Thank you for choosing Grampians Health - Stawell

Grampians Health Stawell

1. What needs to happen now

To confirm your operation booking please complete:

1. Pre-Admission Patient Details
2. Pre-Anaesthetic Questionnaire
3. Patient Antithrombotic Medication Questionnaire

Please return these forms immediately - Via fax or email.
Otherwise return in reply paid envelope.
Please note that failure to return these forms more than 2 weeks prior to procedure may delay your procedure.
Email: admissiondetails@srh.org.au Fax: (03) 5358 8520
Mail: REPLY PAID 79337, STAWELL VIC 3380

1. Before procedure

A Nurse from the Pre-Admission Clinic will telephone you for your Pre-Admission assessment prior to your procedure date.

2. The day prior to procedure

You will receive a **SMS message** with your admission time *(Cataract Surgery will be 2 days prior).*
If you do not receive a SMS message with your admission time by 4:00pm the day prior, please call (03) 5358 8500.

3. Day of Procedure

Fasting: Nothing to eat or drink.
Food: Nothing to eat 6 hours prior to your admission time.
Fluids: Nothing to drink 2 hours prior to your admission time (No Chewing gum allowed)
Please note: If you are having a Colonoscopy or Cataract procedure specific fasting instructions apply, please see your brochure.
Please bring a soft reusable bag for your belongings.
Presenting to Hospital:
On arrival you must stay in your car and call **(03) 5358 8524** for further instructions, before entering the hospital.
Please ensure you have organised someone to pick you up from hospital and provide care for you overnight.

More Information:

For further assistance please contact the Pre-Admission team.
Telephone: (03) 5358 8569
Fax: (03) 5358 8520
Preadmission Email: admissiondetails@srh.org.au
Grampians Health – Stawell Website: srh.org.au

Grampians Health Stawell

PRE-ADMISSION PATIENT DETAILS

TO CONFIRM YOUR OPERATION BOOKING, PLEASE RETURN THIS COMPLETED FORM TO GRAMPIANS HEALTH STAWELL IN THE ENCLOSED STAMPED SELF-ADRESSED ENVELOPE TO Grampians 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

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

Name:_____

Address:_____

_____

Relationship:_____

Home phone number:_____

Business / mobile phone number:_____

SECOND CONTACT PERSON

Name:_____

Address:_____

_____

Relationship:_____

Home 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 ☐ Department of Veterans Affairs patient

☐ Private patient – self funded ☐ WorkCover patient

☐ Public patient (Medicare) ☐ 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

Name of fund:_____

Membership number: _____Have you been a member for longer than 12 months? ☐Yes ☐No

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

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.

PRE-ANAESTHETIC QUESTIONNAIRE

MR49.01

DO NOT WRITE IN MARGIN

Revised August 2020

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 ☐ 2 flights stairs ☐ 1 flight stairs ☐ Half a flight of stairs ☐ Unable to walk ☐ What restricts you?	☐ No limit ☐ Less than 1km **Do you use?** ☐ Walking stick ☐ Frame ☐ Wheelchair ☐ 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: _____

Grampians Health Stawell

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	**APIXABAN** (Eliquis®)
Yes	No	**DABIGATRAN** (Pradaxa®)
Yes	No	**RIVAROXABAN** (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

Grampians Health Stawell

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 _____

YES NO Follow up appointment and INR post procedure booked _____

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: ____/____/____

Place of Practice: _____

Information

You have the right to get clear information about your health and different services available, such as public and private options.

You need to give informed consent before having any treatment. This means you fully understand your treatment options, the possible benefits and risks, and the costs.

You should be given information about your healthcare options, where to go, waiting times and if you'll need to pay for anything.

If something goes wrong during your health care, you have the right to be told about it. The health service should explain what happened, how you may be affected and what is being done to make care safer.

Privacy

You have the right to have your privacy respected. This includes the privacy of your body, belongings, information and personal space.

Your personal and medical information must be kept secure and confidential.

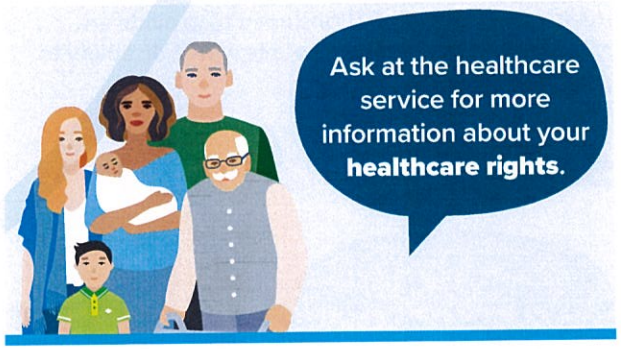
Give feedback

You have the right to provide feedback or make a complaint. Your concerns should be addressed openly and within a reasonable time frame. Providing feedback or a complaint should not negatively affect the way you are treated.

Sharing your experiences can improve the quality of health care.

If you are concerned that your rights have not been met, talk with your clinician or health service organisation. If you are not able to do this, or are not happy with their response, contact the health complaints organisation in your state or territory.

For more information about the Charter or the contact details for health complaints organisations, visit:
www.safetyandquality.gov.au/your-rights



Level 5, 255 Elizabeth Street
Sydney NSW 2000

GPO Box 5480
Sydney NSW 2001

Telephone: (02) 9126 3600
mail@safetyandquality.gov.au

safetyandquality.gov.au

SCAN ME

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

DECEMBER 2021

My Healthcare Rights

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

You have the right to safe and high-quality health care, as described in the **Australian Charter of Healthcare Rights (the Charter)**.

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

The rights apply to everyone and everywhere health care is provided in Australia.

Take the time to read and understand your rights.

Access

You have a right to receive health care that meets your needs.

Medicare helps with the costs of seeing a doctor, as well as many treatments and medicines. You have a right to know, before you receive treatment, if there are any fees and charges that you need to pay.

Health service organisations need to provide an environment that enables people with a disability to use its services.

Safety

You have the right to receive safe and high-quality health care that meets national standards.

Your health care and treatment should be based on the best available evidence, and your needs and preferences.

If you are concerned about your health, notice a worrying change or think something has been missed, you have the right to ask for a review.

Respect

You have the right to be treated with dignity, respect and compassion.

You should be asked about your needs, and your care should reflect your choices.

Partnership

You have the right to be treated as an equal partner in your health care. You can ask as many questions as you need to. Your clinician should talk to you about your health care openly and honestly.

You can include other people in your care, such as family, friends, a carer or a consumer advocate.

"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.

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Looking after your cannula

What you need to know

If you need to have medicines or fluids directly into your bloodstream, you may need a cannula.

A cannula is a small flexible tube that is inserted into a vein. It may also be called a peripheral intravenous catheter, IV, or drip. It is usually inserted into a vein in your arm, hand or foot and is connected to medicines and fluids when you need them.

This information lets you know what you can do to help avoid problems and to stay as comfortable as possible with your cannula.

What you can do

Tell your healthcare team about your past experiences

A member of your healthcare team will talk to you about having a cannula before it is inserted. For some people, inserting a cannula is more difficult because of their age, medical condition, vein health or the treatment being used.

It is important for you to tell your healthcare team:

- If it has taken several attempts to insert a cannula for you in the past
- Anything that has worked well before
- Your preference or any physical problems that could affect where the cannula is placed
- Any allergies you have, such as to tapes and dressings.

05/2021

Help to prevent complications

Problems can include pain and discomfort, leakage from the cannula onto your skin or below the skin, blockages, or germs getting into your bloodstream causing infection.

To help to look after your cannula:

- Protect it from knocks or being pulled
- Wear loose clothing over the cannula
- Do not touch, fiddle with, or move the device
- Keep the cannula and the dressing site clean and dry and try not to get it wet in the shower
- Make sure the dressing stays in place
- Keep your hands clean by washing with soap or using sanitiser.

Report any problems or concerns

Your healthcare team will provide regular care to prevent complications from developing. Let them know if you have any concerns about your cannula at any time.

It is important that you tell your healthcare team if you notice:

- Redness, pain or swelling at the insertion site
- Feeling hot, cold or shivery
- Leakage from the device
- The dressing getting wet, bloodstained or loose.

If you have any of these problems in the first few days after you leave hospital, seek medical advice.

Check if your cannula is still needed

Your cannula should be removed if it is no longer needed.

Speak to your healthcare team if your cannula:

- Has not been used in the last 24 hours to check if you still need it
- Has not been removed before you go home, unless you need ongoing treatment.

Questions?

If you have any questions about your cannula talk to a member of your healthcare team.