

MR 200



Western Private Hospital

PRE-ADMISSION HEALTH QUESTIONNAIRE

PLEASE COMPLETE ALL 4 PAGES

Attach patient identification label

UR No: Admission No: Surname: Name: Date of Birth: Gender: Dr:

Patient Details

Table with admission date, time, staff use only section, and admission text tracking (Text Sent, Response Received, Date, Time, Initial of Staff Member).

PATIENT HISTORY - Please circle appropriate box. Includes Reason for Admission, Proposed operation, Interpreter needs, Religious/cultural needs, Height, Weight, BMI, Theatre notified if BMI >40.

ALLERGIES - Please document any known allergies. Includes Latex allergy, Food allergy, Allergy/Sensitivity table with Reaction, Red alert bands applied, Adverse Reaction Alert Record & Medication Chart completed.

CURRENT MEDICATIONS - Please list ALL medications and bring these into hospital with you in their original containers / boxes. Table with columns for Drug Name, Dose, Frequency.

Staff Use Only Medication Information Source [] GP [] Community Pharmacy [] Patient/NOK Reviewed using BPMH 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. Multiple empty rows for listing surgery.

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

TO BE COMPLETED BY THE PATIENT

PRE-ADMISSION HEALTH QUESTIONNAIRE

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BINDING MARGIN - DO NOT WRITE IN THIS AREA

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UR Number: Patient Name: DOB:/...../.....

ENDOCRINOLOGY - Please circle appropriate box.			Name of Treating Dr			STAFF USE ONLY Please initial
Diabetes?	No	Yes	Type 1		Type 2	<input type="checkbox"/> Diabetic chart in history <input type="checkbox"/> BSL on admission <input type="checkbox"/> IBA Diet List updated <input type="checkbox"/> Management plan documented
controlled by			Diet	Tablets	Insulin	

Thyroid problems?	No	Yes	Specify:			
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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 this admission 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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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			

HAEMATOLOGICAL DISORDERS - Please circle appropriate box.			Name of Treating Dr		STAFF USE ONLY Please initial
Leukaemia / Myeloid Disorders Coagulopathy / Dyscrasia Other	No	Yes	Please specify:		

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	No	Yes			TEDS required? Y N
Pulmonary embolism	No	Yes			TEDS required? Y N
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 attack / AMI	No	Yes			
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	No	Yes	CPAP used? No Yes		CPAP machine in hospital? Y N
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:		



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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
	Medical Power of Attorney	Yes	No	Refusal of Treatment	Yes	No

Please document on ADR

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:
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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
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Where do you plan to go after discharge?

Who will be caring for you after discharge?	Name:	Phone:
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Who can we contact during your admission regarding discharge issues?	Name:	Phone:
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Discharge time is 10am. Who will transport you home?	Name:	Phone:
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List any community services you have in place.

ORIENTATION TO WARD (Staff Use ONLY)

<input type="checkbox"/> ID Band	<input type="checkbox"/> Visiting hours	<input type="checkbox"/> Meal times
<input type="checkbox"/> Toilet / bathroom	<input type="checkbox"/> Bed controls	<input type="checkbox"/> Lounge room
<input type="checkbox"/> Fire Exits	<input type="checkbox"/> Telephone	<input type="checkbox"/> Direct phone number
<input type="checkbox"/> WiFi password	<input type="checkbox"/> TV / Call bell	<input type="checkbox"/> Valuable policy

VALUABLE POLICY

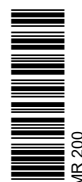
I understand that whilst care is taken, all personal belongings are left at my own risk. Western Private Hospital can take no responsibility for belongings left in our care.

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: _____

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



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