PRE-ADMISSION PATIENT DETAILS

TO CONFIRM YOUR OPERATION BOOKING, PLEASE RETURN THIS COMPLETED FORM TO STAWELL REGIONAL HEALTH IN THE ENCLOSED STAMPED SELF-ADRESSED ENVELOPE TO STAWELL REGIONAL HEALTH
Mail: REPLY PAID 79337,STAWELL VIC 3380
Email: admissiondetails@srh.org.au
Fax: TO 03 5358 8520
Please complete all information and ✓ appropriate responses

PATIENT DETAILS:

Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Master ☐Other (please specify):_____

Surname:_____ Date of birth: ____/____/____

Maiden/previous surname:_____ Country of birth (if Australia, please specify state):_____

Given name/s:_____

Address: _____ Sex:_____

_____ Religion (if applicable) :_____

_____ Do you wish for a member of clergy to visit? ☐Yes ☐No

State: _____ Post code: _____ Do you require an interpreter? ☐Yes ☐No

Home phone number:_____ If you require an interpreter, please indicate the language:

Work / mobile number: _____

Email address:_____

Marital status: ☐Married ☐Single ☐Divorced ☐Separated ☐Defacto ☐Widowed

Are you (the patient) of Aboriginal or Torres Strait Islander descent?

☐No ☐Yes, Aboriginal ☐Yes, Torres Strait islander ☐Yes, both Aboriginal and Torres Strait Islander

Medicare number:_____ Position on card:_____

Pension or Health Care card number (if applicable):_____

Repatriation (DVA) number: _____ ☐ Gold card ☐ Other

FIRST CONTACT PERSON	SECOND CONTACT PERSON
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Relationship:_____	Relationship:_____
Home phone number:_____	Home phone number:_____
Business / mobile phone number:_____	Business / mobile phone number:_____

Date of operation (if known):____/____/____

Surgeon performing the operation/treatment:_____

Operation/treatment to be performed:_____

Your usual Doctor/GP:_____

Address:_____

Phone number:_____ Fax number (if known):_____

INPATIENT ELECTION: For this admission, do you elect to be admitted as:

☐ Private patient – with Hospital Benefits Insurance
☐ Private patient – self funded
☐ Public patient (Medicare)
☐ Department of Veterans Affairs patient
☐ WorkCover patient
☐ Transport Accident Commission patient

If you have elected to be treated as a Private patient with hospital benefits insurance, please complete your health insurance details below (please provide proof of membership on admission (eg member card):

Name of fund:_____

Membership number: _____ Table:_____

Have you been a member for longer than 12 months? ☐Yes ☐No

Please leave Blank

STAWELL REGIONAL HEALTH

PRE-ANAESTHETIC QUESTIONNAIRE

PATIENT ID NUMBER :_____

SURNAME:_____

GIVEN NAME/S:_____

ADDRESS_____

DATE OF BIRTH: ____/____/____ SEX: _____

(Affix patient identification label here)

Admission date: ____/____/____ **Expected discharge date:** ____/____/____

Surgeon: _____ **What operation are you having?** _____

_____

You are required to have an adult pick you up and care for you overnight following your procedure. Your surgery may be rescheduled if this is not organised. Please provide their details below:

Name: _____ **Relationship:** _____

Phone number: _____

Language / cultural needs:

Main language spoken: _____ Other language: _____

Interpreter required? ☐Yes ☐No

Are you Aboriginal or Torres Strait Islander? ☐Yes ☐No

If yes, do you wish to be referred to the Aboriginal Health Worker? ☐Yes ☐No

If yes, Pre Admission Nurse contact Budja Budja or Grampians Community Health (circle nominated service).

Sensory:

Do you wear glasses? ☐Yes ☐No **(If yes, please bring case with you on admission)**

Do you wear contact lenses? ☐Yes ☐No **(If yes, please do not wear on day of surgery)**

Do you wear hearing aids? ☐Yes ☐No

If yes, are they (circle): Both ears / Right ear / Left ear **(Please wear on the day of surgery)**

Legal directives:

Do you have an Advanced Care Directive? ☐Yes ☐No **(If yes, please bring copy on admission)**

Do you have a Medical Treatment Decision Maker? ☐Yes ☐No **(If yes, please bring copy on admission)**

If yes, who is the appointed person(s): _____

If yes, Pre Admission Nurse document on MR AA.

Neurological:

Do you have difficulty with memory, thinking or confusion e.g. dementia? ☐Yes ☐No

If yes, specify: _____

Do you have anxiety, depression or any mental health problems? ☐Yes ☐No

If yes, specify: _____

Do you have epilepsy, fits or blackouts? ☐Yes ☐No

If yes, specify: _____

Infections:

Have you had an infection resistant to antibiotics, e.g. MRSA (Golden Staph) / VRE (circle)?

☐Yes ☐No ☐Other: _____

Have you been overseas within the last 21 days? ☐Yes ☐No

If yes, where: _____

Have you been in hospital overseas? ☐Yes ☐No

If yes, when and where: _____

Blood transfusions:

Have you had a transfusion of blood or blood product before? ☐Yes ☐No

Have you had a reaction to the blood or blood products? ☐Yes ☐No

If yes, what was the reaction? _____

If yes, Pre Admission Nurse document on MRAA and MR165.

DO NOT WRITE IN MARGIN

Revised August 2020

PRE-ANAESTHETIC QUESTIONNAIRE

MR49.01

STAWELL REGIONAL HEALTH

PRE ANAESTHETIC QUESTIONNAIRE

PATIENT ID NUMBER :_____

SURNAME:_____

GIVEN NAME/S:_____

ADDRESS_____

DATE OF BIRTH: ___/___/___ SEX: _____

(Affix patient identification label here)

Cardiovascular:

Do you suffer from current / previous heart conditions, or an irregular pulse? ☐Yes ☐No

If yes, specify: _____

Do you have poor circulation / fluid in the legs? ☐Yes ☐No

If yes, specify: _____

Do you get chest pain? ☐Yes ☐No

If yes, date of last episode: ___/___/___

If yes, is it angina ☐ or other? ☐ (specify): _____

Do you have a pacemaker? ☐Yes ☐No ☐Right side ☐Left side

Do you have a chest port? ☐Yes ☐No ☐Right side ☐Left side

Do you have high blood pressure / cholesterol (circle)? ☐Yes ☐No

Have you had bleeding / blood clotting problems? ☐Yes ☐No

If yes, specify: _____

Is there a family history of bleeding / blood clotting problems? ☐Yes ☐No

If yes, specify: _____

Respiratory:

Do you smoke? ☐Yes ☐No Amount per day: _____

Have you ever smoked? ☐Yes ☐No Quit date: _____

Do you have sleep apnoea? ☐Yes ☐No

If yes, do you use a CPAP machine? ☐Yes ☐No

Do you have troublesome shortness of breath? ☐Yes ☐No If yes, specify: _____

Have you had breathing problems needing hospitalisation? ☐Yes ☐No If yes, specify: _____

Do you have asthma? ☐Yes ☐No

If yes, how often do you use an inhaler? _____

Do you use home oxygen? ☐Yes ☐No

Genitourinary:

Are you pregnant? ☐Yes ☐No ☐Unknown ☐Not applicable

If yes, have you notified your surgeon? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Do you have trouble passing urine? ☐Yes ☐No If yes, specify: _____

Do you have kidney problems? ☐Yes ☐No If yes, specify: _____

Musculoskeletal:

Do you have problems with your neck / back (circle)? ☐Yes ☐No If yes, specify: _____

Can you normally walk without stopping:	**How far can you walk on flat / level ground:**
☐ More than 2 flights stairs	☐ No limit ☐ Less than 1km
☐ 2 flights stairs	**Do you use?**
☐ 1 flight stairs	☐ Walking stick
☐ Half a flight of stairs	☐ Frame
☐ Unable to walk	☐ Wheelchair
☐ What restricts you?	☐ No walking aids

Do you have problems with balance? ☐Yes ☐No

Have you had a fall in the last 12 months? ☐Yes ☐No

If yes, please provide details: _____

Pre Admission Nurse complete Falls Risk Assessment Tool and Prevention Plan MR198A as necessary.

Integumentary:

Do you have any current rash / wounds to the skin? ☐Yes ☐No

If yes, what and where? _____

Have you ever had a pressure injury (bed sore)? ☐Yes ☐No

If yes, where? _____

STAWELL REGIONAL HEALTH

PRE ANAESTHETIC QUESTIONNAIRE

PATIENT ID NUMBER :_____
SURNAME:_____
GIVEN NAME/S:_____
ADDRESS_____
DATE OF BIRTH: ____/____/____ SEX: _____
(Affix patient identification label here)

Gastrointestinal tract:

Weight: _____ kg Height: _____ cm _____ feet **Office use: BMI =_____**

Have you lost weight recently without trying? ☐Yes ☐No If yes, how much? _____ kg
Do you have a reduced appetite? ☐Yes ☐No
Do you have any food allergies/sensitivities? ☐Yes ☐No

If yes, specify: _____
If yes, is it with anaphylaxis? ☐Yes ☐No

For all food allergies, Pre-Admission Nurse to email food services staff and document on MRAA and MR165. For anaphylaxis, also email Dietitian.

Do you have any special dietary requirements? ☐Yes ☐No
If yes, specify: _____
Pre Admission Nurse email kitchen as required.
Do you get indigestion / heartburn / reflux? ☐Yes ☐No
Do you have a liver condition? ☐Yes ☐No

If yes, specify: _____

Do you drink alcohol? ☐Yes ☐No If yes, glasses / day: _____
Do you have trouble with your bowels? ☐Yes ☐No

If yes, specify: _____

Do you have an ostomy? ☐Yes ☐No

If yes, specify type: _____

Do you have full dentures? ☐Yes ☐No ☐Top ☐Bottom
Do you have partial dentures / plate? ☐Yes ☐No ☐Top ☐Bottom
Do you have caps / crowns / loose teeth (circle)? ☐Yes ☐No ☐Top ☐Bottom
Do you have mouth / tongue piercings? ☐Yes ☐No
Do you have problems with your teeth / gums? ☐Yes ☐No

If yes, specify: _____

Do you have difficulty opening your mouth / swallowing (circle)? ☐Yes ☐No

Endocrine / immune system:

Are you diabetic? ☐Yes ☐No
If yes: ☐Type 1 ☐Type 2
Are you on? ☐Insulin ☐Tablets by mouth ☐Diet controlled
Pre Admission Nurse obtain consent to email Diabetes Educators if inpatient.

Child: Immunisations up to date? ☐Yes ☐No ☐N/A
Are you receiving chemotherapy? ☐Yes ☐No If yes, date last given: ____/____/____

Specialist doctors:

Have you seen any other specialist doctors in the last 5 years? ☐Yes ☐No

Reason for seeing:	Doctor's name:	Dr's phone number:	Last visit:

Other conditions:

Do you have any other physical problems or medical conditions not mentioned above? ☐Yes ☐No

If yes, specify: _____

STAWELL REGIONAL HEALTH

PRE-ANAESTHETIC QUESTIONNAIRE

PATIENT ID NUMBER :_____

SURNAME:_____

GIVEN NAME/S:_____

ADDRESS_____

DATE OF BIRTH: ____/____/____ SEX: _____

(Affix patient identification label here)

Medications:

Do you have any medication allergies / sensitivities? ☐Yes ☐No

If yes, specify: _____

If yes, is it with anaphylaxis? ☐Yes ☐No

If yes, Pre Admission Nurse document on MRAA and MR165.

Have you had cortisone in the past 6 months? ☐Yes ☐No

Do you take any medications (including puffers/inhalers)? ☐Yes ☐No

If yes and inpatient > 24 hours, PAC Nurse to complete the Medication Management Plan MR168.

Please list medications:	Dose: Time taken:

Previous anaesthetics / operations (please list):

Operation:	Hospital:	Year:	Problems / comments:

Have you or your family had problems with anaesthetics in the past? ☐Yes ☐No

If yes, what are they? _____

Do you have any prostheses / implants / metal pins, plates, screws? ☐Yes ☐No

If yes, what type and where are they? _____

Social / home services:

Do you live in? ☐House / Flat / Unit ☐Caravan ☐Hostel / Retirement Village ☐Nursing Home

☐Other (specify): _____

Do you live alone? ☐Yes ☐No

Do you have problems managing self-care? ☐Yes ☐No

Do you use? ☐Meals on Wheels ☐Home Help / House-cleaner ☐District Nursing

☐Other e.g. carer (specify): _____

Form completed by (Sign): _____ Date: _____

Print Full Name: _____ Relationship to patient: _____

Clinician Sign: _____ Date: _____

Print Full Name: _____ Designation: _____

STAWELL REGIONAL HEALTH

PATIENT ANTITHROMBOTIC MEDICATION QUESTIONNAIRE

PATIENT ID NUMBER: _____

SURNAME: _____

FORENAME: _____

ADDRESS: _____

D.O.B: _____/_____/_____ SEX: _____

PATIENT TO COMPLETE

Are you using any of the blood thinning medications listed below (please circle yes or no)

Yes	No	**ASPIRIN** (Astrix®/Solprin®/Cartia®)
Yes	No	**WARFARIN** (Coumadin®/Marevan®)
Yes	No	**APIXIBAN** (Eliquis®)
Yes	No	**DABIGATRAN** (Pradaxa®)
Yes	No	**RIVAROXIBAN** (Xarelto®)
Yes	No	**CLOPIDOGREL** (Plavix®/Iscover®)
Yes	No	**CLOPIDOGREL / ASPIRIN** (Co-Plavix®)
Yes	No	**PRASUGREL** (Effient®)
Yes	No	**TICAGRELOR** (Brillinta®)
Yes	No	**DIPYRIDAMOLE** (Persantan®)
Yes	No	**DIPYRIDAMOLE/ASPIRIN** (Asasantin®)
Yes	No	**ENOXAPARIN** (Clexane®)
Yes	No	**DALTEPARIN** (Fragmin®)
Yes	No	**FONDAPARINUX** (Arixtra®)
Yes	No	**HEPARIN**
Yes	No	**ECHINACEA**
Yes	No	**FEVER FEW**
Yes	No	**FISH OILS** (Fish/Salmon/Krill/Calamari)
Yes	No	**GARLIC**
Yes	No	**GINGKO**
Yes	No	**GINGER**
Yes	No	**GINSENG**
Yes	No	**St JOHNS WART**
Yes	No	**VITAMIN E**

If you are taking <u>ANY</u> of the blood thinning medications listed above, please consult your Doctor at least <u>TWO</u> weeks before your procedure to gain advice on stopping them. Please take this questionnaire with you for your Doctor to complete the section on the back of this form.

Form completed by (print name): _____

Relationship to patient (if applicable eg. parent): _____

Signature: _____ Date: ____/____/____

DO NOT WRITE IN BINDING MARGIN

Developed June 2014
Revised April 2017 V.2

PATIENT ANTITHROMBOTIC MEDICATION QUESTIONNAIRE MR 44

STAWELL REGIONAL HEALTH

PATIENT ANTITHROMBOTIC MEDICATION QUESTIONNAIRE

PATIENT ID NUMBER: _____

SURNAME: _____

FORENAME: _____

ADDRESS: _____

D.O.B: ____/____/____ SEX: _____

GENERAL PRACTITIONER TO COMPLETE

(If your patient has circled yes to any of the medication over the page, please assess the following questions and document appropriately)

YES NO Is this patient at a high risk of clotting if regular anticoagulant is ceased prior to this procedure

YES NO Is this patient on an antiplatelet medication for a recent Cardiac stent (if stent within the last 2 years, seek specialist advice)

YES NO Does this patient require bridging anticoagulation before this procedure? If yes please document the following:

Medication required for bridging _____

Dose required _____

Start date of bridging medication _____

YES NO INR test required If yes date of test _____

Section completed by (print name): _____

Signature: _____ Date: ____/____/____

Place of Practice: _____

SPECIALIST/THEATRE TEAM TO COMPLETE

(Please complete the following questions if a patient has had their regular anticoagulation treatment ceased prior to this procedure)

Operation being performed_____

Plan for anticoagulation post procedure (include date to restart regular medication, and any bridging required)

_____

_____

_____

YES NO Does the patient require District Nursing to administer medication on discharge?

YES NO Has the patient been informed on the above plan for anticoagulation?

Section completed by (print name and designation): _____

Signature: _____ Date: ____/____/____

For patients having surgery at Stawell Regional Health

STAWELL REGIONAL HEALTH

Requirements for Heart (ECG) & Blood Pressure (BP) Check

You will need to have the above done at your local doctor's clinic before surgery if you have any of the following:

- ✓ **Are over 50 years of age**
- ✓ **Have a history of heart condition** **i.e. High blood pressure, high Cholesterol or have a history of chest pain or any fainting/dizzy episodes**
- ✓ **Are on Medication for Heart problems**
- ✓ **You have diabetes**

If you have had a recent ECG (within the last 12 months) and have had no changes with your medical conditions, a previous ECG will be acceptable.

Please get your GP to send ECG and BP results with your NAME, DATE OF BIRTH AND ADDRESS clearly visible on the results to:

Stawell Regional Health
admissiondetails@srh.org.au
Fax 03 5358 8520

For further information please contact the Preadmission Clinic:

Stawell Regional Health
Sloane Street • Stawell Victoria 3380
Phone 03 5358 8569 • Fax 03 5358 8520
admissiondetails@srh.org.au • www.srh.org.au

Please leave Blank.

My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights.**

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access

- Healthcare services and treatment that meets my needs

Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information ask a member of staff or visit safetyandquality.gov.au/your-rights

"Are you worried?"

Blue Flag call

Blue Flag is a three-step process to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected.

The Blue Flag escalation process is as follows:

- Step 1: Talk to a nurse or doctor about your concerns. If you are not satisfied with the response, go to the next step.
- Step 2: Talk to the nurse in charge of the shift. If you are not satisfied with the response, go to the next step.
- Step 3: Ask the nurse in charge of the shift to place a Blue Flag call to the Executive on call.

SRH supports Blue Flag.

Requesting a Blue Flag call will not have a negative impact on your care.

Who can use Blue Flag?

•Patients •Families •Guardians •Carers

When to use Blue Flag?

Patients
When you feel your health condition is getting worse and you are worried.

Families/carers
When the patient is looking worse or is not doing as well as expected.

When the patient shows any behaviour that is not normal for them.

When not to use Blue Flag?

Please do not use Blue Flag for any concerns which do not relate to the patient's health condition getting worse or not improving as expected. If you have any complaints or suggestions please ask for complaints form from the nurses.