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?	☐	☐
Do you have a problem with your eyesight?	☐	☐
Do you wear ☐ Glasses ☐ Contact Lens ☐ Eye prosthesis	☐	☐
Do you have any hearing difficulty?	☐	☐
Do you wear a hearing aid? ☐ Left ☐ Right ☐ Both	☐	☐
Has your bowel pattern changed recently?	☐	☐
Do you suffer from? ☐ Constipation ☐ Diarrhoea ☐ Blood in Stools	☐	☐
Do you have a stoma? (colostomy, ileostomy etc.)	☐	☐
Do you have any problems passing urine (eg. pain, odour, blood, incontinence, flow)	☐	☐
Please state:		
Do you have any dentures: ☐ Upper ☐ Lower ☐ Partial plate	☐	☐
Do you have any loose or broken teeth	☐	☐

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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
...../ ...../	...../ ...../	.....					

PRE ADMISSION SERVICE QUESTIONNAIRE MR/004 PACQ

Discharge Planning **Page 4**

	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

HEIGHT/WEIGHT/AGE

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

How old are you?.....

What is your weight .....kgs or ..... stone

What is your height.....cms or ..... feet and inches

Has your weight changed much in the last 3 months ☐ No ☐ Yes

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BMI .....

(BMI> 35 not suitable for Rosebud)

MEDICATIONS

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

ALLERGIES

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? e.g. bandaids, tapes, food etc. ☐ No ☐ Yes What reaction: .....

SURGICAL HISTORY

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.

CARDIAC

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

		No	Yes	
1.	High blood pressure.....	☐	☐	When .....
2.	Angina or chest pain, ...	☐	☐	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.....	☐	☐	When.....
4.	Palpitations or irregular heart beat.....	☐	☐	When.....
5.	Insertion of heart valve or other heart prosthesis or pacemaker (*please specify*)	☐	☐	When.....
6.	Rheumatic fever.....	☐	☐	When.....
7.	Heart Murmur.....	☐	☐	
8.	(a) Are you being treated by a Cardiologist / Heart Specialist	☐	☐	Last Visit ...../...../.....
	(b) What is the Specialist's name			

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

RESPIRATORY

		No	Yes	
9.	Are you being treated by a Lung / Respiratory Specialist	☐	☐	Last Seen ...../...../.....
	(b) What is the Specialist's name			
10.	Do you smoke	☐	☐	How many per day .....
11.	Are you an ex-smoker.....	☐	☐	When did you stop .....
12.	Asthma or shortness of breath (*please specify*)	☐	☐	When.....
13.	Bronchitis or emphysema (*please specify*).....	☐	☐	When.....
14.	Pneumonia or tuberculosis (T.B.) (*please specify*)	☐	☐	When.....
15.	Obstructive sleep apnoea as diagnosed by your doctor.....	☐	☐	CPAP Machine☐No ☐Yes

GENERAL

16.	Shortness of breath that prevents you from climbing one flight of stairs	☐	☐	
17.	Home Oxygen therapy.....	☐	☐	
18.	Do you drink alcohol	☐	☐	How much per week.....
19.	Problem with alcohol or drug use.....	☐	☐	
20.	Hepatitis, jaundice, cirrhosis or pancreatitis (*please specify*).....	☐	☐	What and When .....
21.	Kidney disorder - stones, infection, failure, dialysis (*please specify*).....	☐	☐	What and When .....
22.	Organ transplant (*please specify*).....	☐	☐	When.....
23.	Diabetes.....	☐	☐	Treated by: ☐ diet ☐ tablets ☐ insulin
24.	Gastric reflux, hiatus hernia, heartburn, indigestion (*please specify*)	☐	☐	What.....
25.	Stroke.....	☐	☐	When.....
26.	Epilepsy, fits, fainting or "funny turns" (*please specify*).....	☐	☐	What .....
27.	Significant neck or back injury/disorder (*please specify*).....	☐	☐	What and When .....
28.	Blood disorder (leukaemia, anaemia, haemophilia or other) (*please specify*).....	☐	☐	What and When .....
29.	Blood transfusion	☐	☐	When.....
30.	Blood clot in legs or lungs (*please specify*).....	☐	☐	When.....

ANAESTHETIC

31.	Do you have any risk factors for Creutzfeldt Jakob Disease (CJD).....	☐	☐	What.....
32.	Psychiatric problems.....	☐	☐	When.....
33.	Does any condition prevent you from undertaking normal daily activities	☐	☐	What.....
34.	Have you ever had any problems with anaesthetics or surgery before (e.g. prolonged nausea, high temperature, prolonged drowsiness)	☐	☐	What.....
35.	Do you have any blood relatives who have had problems with anaesthetics.....	☐	☐	What.....
36.	Female patients only: Could you be pregnant?	☐	☐	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	☐	☐	What .....

PLEASE GO TO PAGE 4

***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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