



**Pre Admission Service
QUESTIONNAIRE**

Page 1

UR NUMBER:
 SURNAME:
 GIVEN NAMES:
 DATE OF BIRTH:
Please fill in if no Patient Label available

Rev. 11/7/07 - 10562

Please complete this questionnaire and return immediately, in the Reply Paid Envelope provided. Incomplete or unreturned forms may cause your surgery to be delayed.
 You may wish to ask a family member, friend or carer to help you. If you require further information, your local Doctor may be able to assist. To contact the Pre Admission Service phone 9784 7340, during business hours.

Name:
 Address: Postcode:
 Phone Work/Contact No Marital Status Sex
 Religion Country of Birth
 Public patient Private patient DVA - No Other (specify)

Next of Kin: Name Relationship
 Address Postcode
 Phone No. (home) (other)
 Second Contact: Name Phone No.

Local Doctor: Name Phone No.
 Do you require an Interpreter? No Yes If yes, what language?
If you do require an interpreter, please phone us on 9784 7340 to arrange a booking

General Health Information Please ✓ boxes as appropriate

	No	Yes
Do you have a problem with your speech?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a problem with your eyesight?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lens <input type="checkbox"/> Eye prosthesis.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any hearing difficulty?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a hearing aid? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both.....	<input type="checkbox"/>	<input type="checkbox"/>
Has your bowel pattern changed recently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from? <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a stoma? (colostomy, ileostomy etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems passing urine (eg. pain, odour, blood, incontinence, flow).....	<input type="checkbox"/>	<input type="checkbox"/>
Please state:.....		
Do you have any dentures: <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial plate.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any loose or broken teeth.....	<input type="checkbox"/>	<input type="checkbox"/>

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OFFICE USE ONLY

Planned Procedure / Operation:

Proposed date of operation:/...../.....	Admission Date/...../.....	Admission Time	M.T.	D.S.U.	Rosebud	Radiology	Endoscopy
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PRE ADMISSION SERVICE QUESTIONNAIRE MR/004 PACQ

Discharge Planning

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No Yes

1. Do you live alone?

2. Do you live in a rooming house or in a long term care facility e.g. nursing home, hostel, special accommodation - *circle*

3. Do you have responsibility for the care of others at home? e.g. sole parent, care of disabled relative - *circle*

4. Do you currently require assistance with
 toileting / showering / bathing / dressing / cooking / housework /shopping?

5. If needed will assistance be available when you return home?

6. Do you currently receive any support services? e.g. district nursing, meals on wheels, home-help, personal care,
 respite care, Linkages, Community Aged Care Packages - *please circle*

7. Are you currently employed?

8. What is your occupation

9. Will there be a change in your financial situation due to your hospitalisation (eg. income loss)?

10. Do you receive a pension?

11. Have you had any falls in the past few months?

12. Do you use any mobility aids such as a stick, frame or wheelchair etc.?

13. Do you have any eating difficulties or special eating/dietary needs?

14. Have you experienced a recent change in swallowing (eg. choking, difficulty chewing)?

15. Has your speech deteriorated in the last few months?

16. Are you concerned about rehabilitation after your surgery?

17. We advise that you should have someone to stay with you on your first night at home after discharge from hospital ..
 Who will stay with you? - Name: Phone No.

18. Do you have an adult to take you home from hospital - Name: Phone No.

19. How long do you expect to be in hospital

Signature of Person Completing Form: Date Signed

Relationship to Patient (if not completed by the patient):

REMEMBER: Please post this questionnaire immediately using the Reply Paid Envelope provided. Incomplete forms may delay your admission. Thank you for completing this form.

Frankston Pre Admission Clinic Nursing Staff use only

Screened by: Date.....

PAC Attendance required - Mandatory Category Anaesthetic Assessment Yes No

Further assessment required (non mandatory category) G.P. Review Phone Patient Review History

PAC Attendance required - Non - Mandatory Category for Anaesthetic Assessment

Admit as arranged

Action:

.....

.....

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IMPORTANT - PLEASE COMPLETE ALL 4 PAGES OF THIS FORM ACCURATELY

Please complete this section carefully - It is very important to give an accurate weight

How old are you?.....
What is your weightkgs or stone
What is your height.....cms or feet and inches
Has your weight changed much in the last 3 months No Yes

OFFICE USE ONLY

BMI
(BMI> 35 not suitable for Rosebud)

Medications: Please list all medications you are taking including any drugs or medicine not prescribed by a doctor:

Allergies
Are you allergic to any Medications? No Yes What medication or product:.....
Are you allergic to Latex or rubber products? No Yes What reaction:
Are you allergic to anything else? No Yes What reaction:
e.g. bandaids, tapes, food etc.

	Surgery	Year	Surgery	Year

Please ✓ boxes as appropriate.
If you answer Yes to any questions, please give as much information as possible. You may attach a separate piece of paper if you need to write more information.

Do you have or have you ever had any of the following

1. High blood pressure..... No Yes When

2. Angina or chest pain, No Yes If no go to Question 3
(a) How often do you get angina?
(b) Do you get angina during activity or exercise?
(c) Do you get angina when resting or at night?

3. Heart attack..... No Yes When.....

4. Palpitations or irregular heart beat..... No Yes When.....

5. Insertion of heart valve or other heart prosthesis or pacemaker (please specify) No Yes When.....

6. Rheumatic fever..... No Yes When.....

7. Heart Murmur..... No Yes

8. (a) Are you being treated by a Cardiologist / Heart Specialist No Yes Last Visit / /
(b) What is the Specialist's name

Do you have or have you ever had any of the following

9. Are you being treated by a Lung / Respiratory Specialist No Yes Last Seen / /
(b) What is the Specialist's name

10. Do you smoke No Yes How many per day

11. Are you an ex-smoker..... No Yes When did you stop

12. Asthma or shortness of breath (please specify) No Yes When.....

13. Bronchitis or emphysema (please specify) No Yes When.....

14. Pneumonia or tuberculosis (T.B.) (please specify) No Yes When.....

15. Obstructive sleep apnoea as diagnosed by your doctor No Yes CPAP Machine No Yes

16. Shortness of breath that prevents you from climbing one flight of stairs No Yes

17. Home Oxygen therapy No Yes

18. Do you drink alcohol No Yes How much per week.....

19. Problem with alcohol or drug use..... No Yes

20. Hepatitis, jaundice, cirrhosis or pancreatitis (please specify) No Yes What and When

21. Kidney disorder - stones, infection, failure, dialysis (please specify)..... No Yes What and When

22. Organ transplant (please specify)..... No Yes When.....

23. Diabetes..... No Yes Treated by:
 diet tablets insulin

24. Gastric reflux, hiatus hernia, heartburn, indigestion (please specify) No Yes What.....

25. Stroke..... No Yes When.....

26. Epilepsy, fits, fainting or "funny turns" (please specify)..... No Yes What

27. Significant neck or back injury/disorder (please specify)..... No Yes What and When

28. Blood disorder (leukaemia, anaemia, haemophilia or other) (please specify)..... No Yes What and When

29. Blood transfusion No Yes When.....

30. Blood clot in legs or lungs (please specify)..... No Yes When.....

31. Do you have any risk factors for Creutzfeldt Jakob Disease (CJD)..... No Yes What.....

32. Psychiatric problems..... No Yes When.....

33. Does any condition prevent you from undertaking normal daily activities No Yes What.....

34. Have you ever had any problems with anaesthetics or surgery before (e.g. prolonged nausea, high temperature, prolonged drowsiness) No Yes What.....

35. Do you have any blood relatives who have had problems with anaesthetics No Yes What.....

36. Female patients only: Could you be pregnant? No Yes How many weeks

37. List any serious illness or medical condition (eg. cancer or HIV) or admissions to hospital not already listed:.....
.....
.....

38. Have any of the above medical conditions become worse in the last 3 months No Yes What

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OFFICE USE ONLY - Anaesthetic Screening

Screened by: Date

Further assessment required Re:.....
 G.P. Review Appt. Contact G.P. only Phone Patient Review History

PAC Attendance required for Anaesthetic review Admit as arranged Suitable only for Main Theatre

Comments:.....
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