MR 200

Western Private Hospital

PRE-ADMISSION HEALTH QUESTIONNAIRE

PLEASE COMPLETE ALL 4 PAGES

Attach patient identification label

Patient Details

UR No: ..... Admission No: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Admission Date:		**STAFF USE ONLY**	**Admission Text Tracking**			**Initial of Staff Member** ↓
Admission Time:			**Text Sent**	Date:	Time:	
			Response Received	Date:	Time:	

PATIENT HISTORY - *Please circle appropriate box.*		**STAFF USE ONLY**
Reason for Admission / Operation:		
Proposed operation / procedure:		
Do you require an interpreter? No Yes	Language:	Refer Policy C30P
Do you have any religious / cultural needs: No Yes (specify)		
Height:	Weight: / BMI (Staff Use Only):	Theatre notified if BMI >40

ALLERGIES - *Please document any known allergies.*		**STAFF USE ONLY** *Please initial*
ALLERGY / SENSITIVITY	REACTION	Red alert bands applied? Y N
		Adverse Reaction Alert Record & Medication Chart completed
Food allergy: No Yes		Kitchen notified? Y N
Latex allergy: No Yes		Theatre notified? Y N

CURRENT MEDICATIONS - *Please list ALL medications and bring these into hospital with you in their original containers / boxes.*

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency
			Staff Use Only Documented on Medication chart? Y N		

Have you had a previous blood transfusion? No Yes Did you have any reaction? No Yes (specify)

SURGICAL HISTORY - *Please list any previous surgery you have had.*

Any previous problems with Anaesthetics? No Yes (specify)	Theatre notified? Y N

TO BE COMPLETED BY THE PATIENT

PRE-ADMISSION HEALTH QUESTIONNAIRE MR 200

Patient Name: ..... UR Number: .....

ENDOCRINOLOGY - *Please circle appropriate box.*			*Name of Treating Dr*			**STAFF USE ONLY** *Please initial*
Diabetes?	No	Yes	Type 1		Type 2	☐ *Diabetic chart in history* ☐ *BSL on admission* ☐ *IBA Diet List updated* ☐ *Management plan documented*
controlled by			Diet	Tablets	Insulin	
Thyroid problems?	No	Yes	Specify:			

GASTROINTESTINAL - *Please circle appropriate box.*			*Name of Treating Dr*			**STAFF USE ONLY** *Please initial*
Indigestion / reflux	No	Yes				
Gastric / Peptic Ulcer	No	Yes				
Bowel elimination issues	No	Yes	Ileostomy		Colostomy	*Bowel management plan / stomal therapist required?* *Y N*
			Constipation		Diarrhoea	
Liver Disease	No	Yes	Specify:			
Hepatitis	No	Yes	Type A	Type B	Type C	

OTHER - *Please circle appropriate box.*						**STAFF USE ONLY** *Please initial*
Do you have existing wounds, pressure areas, ulcer, broken or reddened skin?	No	Yes	Specify:			*Wound chart completed?* *Y N* *Riskman completed? Y N*
Females - Are you pregnant?	No	Yes	_____ Weeks		Breastfeeding? Y N	*Consultant notified? Y N*
Do you drink alcohol?	No	Yes	How many per day?			*MR 715 AWS required?* *Y N*
Smoker?	No	Yes	How many per day?			
Ex-smoker?	No	Yes	When ceased?			
Do you use recreational drugs?	No	Yes	Specify:			
Visual Aids?	No	Yes	Glasses		Contact Lenses	*Aids labelled? Y N*
			Slight impairment		Prosthesis	
Hearing Aids?	No	Yes	Left	Right	Both	*Aids labelled? Y N*
Walking Aids?	No	Yes	Stick	Crutches	Wheelchair	*Aids labelled? Y N*
			Pick up frame	2 wheel frame	4 wheel frame	
Dentures?	No	Yes				
Do you have Creutzfeldt Jacob Disease (CJD)?	No	Yes	Unsure			
Have you had Human Pituitary Growth Hormone prior to 1985?	No	Yes				*Theatre notified? Y N*
Have you had neurosurgery prior to 1985?	No	Yes				
Have you or do you have MRSA, VRE or any other infectious disease?	No	Yes	Specify:			*NUM and Infection Control notified? Y N*

PATHOLOGY / MEDICAL IMAGING - *Please circle appropriate box.*					**STAFF USE ONLY** *Please initial*
For **<u>this admission</u>** have you had any:					
Pathology tests	No	Yes	At:	Date:	*Received? Y N* *Sign:*
ECG / Stress ECG	No	Yes	At:	Date:	*Received? Y N* *Sign:*
Echocardiogram / Stress Echo	No	Yes	At:	Date:	*Received? Y N* *Sign:*
X-rays	No	Yes	At:	Date:	*Received? Y N* *Sign:*
CT / MRI / CT Coronary Angiogram	No	Yes	At:	Date:	*Received? Y N* *Sign:*
Other (Specify)					*Received? Y N* *Sign:*

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Patient Name: ..... UR Number: .....

NEUROLOGICAL - *Please circle appropriate box.*			*Name of Treating Dr*	**STAFF USE ONLY** *Please initial*
Stroke	No	Yes	Residual effects:	*Falls risk? Y N*
Epilepsy / Seizures	No	Yes	Last episode:	*Falls chart completed? Y N*
Short term memory loss / Confusion	No	Yes		
Alzheimer's / Dementia	No	Yes		
MS / MND / Parkinson's	No	Yes		
Mental Illness, Anxiety / Depression	No	Yes		

CARDIOVASCULAR - *Please circle appropriate box.*			*Name of Treating Dr*	**STAFF USE ONLY** *Please initial*
Elevated cholesterol / triglycerides	No	Yes	Taking cholesterol medication? No Yes	*Admission ECG? Y N*
High blood pressure / Hypertension	No	Yes	Taking blood pressure medication? No Yes	*Preadmission Echo? Y N*
Chest pain / angina	No	Yes		
Palpitations, irregular heartbeats / AF	No	Yes		
Rheumatic fever / heart murmur / valvular disease	No	Yes		
Replacement / Repair heart valve	No	Yes	Year: Type:	
Previous DVT, pulmonary embolism, varicose veins	No	Yes		*TEDS required? Y N*
Coronary Bypass Surgery	No	Yes	Year: Vessels Bypassed:	
Coronary / Vascular stent	No	Yes	Year: Vessels Stented:	
Pacemaker / AICD	No	Yes	Year: Model:	
Heart failure	No	Yes		*Fluid Balance Chart? Y N*
Family history of heart disease	No	Yes		
Peripheral Vascular Disease	No	Yes	Specify:	

RESPIRATORY - *Please circle appropriate box.*			*Name of Treating Dr*	**STAFF USE ONLY** *Please initial*
Bronchitis / Asthma / COAD / Emphysema / Asbestosis	No	Yes	Specify:	*CXR required? Y N*
Sleep Apnoea or Snoring	No	Yes	CPAP used? No Yes	*CPAP machine in hospital? Y N*
Shortness of breath or other lung problem	No	Yes	Specify:	

RENAL - *Please circle appropriate box.*			*Name of Treating Dr*	**STAFF USE ONLY** *Please initial*
Renal failure / Impairment	No	Yes	Last Creatinine Date	*Preadmission pathology? Y N*
Renal Disease	No	Yes	Specify:	*FBC required? Y N*
Are you on renal dialysis?	No	Yes	Peritoneal or Haemodialysis Access site - specify:	
Bladder issues	No	Yes	Specify:	
Urinary incontinence	No	Yes	Specify:	

BINDING MARGIN – DO NOT WRITE IN THIS AREA

Patient Name: ..... UR Number: .....

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CARE DIRECTIVES - *Please circle Yes or No.*					**STAFF USE ONLY**
Do you have any of the following in place? If yes, please ensure you bring a copy to the hospital.	Advanced Care Directive	Yes No	End of life Plan	Yes No	*Please document on ADR*
	Medical Power of Attorney	Yes No	Refusal of Treatment	Yes No	

DISCHARGE PLANNING / READMISSION RISK SCREENING - *Please circle appropriate box.*					**STAFF USE ONLY** *Please initial*
Do you live alone?	Yes	No	Partner	Spouse	
			Family	Other	
Comment: _____					
Are you the primary caregiver for another person?	No	Yes	Specify:		
Do you live in your own home?	Yes	No	Hostel	Independent living unit	
			Nursing home	Other	
Comment: _____					
Have you tripped or fallen in the last 6 months?	No	Yes	Specify:		*Falls Risk chart completed? Y N*
Where do you plan to go after discharge?					
Who will be caring for you after discharge?	Name:		Phone:		
Who can we contact during your admission regarding discharge issues?	Name:		Phone:		
Discharge time is 10am. Who will transport you home?	Name:		Phone:		
List any community services you have in place.					

ORIENTATION TO WARD (Staff Use ONLY)

☐ ID Band	☐ Visiting hours	☐ Meal times
☐ Toilet / bathroom	☐ Bed controls	☐ Lounge room
☐ Fire Exits	☐ Telephone	☐ Direct phone number
☐ WiFi password	☐ TV / Call bell	☐ Valuable policy

VALUABLE POLICY

I understand that whilst care is taken, all personal belongings are left at my own risk. Western Private Hospital can take no responsibility for belongings left in our care.

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

Patient Name: _____

Signature: _____ Date: _____

	Name:	*Signature / Designation:*	*Date:*
Preadmission Planner			
Admitting Nurse			
Accepting Ward Staff			

BINDING MARGIN – DO NOT WRITE IN THIS AREA