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Government of South Australia

Health
Limestone Coast
Local Health Network

Patient Elective Surgery Package

Mount Gambier & Districts Health Service
Phone 8721 1245 SUBMIT FORM

Millicent & District Hospital & Health Services
Phone 8733 0100 SUBMIT FORM

Naracoorte Health Service
Phone 8762 8100 SUBMIT FORM

Scan the QR code to access on your smart device

Surgery / Theatre Details

Admission / Theatre Date:

Admission Time:

Fasting Time:

Pre-Admission Clinic Appointment

Date:

Time:

Pre-Anaesthetic Appointment

Date:

Time:

HOW TO SUBMIT THE PATIENT ELECTIVE SURGERY PACKAGE

1. **Post:** Print and fill in with black pen and post to address on next page.
2. **Email:** Use 'submit form' button above.
3. **Mount Gambier** - Return via 'submit form' button above or print and hand it in at a drop-in clinic between 1pm and 3pm on Monday to Thursday.

ADMISSION INFORMATION

Your nominated hospital has been accredited by Australian Council on Healthcare Standards (ACHS) to provide the best possible care for your hospital admission.

It is important that you read this package as it contains:

- The forms you need to complete to provide us with the information we need to finalise your booking and let us know about any special care you may require
- Information on how to prepare for your stay
- Information on how we protect your privacy
- Information on your rights and responsibilities whilst in hospital
- General information about the hospital to assist you whilst you are with us

COMPLETING THE FORMS

Please complete the following three forms using black ballpoint pen.

1. Patient Registration Details
2. Patient Health Assessment
3. Agreement of Care

If you require help with completing these forms please contact the pre-admission nurse at your nominated hospital.

Forms are to be delivered to the hospital within 7 days of receiving this package.

MOUNT GAMBIER
Post or hand deliver to

Consulting Rooms
Mount Gambier & Districts Health Service
PO Box 267, 276-300 Wehl Street North
MOUNT GAMBIER SA 5290

MILLICENT
Post or hand deliver to

Front reception desk
Millicent & Districts Hospital & Health Service
PO Box 93, Mount Gambier Road
MILLICENT SA 5280

NARACOORTE
Post or hand deliver to

Administration staff
Naracoorte Health Service
PO Box 366, 101 Jenkins Terrace
NARACOORTE SA 5271

If for any reason you are not able to submit the forms to us within the required time please call the Pre-Admission Clinic as soon as possible.

Failure to do so may result in your procedure being cancelled.

PRE-ADMISSION CLINIC

If a visit to the Pre-Admission Clinic is required prior to your admission, you will be contacted by the Pre-Admission Clinic staff to:

- Talk to you about your care before and after surgery
- Check your health history and complete other admission paperwork
- Organise blood tests, an Electrocardiogram (ECG) and other tests if ordered by your Doctor
- Commence discharge planning to help you plan for your return home
- Organise a pre anaesthesia consultation by a specialist anaesthetist if required, as part of your preoperative preparation
- Answer any questions you may have about your hospital stay

This means not only do you know what to expect whilst in hospital but ensures your admission on the day of your surgery is well planned, relaxed and not rushed for you or the staff.

MEDICINES

Before your admission to hospital please let your Doctor know what medicines you are taking including prescription, non-prescription and complementary medicines (including creams, eye drops, puffers, vitamins, herbal preparations etc).

You are advised to continue taking all your normal medications. If you are on blood thinning medications (eg aspirin, warfarin), insulin or blood pressure medications, please ensure that you receive clear medication instructions from a doctor or nurse on whether or not to take these. Some of these **must be taken** and some **must not be taken** and your procedure may be cancelled if the correct medications are not taken.

Your Doctor or Pre-Admission Nurse can advise you of which medicines you need to stop before surgery (if any) and when to stop taking them and/or if a change in dose is needed.

Please bring ALL your medicines in their original packaging into the hospital with you (even if you use a Webster / blister pack). This ensures the medicines you need are available when you need to take them.

ADMISSION DATE / TIME

Please contact the hospital at 11am on the last working day **prior to your admission to obtain your admission and fasting times.**

Mount Gambier	**8721 1433**
Millicent	**8733 0100**
Naracoorte	**8762 8100**

Naracoorte Hospital staff will contact you with an admission and fasting time, the week prior to your surgery date. If you have not received a call within 48 hours prior to your surgery please ring 8762 8100.

Please ensure that you DO NOT smoke for 12 - 24 hours prior to your admission.

Please talk to your GP or Pre-Admission Nurse if you require nicotine replacement treatment during your stay in hospital. All sites are a Smoke Free environment. **NO** smoking is permitted within the hospital grounds.

- **DO** follow the **fasting instructions** given to you by the staff when you ring for your admission time. Failure to do so will result in your surgery being cancelled.
- Do **NOT** chew gum or suck lozenges or barley sugar while fasting
- Do **NOT** wear jewellery including all piercings (medic alert bracelet and a wedding ring are permitted)
- Please **REMOVE** all piercings
- Do **NOT** wear make up or nail polish
- Do **NOT** wear talcum powder on the day of the procedure
- Do **NOT** shave the operation site at home
- If you are unwell or develop any infections in the week prior to your surgery date please contact your nominated hospital for advice.

You MUST shower or bathe on the morning of your procedure.

YOUR ADMISSION

On arrival to the hospital please present to the ward clerk of the ward you have been allocated to. This may include the Day Surgery Unit, Surgical Unit, Mount Gambier Private Ward or the Maternity / Paediatric Children's Ward.

If you are unsure please ask at the main reception of the hospital for directions.

PAEDIATRIC WARD ONLY

One parent / guardian may accompany the child into the Theatre Suite and stay with the child until he or she is anaesthetised. For safety reasons **NO** hot drinks are permitted into the ward area.

MONEY / JEWELLERY / VALUABLES

We advise you to leave valuables such as jewellery, large amounts of cash and electronic items at home as we cannot accept responsibility for them if they are lost or stolen.

WHAT TO BRING

On the day of admission please bring:

- All prescriptions, non-prescription and complementary medicines you are taking (in original packaging)
- Hearing aids and dentures (if you have them)
- CPAP Machine if you use one
- Relevant x-rays and scans (procedure may be cancelled if x-rays or scans needed for your procedure are not available)
- Medicare card
- Private health fund details (if applicable)
- Department of Veterans' Affairs (DVA) card (if applicable)
- Healthcare / pension card, pharmaceutical entitlement card (if applicable)
- Letter of approval for WorkCover, Third Party or Public Liability claims (if applicable)
- A certified copy of advanced care directive (if applicable)
- Compression or TED stockings if you have them
- Any other items including crutches, abdominal corsets as instructed by your Doctor

- Toiletries (if staying overnight)
- Comfortable, appropriate, loose fitting clothes or nightwear, slippers / footwear (if staying overnight)
- Day procedure patients will be provided with a gown and dressing gown while admitted
- Naracoorte patients please bring a clean dressing gown.

VISITING HOURS

The safety and welfare of people in our hospitals and health services during the COVID-19 pandemic means that some restrictions for visitors may apply. Please check with the hospital for current visiting hours.

Normal visiting hours are as follows:

Medical Ward, Surgical Ward & Private Ward
11.00am – 8.00pm

Paediatric Children's Ward
2.00pm – 8.00pm

Maternity Ward
2.00pm – 8.00pm

Partners of Maternity patients
10.00am – 12.00pm and 2.00pm – 8.00pm

High Dependency Ward
11.00am – 8.00pm (visitors must be approved by nursing staff – only 2 per patient please)

Millicent / Naracoorte Hospital
Visitors to present to nurses station upon arrival
9.00am – 8.00pm

DISCHARGE

The discharge time is **strictly 11.00am** and we ask that you make arrangements to leave the hospital at this time to allow staff to prepare the room for incoming admissions. You may be asked to sit in the discharge area until you are able to be collected.

Please ensure that you have transport home if you are going home on the day of surgery.
You cannot drive yourself home.

Please be aware that transfers by ambulance will require you to be covered under the South Australian Ambulance Scheme.

SAFETY AND SECURITY OF YOUR CHILD

The staff at your Hospital are committed to providing a safe and secure environment to all children in our care.

To assist us in achieving this we ask that you adhere to the following:

- That you provide written notification to hospital staff of the names of adult/s that have the authority to be present with your child. This will be noted in the medical record
- That you provide written notification to hospital staff of who is able to collect your child upon discharge. Upon discharge the nominated person will be required to produce photographic identification and sign the Security of Minors-Paeds 22 form (Mount Gambier)
- A parent / guardian stays with your child throughout their hospital admission. If staying overnight we will provide you with a bed, bathroom facilities and meals at no charge (Mount Gambier)
- If you need to leave your child unattended please inform staff so that they can organise the appropriate supervision. This includes if you require using the bathroom facilities, going for a walk, visiting the kiosk etc
- The hospital is not responsible for any unaccompanied minors who are not inpatients
- Thank you for assisting us in providing a safe and secure environment for your child. If you have any questions regarding this information please do not hesitate to ask the nursing staff.

PRIVATE PATIENTS

For those being admitted to Mount Gambier, Naracoorte or Millicent Hospitals:

The hospital will contact your health fund to confirm your status and does not add any out-of-pocket expenses for your stay.

Self-insured patients (those electing for private admission but without a health fund) can obtain a quote for their stay by contacting:
Mount Gambier: (08) 8721 1200
Naracoorte: (08) 8762 8100
Millicent: (08) 8733 0100

Private patients will not receive an account from the hospitals for their stay. Your surgeon, anaesthetist, pathology or imaging providers may have out of pocket expenses on top of what your health fund and/or medicare pay and should be contacted for more information.

SA Pathology - SA Pathology bulk-bill patients for all items covered by Medicare, meaning for the majority of tests, no gap payment is required. Your doctor will be aware of any non-Medicare listed tests and can discuss the costs with you. For patients with Private Health Insurance, in most cases your bill will be sent directly to your Private Health Insurer. If for any reason this is not possible, you will be issued with an invoice, which you will need to present to Medicare and your Private Health Insurer.
Please call the toll free number 1800 188 077 for any billing inquiries.

Benson Radiology - Benson Radiology has arrangements with a large number of private health funds which ensures a 'no gap' policy for in-hospital patients. Check with us or your health fund prior to being admitted to hospital.
If you have any queries about your account, please speak with the reception staff on the day of your appointment, or contact the accounts department on 8331 5601.

WORKCOVER, THIRD PARTY AND PUBLIC LIABILITY PATIENTS

- A letter of approval from the relevant insurer must be provided with the Patient Registration Details form prior to admission for WorkCover, Third Party and Public Liability claimants.

MY HEALTHCARE RIGHTS

Based on our values of hospitality, healing, stewardship and respect, the management and staff of our Local Health Network support The Australian Charter of Healthcare Rights developed by the Australian Commission on Safety and Quality in Healthcare.

The Charter describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever care is provided, it is of high quality and is safe.

The Australian Charter of Healthcare Rights describes the right you, your family or someone you care for has when they access health care.

These rights apply to all people in all healthcare settings in Australia.

IF YOU HAVE ANY FEEDBACK ABOUT OUR SERVICE

- Talk to the person in charge or any health worker at the time of the problem
- You can write, phone or see the person in charge at any time during your care or afterwards
- If you are not satisfied with the results of your feedback you can contact the:
  - Safety and Quality Manager at your nominated hospital.
- If you have not been able to resolve the problem, you can write to the appropriate State or Federal independent complaints organisations:

Health and Community Services Complaints Commissioner

PO Box 199
Rundle Mall
Adelaide SA 5001

Phone: 1800 232 007 (free call)

AHPRA

GPO Box 9958
Adelaide SA 5001

Phone: 1800 419 495

(For complaints against Medical Practitioners or nursing staff)

I HAVE A RIGHT TO:

ACCESS

- Access services and treatment to meet my heathcare needs

SAFETY

- Safe and high quality health care
- Receive care in a safe environment

RESPECT

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

PARTNERSHIP

- Engage in open communication and make decisions about my health care
- Include the people that I want in planning and decision-making
- Share my experience and participate in improving the quality

INFORMATION

- Be engaged in informed consent, be told about my condition and the possible benefits and risks of tests and treatments
- Clear and timely information about services, waiting time and costs
- Be given assistance to help me to understand health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened and what is being done to make care safer

PRIVACY

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

GIVE FEEDBACK

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns dealt with in a fair and timely way.

Surname .....

Given Names .....

Please cross out which ever does not apply.

Date of Birth..... M / F

PLEASE ENSURE NAME AND DOB ARE ON EACH PAGE

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PATIENT REGISTRATION DETAILS

PATIENT TO COMPLETE

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DETAILS

Surname:

Previous Surname (if applicable):

Given names:

Date of Birth: | Sex: ☐ Male ☐ Female | Country of Birth:

Is the patient a young person under the Guardianship of the Minister? ☐ Yes ☐ No

Residential Address:

Suburb: | Postcode

Postal Address (if different to residential):

Home Ph | Mobile: | Work Ph.

☐ Married ☐ Never Married ☐ De facto ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Unemployed ☐ Home duties
☐ Student ☐ Child not at school ☐ Other

Are you Aboriginal? ☐ Yes ☐ No | Are you Torres Strait Islander origin? ☐ Yes ☐ No

OTHER

Treating Doctor/Surgeon for this Admission

Referring Doctor | Regular GP or Clinic:

INSURANCE

MEDICARE NUMBER ☐☐☐☐ ☐☐☐☐☐

Number in front of your name: ☐ | Expiry Date:

BENEFITS CARD ☐ Pension ☐ Health Care Card ☐ Other - Please specify:

Card Number: | Expiry Date: / /

Do you have **PRIVATE HOSPITAL** cover? ☐ Yes ☐ No

Do you have ambulance cover? ☐ Yes ☐ No

If no, are you self funding this admission? ☐ Yes ☐ No

If yes, will you be using your **PRIVATE HOSPITAL** cover for this admission? ☐ Yes ☐ No

Fund: Membership No.

VETERAN'S AFFAIRS ☐ Yes ☐ No

Card No. | Card colour:

PATIENT REGISTRATION DETAILS

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PATIENT REGISTRATION DETAILS

PATIENT TO COMPLETE

Surname .....

Given Names .....

Date of Birth..... M / F

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INSURANCE

WORKCOVER	☐ Yes ☐ No
Insurance company (if known):	Date of injury: / /
Claim No.	
Employer:	Employer's Ph.
Employer's address:	

MOTOR VEHICLE ACCIDENT	☐ Yes ☐ No
Claim No.	Date of injury: / /

CONTACTS

CONTACT PERSON DETAILS	
Name:	Home Ph:
Relationship to patient:	Mobile:
Residential address:	Work Ph:

Surname .....

Given Names .....

Date of Birth..... M / F

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AGREEMENT OF CARE

PATIENT TO COMPLETE

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AGREEMENT OF CARE

I understand that my care plan will be developed in consultation with the Medical Officers Orders, this nursing and midwifery assessment, other clinical assessments and my participation. I am aware that my care plan will be assessed/reviewed and appropriate care implemented as my needs change.	Yes ☐
I consent to the release and exchange of information by staff to other health and welfare providers and relevant others involved in my care. I understand that such information may be used for statistical and Audit purposes.	Yes ☐ No ☐
I understand that my casenotes will be stored in a common file and can be accessed by staff involved in my care. I understand that such information will be secure, and treated in a confidential and professional manner.	Yes ☐
I understand that I am responsible for all items in my possession and for any item not sent home or given to the health unit for safe keeping	Yes ☐
I consent to student participation.	Yes ☐ No ☐

This form can be digitally signed, or printed and signed

PATIENT/ADVOCATE SIGNATURE.....**Date**.....

If patient unable to sign the form please supply name and relationship to the patient

Name .....Relationship .....

This form has been completed in conjunction with patient and/or carer

NURSE/MIDWIFE SIGNATURE..... **Date**.....

Name .....Designation .....

AGREEMENT OF CARE

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

Surname .....

Given Names .....

Date of Birth..... M / F

PLEASE ENSURE NAME AND DOB ARE ON EACH PAGE

General Practitioner:	Admission date:
Surgeon:	Operation date:
Operation:	
Please circle Day / Overnight	
Please circle Private DVA Public Self Funding	
Current **HEIGHT**: (cm)	Current **WEIGHT**: (kg) **BMI**:
Do you need an interpreter? YES NO	If so, what language?

MEDICATION

PLEASE LIST BELOW OR ATTACH A CURRENT LIST OF MEDICATIONS THAT YOU ARE TAKING

Name of medication	How much? Dose	Time taken each day
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT
		MORNING MIDDAY EVENING NIGHT

PLEASE BRING YOUR MEDICATIONS TO HOSPITAL WITH YOU IN THEIR ORIGINAL PACKAGING

Surname .....

Given Names .....

Date of Birth..... M / F

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

PLEASE WRITE AS MUCH INFORMATION AS POSSIBLE IN THE SPACE PROVIDED

MEDICATION HISTORY

Could you possibly be **PREGNANT** or are you **BREAST FEEDING?** (Please circle)	☐ Yes ☐ No
Have you recently taken **WARFARIN / ASPIRIN** or **BLOOD THINNERS** (eg Plavix, Isocover, Asasantin, persantin, cardiprin or Pradaxa) or complementary medicines such as glucosamine, fish oils? If yes, have you been asked by your Doctor to stop prior to this surgery? From what date?	☐ Yes ☐ No ☐ Yes ☐ No
Are you currently on **PREDNISOLONE**, cortisone or other steroids? If yes, what for?	☐ Yes ☐ No
Are you **ALLERGIC** to any **MEDICINES**, tapes, antiseptics, **LATEX/RUBBER**, **IODINE** or foods? (Attach list if needed) Details:	☐ Yes ☐ No
Do you have more than **3 ALCOHOLIC DRINKS** most days? Number of days a week? Number of glasses per day? **PLEASE ABSTAIN FROM DRINKING ALCOHOL FOR 12 - 24 HOURS PRIOR TO YOUR SURGERY**	☐ Yes ☐ No
Do you take **RECREATIONAL DRUGS, INCLUDING MARIJUANA?** The use of recreational drugs before Anaesthesia and Surgery can be significantly harmful to a patient's health. Therefore, patients are advised to abstain from the use of recreational drugs for **7 DAYS** prior to their surgery, or risk **CANCELLATION** of their procedure on the day.	☐ Yes ☐ No

RESPIRATORY & AIRWAY

Do you have any **RESPIRATORY** problems? (*Please circle)* Shortness of breath / TB / Asthma / Cough / Wheeze pneumonia If yes, has your condition become worse in the last 3 months? Do you use nebulisers, puffers or home oxygen?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Have you been diagnosed with **SLEEP APNOEA?** If yes, do you use a CPAP machine? Have you been observed to stop breathing whilst asleep?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

Surname .....

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Date of Birth..... M / F

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RESPIRATORY & AIRWAY

DO YOU SMOKE? If yes, how many per day?	☐ Yes ☐ No
Have you ever smoked? If yes, when did you stop? ☐	☐ Yes ☐ No
DO NOT SMOKE ON THE DAY OF SURGERY	
Do you get **BREATHLESS**...	
Doing normal housework?	☐ Yes ☐ No
Walking 50m?	☐ Yes ☐ No
Walking 100m?	☐ Yes ☐ No
Would you get breathless...	
Climbing half a flight of stairs (5 steps)?	☐ Yes ☐ No
Climbing a flight of stairs (10 steps)?	☐ Yes ☐ No
Climbing two flights of stairs (20 steps)?	☐ Yes ☐ No
Do you have any: (*Please tick*)	☐ Yes ☐ No
☐ **HEARTBURN** ☐ **INDIGESTION** ☐ **HIATUS HERNIA**	
☐ **REFLUX** ☐ **GASTRIC ULCERS**	
Do you have neck stiffness?	☐ Yes ☐ No
Do you have difficulty opening your mouth?	☐ Yes ☐ No
Do you have a gastric band or have had weight reduction surgery?	☐ Yes ☐ No
Do you have trouble **CHEWING** or **SWALLOWING** food/drink?	☐ Yes ☐ No
Do you have **DENTURES** or implanted teeth?	☐ Yes ☐ No
☐ Full dentures or ☐ partial dentures	
Do you have:	☐ Yes ☐ No
☐ Chipped teeth ☐ Capped/crowned ☐ Loose teeth	

CARDIAC

Do you have, or have you had in the past, problems with your **HEART** heart murmur, chest pain, chest tightness, angina, swollen ankles, heart attack, heart surgery (eg stents, valve replacement), atrial fibrillation (AF) **RHEUMATIC FEVER** or **HIGH BLOOD PRESSURE?**	☐ Yes ☐ No
DO YOU GET CHEST PAIN OR TIGHTNESS ON EXERTION?	☐ Yes ☐ No
Details: ☐	
If yes, has your condition become worse in the last 3 months?	☐ Yes ☐ No

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

CARDIAC

Do you see a cardiologist? If yes, what is their name and contact details? ☐ Yes ☐ No

When did you last see them? _____

Do you have a **PACEMAKER** or an **IMPLANTABLE DEFIBRILLATOR?** ☐ Yes ☐ No

If yes, what type?

☐ Medtronic ☐ Boston Scientific ☐ Guidant ☐ St Jude

Device / Model No. _____

PLEASE ENSURE YOU HAVE YOUR CARD WITH YOU

ANAESTHETIC HISTORY

Have you or a blood relative ever had a problem with **ANAESTHETIC?** (eg vomiting, nausea, aggression, awakening, delirium ,other?) ☐ Yes ☐ No

Details: _____

Do you have any questions about your anaesthetic, procedure, operation or concerns such as anxiety, needle phobia or claustrophobia? ☐ Yes ☐ No

Details: _____

MEDICAL & SURGICAL HISTORY

Do you have any **MAJOR ILLNESSES** (eg cancer, psychiatric treatment) or **DISABILITIES** (eg intellectual, physical), **DEMENTIA/ ALZHEIMERS DISEASE, MENTAL HEALTH PROBLEMS** (eg anxiety, depression, bipolar)? ☐ Yes ☐ No

Details: _____

Are you seeing any specialists? If so, what for? ☐ Yes ☐ No

If yes, what is their name and contact details?

Have you had any tests done in the last 6 months? ☐ Yes ☐ No

Have you had any test done for this admission? (bloods, scans etc) ☐ Yes ☐ No

Have you had any **PREVIOUS OPERATIONS?** Please list below ☐ Yes ☐ No

TYPE OF SURGERY	WHERE YOU HAD SURGERY	WHEN YOU HAD SURGERY

Do you have **DIABETES?** ☐ Yes ☐ No

If so, do you use Insulin? ☐ Yes ☐ No

Do you use an Insulin Pump? ☐ Yes ☐ No

Do you take oral diabetes tablets or injectables? ☐ Yes ☐ No

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EYE SURGERY PATIENTS

Have you had **PREVIOUS EYE SURGERY?** (Eye surgery only) ☐ Yes ☐ No
If so, did you experience any problems?
Details:

Do you take **FLOMAX?** (Patients for eye surgery) ☐ Yes ☐ No

Are you able to lie flat and still? If not why? ☐ Yes ☐ No

GENERAL MEDICAL

Do you have problems **PASSING URINE?** ☐ Yes ☐ No
Problems with ☐ flow ☐ Frequency at night ☐ Incontinence

DO YOU HAVE KIDNEY DISEASE? ☐ Yes ☐ No
Please specify:

Do you have **BLEEDING** problems? (Bruise easily, excessive bleeding after dental extractions, anaemia) or any other blood disorders (eg thalassaemia)? ☐ Yes ☐ No
Details:

Have you ever had **BLOOD CLOTS** in the legs or lungs? ☐ Yes ☐ No
Details:

Have you ever had **JAUNDICE** or **HEPATITIS?** ☐ Yes ☐ No
If hepatitis what type? (eg A,B,C etc)

Have you had a problem with (*Please circle)* ☐ Yes ☐ No
☐ **EPILEPSY** ☐ **STROKE** ☐ **LEG OR ARM WEAKNESS** ☐ **FITS**
Details:

Do you have **THYROID DISEASE?** (Recent blood tests) ☐ Yes ☐ No
Details:

Have you ever had a **BLOOD TRANSFUSION?** ☐ Yes ☐ No
Details:

Do you have **ARTHRITIS?** ☐ Yes ☐ No
☐ Osteoarthritis ☐ Rheumatoid
Details:

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PATIENT HEALTH ASSESSMENT

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GENERAL MEDICAL

Do you have any back problems (present or past)?	☐ Yes ☐ No
Do you have **BOWEL PROBLEMS?** (eg constipation / frequency) If yes, what do you do to help this problem?	☐ Yes ☐ No
Do you have a problems with your **SIGHT?** Details: Do you wear ☐ contact lenses or ☐ glasses?	☐ Yes ☐ No
Do you have **HEARING PROBLEMS?** Or Problems with your **SPEECH?** Details: Do you wear a hearing aid? (Bring into hospital)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Have you had any recent **WEIGHT LOSS** without trying? If yes, how much ☐ 1-5kg=1 ☐ 6-10kg=2 ☐ 11-15kg=3 ☐ >15kg=4 (Score of 2 or more refer to dietician)	☐ Yes ☐ No
Do you suffer from **NAUSEA, VOMITING, APPETITE LOSS?** (Including travel sickness) Details:	☐ Yes ☐ No
Do you require a **SPECIAL DIET?** (eg low sugar, vegetarian, Kosher, Coeliac etc) Please specify:	☐ Yes ☐ No
Is there anything else you think the surgeon, anaesthetist or nurse should know? If yes, please describe:	☐ Yes ☐ No

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

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Given Names .....

Date of Birth..... M / F

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INFECTION CONTROL

In the last 6 months have you been in a long term care facility or another hospital? ☐ Yes ☐ No

(Follow SA Health infection control guidelines, management of multi resistant organisms)

Do you have any skin **RASHES, WOUNDS, ULCERS, DRESSINGS** or **PRESSURE ULCERS?** ☐ Yes ☐ No

Details:

Have you had, or do you have: ☐ Yes ☐ No

☐ MRSA ☐ VRE ☐ ESBL Infectious Disease Details:

COVID-19 / SARS / AVIAN FLU RISK FACTORS

Have you recently travelled outside Australia? ☐ Yes ☐ No

If yes, which country

Have you been in Australia less than 14 days? ☐ Yes ☐ No

Have you had direct contact with a patient diagnosed with an acute respiratory infection in the last 7 days? ☐ Yes ☐ No

Have you received all required COVID-19 vaccinations? ☐ Yes ☐ No

Have you had signs or symptoms of a respiratory infection or fever? ☐ Yes ☐ No

CREUTZFELDT – JAKOB DISEASE (CJD) RISK FACTORS

Have you had a dura mater graft prior to 1990? ☐ Yes ☐ No

Do you, or two or more first degree family members have a history of **CREUTZFELDT – JAKOB DISEASE** or other non-specific progressive neurological disorder? ☐ Yes ☐ No

Have you received human pituitary hormones (growth hormones, gonadatrophins) prior to 1986? ☐ Yes ☐ No

Do you suffer from progressive dementia (physical or mental) the cause of which has not been diagnosed? ☐ Yes ☐ No

Have you been involved in a “Look back” study for CJD or are in the possession of a “Medical in Confidence" letter regarding risk of CJD? ☐ Yes ☐ No

(If yes to any of the above questions contact infection control nurse)

PAEDIATRIC PATIENTS

Does your child have any special feeding techniques or problems? ☐ Yes ☐ No

☐ Drinks from feeding cup ☐ Drinks from cup

☐ Drinks from bottle ☐ Breast fed

Does your child have emotional or developmental problems? ☐ Yes ☐ No

Details

Surname .....

Given Names .....

Date of Birth..... M / F

PLEASE ENSURE NAME AND DOB ARE ON EACH PAGE

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

PAEDIATRIC PATIENTS ONLY (UNDER 16 YEARS)

Is your child toilet trained, wear a nappy or have a toileting routine? Details:	☐ Yes ☐ No
Does your child have a favourite toy that they would like to take to theatre with them?	☐ Yes ☐ No
Does your child have a dummy / pacifier?	☐ Yes ☐ No
Does your child use special words or language? Details:	☐ Yes ☐ No
Are your child's immunisations up to date? **PLEASE ENSURE YOU BRING IN YOUR CHILD'S IMMUNISATION AND DEVELOPMENTAL PROGRESS (BOOKLET) FOR THIS ADMISSION**	☐ Yes ☐ No
School attended:	
Current year:	
Child care centre	

DISCHARGE PLANNING

Do you need a sick certificate? Do you live with: *(Please circle)* ☐ Spouse ☐ Friends ☐ Family ☐ Alone ☐ In a nursing home, hostel or supported residential care	☐ Yes ☐ No
Do you care for others?	☐ Yes ☐ No
If you live with other people, are they able to care for you when you go home from hospital?	☐ Yes ☐ No
If you live alone, have you anyone to stay with you when you go home from hospital?	☐ Yes ☐ No
Has anyone been appointed as your power of attorney? **PLEASE BRING IN A CERTIFIED COPY OF DOCUMENTATION**	☐ Yes ☐ No
Do you have an advanced care directive? **PLEASE BRING IN A CERTIFIED COPY OF DOCUMENTATION**	☐ Yes ☐ No
Have you nominated a substitute decision maker or makers?	☐ Yes ☐ No
Do you have at home: ☐ Steps ☐ Stairs ☐ Handrails in bathroom ☐ toilet ☐ Shower over bath	☐ Yes ☐ No

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PATIENT HEALTH ASSESSMENT

PATIENT TO COMPLETE

Surname .....

Given Names .....

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DISCHARGE PLANNING

Do you use: ☐ Yes ☐ No

☐ Walking stick ☐ Frame ☐ Assistance to walk ☐ Wheelchair

Have you ever had a **FALL** because you are unsteady on your feet? ☐ Yes ☐ No

Details:

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

Do you need help with the following activities?

Getting in and out of bed / chair? ☐ Yes ☐ No

Dressing, showering, toileting, cleaning, taking medicines, shopping etc? ☐ Yes ☐ No

Do you receive help from: ☐ Yes ☐ No

☐ Community nurses ☐ Personal carers

☐ Home help ☐ Meals on wheels ☐ Other help

When you are discharged you may not be able to do the same things around the home. With this in mind do you feel you require a referral to community health for assistance? ☐ Yes ☐ No

Have you completed this questionnaire yourself? ☐ Yes ☐ No

If no, what is your relationship to the patient?

DAY SURGERY ONLY

I certify that I have a responsible adult to both accompany me home and stay with me overnight. I understand that surgery may be cancelled if I do not have a responsible adult to accompany me home and stay overnight.

I understand the importance of, and agree to, the following instructions regarding my post operative care. I undertake **NOT TO DRIVE, OPERATE MACHINERY**, drink alcohol, sign legal documents or make significant decisions following my anaesthetic, until the next day as advised by my doctor.

Signature of patient:

Name of responsible adult: Phone No.

STAFF USE ONLY

STAFF USE ONLY

Information on this patient health assessment has been discussed and confirmed with the patient.

Name of Pre-Admission Nurse

Signature: Designation: Date:

Name of Admitting Nurse:

Signature: Designation: Date:

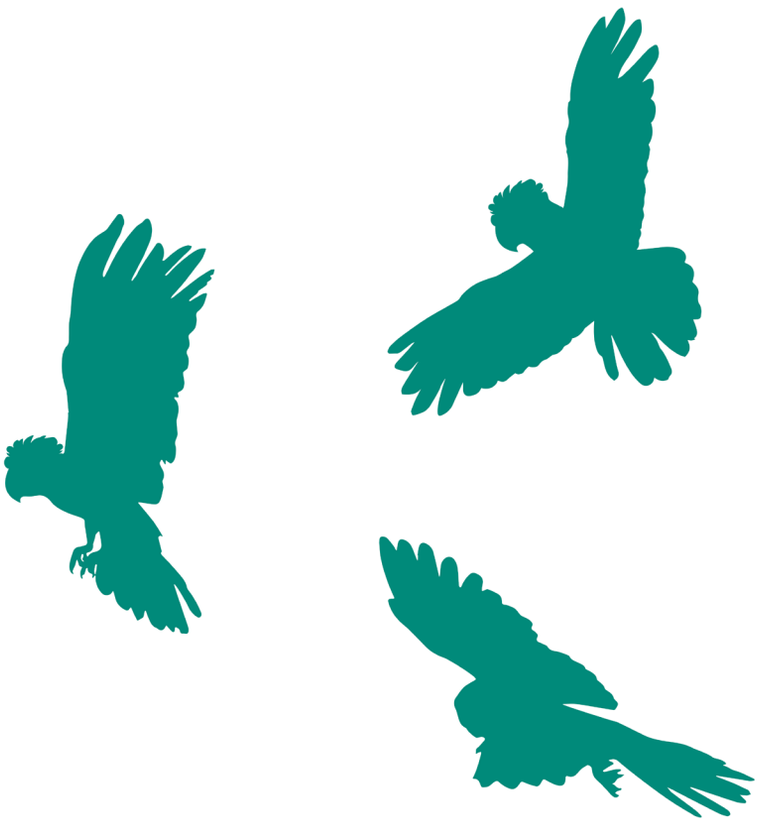
Hand Hygiene Australia

www.hha.org.au

Important information from Hand Hygiene Australia

Hand hygiene is the single most important factor in reducing healthcare associated infections.

Your healthcare worker should always perform hand hygiene in front of you. If you did not see them and are worried, please feel free to remind them.



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