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: .................................... Sex at Birth: ...............................

Dr: ............................................................................................................

**TO BE COMPLETED BY THE PATIENT**

| 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 to Interpreter Service Policy |
| 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* |
|---|---|---|---|
| Latex allergy: No Yes | Drug allergy: No Yes | | Theatre notified? Y N |
| Food allergy: No Yes | | | Kitchen notified? Y N |
| **ALLERGY / SENSITIVITY** | **REACTION** | **DATE OF REACTION** | Red alert bands applied? Y N |
| | | | |
| | | | |
| | | | *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.*

| Drug Name | Dose | Frequency | 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.*

| |
|---|
| |
| |
| |
| |
| |
| |

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

**PRE-ADMISSION HEALTH QUESTIONNAIRE MR 200**

MR 200

BINDING MARGIN – DO NOT WRITE IN THIS AREA

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 | ☐ *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 | | | | |
| **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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UR Number: ................................................ Patient Name: ........................................................................................... DOB: ......../......../.............

| 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 HEALTH** - *Please circle appropriate box.* | | | *Name of Treating Dr* | | ***STAFF USE ONLY*** *Please initial* |
| Mental Health or Psychological Diagnosis *(e.g. panic disorder, anxiety depression, Post Traumatic Stress Disorder (PTSD) etc)* | No | Yes | Please specify: | | |
| Are you currently experiencing or having suicidal or self harm thoughts | No | Yes | | | *If YES, notify treating dr* |
| **HAEMATOLOGICAL DISORDERS** - *Please circle appropriate box.* | | | *Name of Treating Dr* | | ***STAFF USE ONLY*** *Please initial* |
| Leukaemia / Myeloid Disorders<br>Coagulopathy / Dyscrasia<br>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<br>Access site - specify: | | |
| Bladder issues | No | Yes | Specify: | | |
| Urinary incontinence | No | Yes | Specify: | | |

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

| 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. | Enduring Power of Attorney / Medical Treatment Decision Maker Yes No<br>Advanced Care Directive Yes No<br>(i.e. End of Life plans, Treatment Limitations, Refusal of Treatment)<br>Comments: ________________ | *Please document on ADR* |
| **GOALS OF ADMISSION** | | |
| What is important to you during this admission or what would you like to achieve during this admission? | | |

| DISCHARGE PLANNING / READMISSION RISK SCREENING - *Please circle appropriate box.* | | | | | STAFF USE ONLY *Please initial* |
|---|---|---|---|---|---|
| Do you live alone? | Yes | No | Partner / Family | Spouse / Other | |
| Comment: ________________ | | | | | |
| Are you the primary caregiver for another person? | No | Yes | Specify: | | |
| Do you live in your own home? | Yes | No | Hostel / Nursing home | Independent living unit / 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