes ☐ No	☐ Online
Have ☐ X-rays ☐ CT scan ☐ MRI been taken for this admission? If yes, please bring with you for this admission ☐ Yes ☐ No	☐ Not available

Current Medications

Please list **All** medications including complimentary medications & bring these to hospital in their original container (attach a list if insufficient space).

Do you take or have recently taken blood-thinning medication eg. **Aspirin**, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix or natural blood thinning medication? ☐ Yes ☐ No

Have you been told to cease this? ☐ Yes ☐ No by who.....

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

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

Drug Name	Dose	Frequency

Surgical History - list and date previous surgery & where. (attach list if insufficient space)		
General Medical History		**Comments & Further information**
Height: ..... Weight:	Yes – No	Weight / Height^{m2} = ... BMI > **120 kg** Notified ward / OT hover matt > 100 kg
Heart Conditions ☐ Heart Attack ☐ Chest Pain ☐ Angina ☐	Y – N	Details
Cardiac Surgery ☐ Pacemaker ☐ Prosthetic Valve ☐ Grafts ☐ Stents ☐ Angioplasty ☐ Any other ☐	Y – N	Bring ID information Is surgeon aware? ☐ Yes ☐ No Pacemaker last checked: .....
Heart Irregularities: Palpitations ☐ Irregular Heart Beat ☐ Heart Murmur ☐	Y – N	Details
High Blood Pressure	Y – N	When was your BP last checked? .....
Blood clots in legs ☐ or lung ☐	Y – N	Specify: Is Surgeon aware? ☐ Yes ☐ No
Have you had any Anaesthetic Reactions Any neck problems	Y – N Y – N	Details:
Diagnosed Sleep Apnoea	Y – N	Bring CPAP Machine to hospital
Asthma ☐ Bronchitis ☐ Emphysema ☐ shortness of breath on exertion ☐ Hay Fever ☐ Pneumonia ☐ TB ☐ COPD ☐	Y – N	Specify: ..... Do you use ☐ Oral Steroids ☐ Puffer ☐ Nebulisers ☐ Home oxygen Bring all Asthma medications
Diabetes: Type 1 ☐ Type 2 ☐	Y – N	Controlled by ☐ Diet ☐ Tablet ☐ Insulin ☐ Pump
Do you have instructions how to manage your diabetes before surgery	Y – N	Details
Blood Disorders ☐ Anaemia ☐	Y – N	Details
Blood Transfusion Reaction	Y – N	Type of reaction .....
Stroke ☐ Mini Stroke ☐ MS Motor Neurone Disease ☐	Y – N	Any residual weakness or symptoms?
Do you have Parkinson's Disease	Y – N	Treatment
Short Term Memory Loss ☐ Confusion ☐	Y – N	Details
Mental Illness ☐ Anxiety ☐ Depression ☐ Psychosis ☐	Y – N	Details
Epilepsy ☐ Fits ☐ Seizures ☐	Y – N	Details: ..... Last seizure..... Treatment.....
Faints ☐ Blackouts ☐ Dizzy Spells ☐ Migraine ☐	Y – N	Details
History of falls	Y – N	Details
Do you have any prosthetics joint replacements Hip ☐ Knee ☐ Mobility aid, eg frame ☐ stick ☐	Y – N	Specify Please bring to hospital
Have you been treated for chronic pain	Y – N	What medications were given? Was this medication effective? ☐ Yes ☐ No

General Medical History		Comments & Further information
Elimination issues: Bowel or bladder problems ☐ incontinence ☐ stoma – colostomy ☐	Y – N	Specify
Reflux ☐ Hiatus Hernias ☐ Gastric Ulcers ☐ Gastric Banding ☐	Y – N	Specify
Cancer - type	Y – N	Date diagnosed ..... ☐ Chemotherapy ☐ Radiotherapy
Skin Conditions: Wounds ☐ ulcers broken skin Dermatitis ☐	Y – N	Details of current treatment
☐ Pregnant ☐ Breastfeeding	Y – N	Due date Details
Do you wear glasses ☐ contact lens or hearing aids ☐	Y – N	Aid used
Do you have Glaucoma	Y – N	Treatment
If you have any other medical problems not listed – give details (attach list if insufficient space).		
Dentures **Upper** ☐ Partial ☐ Full **Lower** ☐ Partial ☐ Full	☐ Crown /Bridges ☐ Loose teeth ☐ Implants ☐ Caps	

Infection Control Assessment			Staff Use
Infectious Disease: HIV / Hepatitis / or other infections	Y - N	Specify: Treatment:	Contact Infection Control Manager
Have you had a respiratory illness or cough recently?	Y - N	Currently taking antibiotics? ☐ Yes ☐ No Surgeon aware? ☐ Yes ☐ No	
Have you had any illness as such gastroenteritis or been in contact with someone who has Chicken Pox with in the last 14 days?	Y - N	Details	
Intravenous Antibiotic treatment > 4 wks	Y - N	Details:..... Why:..... When:	☐ VRE swabs
History of Intensive Care > 1 wk	Y - N	Details:..... Why:..... When:	☐ MRSA swabs ☐ VRE swabs
Transferred from an Overseas Hospital	Y - N	Details	☐ MRSA swabs ☐ VRE swabs

MRSA screening should be performed on patients with risk factors – ie history of MRSA, hospital or nursing home admissions in the past 12 months, existing wounds, ulcers, drains sites and catheter specimens if IDC in situ.

Creutzeldt Jacob Disease			Staff Use
History of acute onset dementia or other progressive neurological conditions	Y - N		☐ Infection Control notified & Theatre ☐ If the patient is having Neuro Surgery a completed CJD Form should be completed/ attached from the Surgeon's room
Have you ever had neurological surgery: eg brain or spinal surgery	Y - N	Surgeon: ..... Hospital:..... When:	
Human pituitary hormones prior to 1985 for growth or infertility	Y - N		
Family history of CJD or progressive neurological disorder	Y - N		

Lifestyle		Comments & Further information
Do you smoke Have you ever smoked	Y – N Y – N	Amount Date ceased
Alcohol intake	Y - N	Amount Frequency: ☐ Any Free Days
Illicit Drugs use	Y - N	Type: .....Frequency: .....

Nutritional Score

Have you recently lost weight without trying? ☐ Yes ☐ No = **0** ☐ Unsure = **2**

If yes to weight loss ☐ 1-5kg = **1** ☐ 6-10kg = **2** ☐ 11-15 kg = **3** ☐ > 15kg = **4**

If you have been eating poorly due to decrease in appetite ☐ Yes = **1** ☐ No = **0**

Food intolerance or allergies ☐ Yes ☐ No Describe exact food & response

Special diet needs ☐ Yes ☐ No

☐ Diabetic ☐ Kosher ☐ Other specify: .....

☐ Texture modified ☐ Gluten Free ☐ Thickened Fluids

Do you require assistance with meals ? ☐ Yes ☐ No

☐ Cut up ☐ Packets opened ☐ Special utensils ☐ Assistance with eating

Staff Use

Nutritional Assessment

Score of **> 2** above – refer to dietician ☐

☐ Hovermatt for **> 100kg or for under weight patients**

Day Surgery Discharge Plan

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

How are you getting home?.....

Who is staying with you overnight? Name:..... Phone: .....

Overnight Patient Discharge Plan (note discharge time is 0930)

Household Arrangement

☐ Alone ☐ With Carer ☐ With Family ☐ Other, specify .....

Home Environment

☐ House /Flat ☐ Retirement Village ☐ Nursing Home ☐ Hostel ☐ Other? .....

At home, are there ☐ Stairs internal /external, with / without rails: How many? .....

☐ Separate Shower ☐ Shower over bath

Activity assessment - do you cope independently with daily living eg showering, dressing?

☐ Yes ☐ No specify assistance required: .....

Support services:

☐ No services ☐ Family /Friends ☐ Personal Carer ☐ Delivered Meals ☐ Shopping

☐ Home Nursing ☐ Home Help ☐ Personal Alarm ☐ Care Package ☐ Case Manager

Staff use

Issues Identified

Referred

☐ DVA Discharge Planner

☐ Social worker

☐ Occupational Therapist

☐ Breast Care Nurse

☐ Stoma Therapist

☐ Speech Therapist

Are you planning on going to Rehabilitation ☐ Yes ☐ No if yes where: .....

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

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

Any additional patient information

Person collecting you from Hospital

Name ..... Phone .....

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

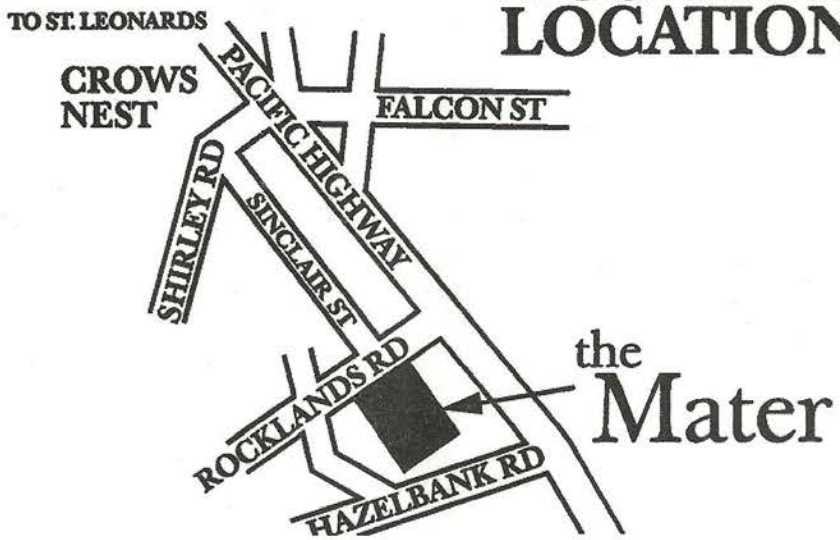
Pre Admission Assessment Nursing & Allied Health Summary

☐ **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	

HOSPITAL LOCATION



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