

| Do you have or have you ever had | YES | NO | COMMENTS |
|-----------------------------------------------------------------------|-------------------------------------|--------------------------|-------------------------------------------------|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | |
| Chest pain / angina | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | |
| Chest palpitations or irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | |
| Artificial heart valves or other heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rheumatic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | |
| TIAs (mini strokes) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | |
| Breathlessness on exertion | <input type="checkbox"/> | <input type="checkbox"/> | |
| Swollen ankles | <input type="checkbox"/> | <input type="checkbox"/> | |
| Asthma or lung problems | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how often do you use your inhaler?..... |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Which type..... |
| Jaundice / Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| CJD or any neurological disease currently under investigation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Undergone a dura mater graft / corneal surgery prior to 1990 | <input type="checkbox"/> | <input type="checkbox"/> | |
| Human pituitary derived gonadotrophin or growth hormone prior to 1990 | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blood clots in the legs or lungs | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bleeding or bruising problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anaemia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blackouts or fainting | <input type="checkbox"/> | <input type="checkbox"/> | |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | |
| Epilepsy / fits / seizures | <input type="checkbox"/> | <input type="checkbox"/> | |
| Previous head injury | <input type="checkbox"/> | <input type="checkbox"/> | |
| Psychiatric illnesses | <input type="checkbox"/> | <input type="checkbox"/> | |
| Memory loss and/or confusion | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis / jaw, neck or back problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Joint replacement surgery | <input type="checkbox"/> | <input type="checkbox"/> | |
| Muscle or nerve disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Severe snoring / sleep apnoea | <input type="checkbox"/> | <input type="checkbox"/> | |
| Severe motion sickness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gastric reflux / stomach ulcer | <input type="checkbox"/> | <input type="checkbox"/> | |
| HIV / AIDS / Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pituitary problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Treatment for cancer | <input type="checkbox"/> | <input type="checkbox"/> | |
| History of eczema, skin conditions | <input type="checkbox"/> | <input type="checkbox"/> | |
| MRSA / VRE ESBL | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| Employed in a health facility within the last 6 months | <input type="checkbox"/> | <input type="checkbox"/> | |

| Anaesthetics | YES | NO | COMMENTS |
|--------------|-----|----|----------|
|--------------|-----|----|----------|

Have you ever had a general anaesthetic? YES NO
 Any problems / side effects, complications with the previous anaesthetics? YES NO
 Do you have any concerns about your anaesthetic that you would like to discuss with your Anaesthetist? YES NO
 If yes please state

If you need more space please attach the additional information on a separate piece of paper)

| Patient Medications |
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It is important that you list **all medications** you are taking, including natural (alternative) and complementary medications. Please bring them into hospital in the original containers. If your medicines are in "Blister Packs", please provide a medicine list from your pharmacist or General Practitioner.

| Medication (drug name on packet) | Dose or strength | Number of times taken each day | Reason for medication (if known) |
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| Allergies and Sensitivites | YES | NO | COMMENTS |
|----------------------------|-----|----|----------|
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Are you allergic / sensitive to any: *If YES, please name the item and describe the reaction*

Medications YES NO

Foods YES NO

Plasters and tape YES NO

Latex YES NO

Other YES NO

| General Questions | YES | NO | COMMENTS |
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Do you smoke? YES NO If yes, how many per day?.....

Did you ever smoke? YES NO If yes, what year did you stop?.....

Do you drink alcohol regularly? YES NO Average weekly intake

Females do you think you could be pregnant? YES NO

Do you presently have any cuts, scratches, sores or abrasions on your skins? YES NO Location.....

Do you have a family history of:

- Anaesthetic reactions YES NO
- Bleeding disorders YES NO
- Other neurological illness currently under investigation YES NO

Do you have any concerns about your hospital stay that you would like to discuss with us? YES NO

| Dietary Needs | YES | NO | COMMENTS |
|---------------|-----|----|----------|
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Do you have specific dietary needs? YES NO

| Cultural Care | YES | NO | COMMENTS |
|----------------------------------------------------------------|--------------------------|--------------------------|----------|
| Do you have any cultural needs we should be aware of? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Would you like us to return any surgically removed body parts? | <input type="checkbox"/> | <input type="checkbox"/> | |

| Spiritual Care | YES | NO | COMMENTS |
|------------------------------------------------------------------------------------------------|--------------------------|--------------------------|----------|
| <i>The inter-denominational hospital chaplain visits as part of Wakefield's spiritual care</i> | | | |
| Would you like to be visited by the hospital chaplain? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Would you like a visit from a pastor/priest of your own faith? | <input type="checkbox"/> | <input type="checkbox"/> | |

| Activities of Daily Living | YES | NO | COMMENTS |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------|----------|
| Do you have any restrictions with mobility? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you had any falls in the last 6 months? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| Do you use any mobility aids ie crutches? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have any stairs at home? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have any problems with speech? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have any problems with vision? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have any problems with hearing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you need assistance with toileting? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you need assistance with showering? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you need assistance with dressing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Referral to an Occupational Therapist is available (There may be a cost involved and with some procedures this service is mandatory) | <input type="checkbox"/> | <input type="checkbox"/> | |

| Discharge arrangements you have made | YES | NO | COMMENTS |
|----------------------------------------------------------------|--------------------------|--------------------------|----------|
| Are you going to your own home on discharge? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Someone to stay with you on the night of discharge? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Someone to drive you home? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have dependants who you care for? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you anticipate any problems on discharge and what are they? | <input type="checkbox"/> | <input type="checkbox"/> | |

| Do you currently receive assistant or have you arranged any Community Services? | YES | NO | COMMENTS |
|---------------------------------------------------------------------------------|--------------------------|--------------------------|----------|
| ACC Home Care | <input type="checkbox"/> | <input type="checkbox"/> | |
| Home Help services | <input type="checkbox"/> | <input type="checkbox"/> | |
| District Nurses | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | |

Is there anything else you wish to add that could assist us with your care?

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Do you wish to proceed with the surgery your surgeon has discussed with you? YES NO

Would you like us to phone you after discharge? YES NO

Patient/Guardian / /

NOTE: If within 10 days prior to your admission you have any sort of infection: ie flu, cold, broken areas or infected areas of the skin, vomiting/diarrhoea – please contact your surgeon.

Admission Assessment

Action required by admitting nurse (after going through this questionnaire with patient)

If action appropriate If action not required

- OT notified immediately of a Latex Allergy or patient over 100kgs
- TRAK updated with allergies and alerts
- TrendCare updated with dietary requirements / food allergies
- Skin assessment completed
- Wound assessment chart commenced
- Request physiotherapist to do a falls assessment
- Patients own medications locked in ward drug room / safe
- Pharmacist required to check medication blister packs
- Discuss possible need for night special if patient has known history of confusion / memory loss
- MRSA/ESBL swabs if patient admitted to (or employed in) a medical facility in last 6 months
- Anaesthetist notified of any issues or concerns

Other actions taken:

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Discharge Planning

Action required by discharge nurse (commenced by admitting nurse)

If action appropriate If action not required

- X-rays to be returned to patient (except CCDHB contracts)
- Referrals to other Agencies will be required
- Patients own medications will need to be returned
- A phone follow up is requested by the patient

Other actions taken:

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Admitting Nurse

Signature

Date / /