Health Questionnaire / Nursing Assessment Form

WAKEFIELD HOSPITAL

IMPORTANT Please deliver, post, fax or email this form **7-10 working days before your admission date** together with the completed Admission and Consent Forms to:

Wakefield Hospital
Private Bag 7909
Wellington South 6242
Fax (04) 381 8101
Email reception@wakefield.co.nz

A stamped, addressed envelope is provided.
If this is not possible, please make sure you bring the forms with you when you arrive for admission.
If you faxed or emailed the forms to us, please bring the originals with you.

Personal Details (patient to complete)

Admission Date

Patient name:

Mr/Mrs/Ms/Miss/Dr

Surname *Given names*

Preferred Name *Known as* Date of birth Height *metres* Weight *kg*

Previous Surname *If applicable* Ethnicity

Please bring any x-rays/scans with you when you come to the hospital.
If you are not filling out this questionnaire for yourself please state the reason why: (eg Parent of a child)

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Language	YES	NO	COMMENTS
Is English your first language?	☐	☐	....
Would you like us to arrange an interpreter? (There is a cost involved)	☐	☐	....
Will you use a family member as an interpreter?	☐	☐	....

Have you had previous surgery or hospital admissions?	YES	NO	COMMENTS
If YES, please provide details below	☐	☐	

Month and Year	Operation/Illness	Hospital
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
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....	....	....
....	....	....

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

General Anaesthetics	YES	NO	COMMENTS
Have you ever had a general anaesthetic?	☐	☐	.... If yes please explain
Any problems / side effects, complications following a general anaesthetic?	☐	☐	....
Do you have any concerns about your anaesthetic that you would like to discuss with your Anaesthetist?	☐	☐	....

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

Medications

It is important that you list **all medications** you are taking, including natural (alternative) and complementary medications. **Please bring all medications 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
Are you allergic / sensitive to any:			***If YES, please name the item and describe the reaction***
Medications	☐	☐	....
Foods	☐	☐	....
Plasters and tape	☐	☐	....
Latex	☐	☐	....
Other	☐	☐	....

General Questions	YES	NO	COMMENTS
Do you smoke?	☐	☐	If yes, how many per day?........................
Did you ever smoke?	☐	☐	If yes, what year did you stop?........................
Do you drink alcohol?	☐	☐	Average weekly intake ....
Females: is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic drugs may cause harm to your baby)	☐	☐	....
Do you presently have any cuts, scratches, sores or abrasions on your skin?	☐	☐	Location..
Do you have a family history of:			
– **Anaesthetic reactions**	☐	☐	....
– **Bleeding disorders**	☐	☐	....
– Other neurological illness currently under investigation	☐	☐	....
Do you have any concerns about your hospital stay that you would like to discuss with us?	☐	☐	....

Dietary Needs	YES	NO	COMMENTS
Do you have special dietary needs?	☐	☐	....

Cultural Care	YES	NO	COMMENTS
Do you have any cultural needs we should be aware of?	☐	☐	....
Would you like us to return any surgically removed body parts or metalware?	☐	☐	....

Spiritual Care	YES	NO	COMMENTS
The inter-denominational hospital chaplain visits as part of Wakefield's spiritual care			
Would you like to be visited by the hospital chaplain?	☐	☐	....
Would you like a visit from a minister/priest of your own faith?	☐	☐	....

Activities of Daily Living	YES	NO	COMMENTS
Do you have any restricitions with mobility?	☐	☐	....
Have you had any falls in the last 6 months?	☐	☐	....
Do you use any mobility aids eg crutches?	☐	☐	....
Do you have any stairs at home?	☐	☐	....
Do you have any problems with speech?	☐	☐	....
Do you have any problems with vision?	☐	☐	....
Do you have any problems with hearing?	☐	☐	....
Do you need assistance with toileting?	☐	☐	....
Do you need assistance with showering?	☐	☐	....
Do you need assistance with dressing?	☐	☐	....

Discharge arrangements you have made	YES	NO	COMMENTS
Are you going to your own home on discharge?	☐	☐	....
Someone to stay with you on the night of discharge?	☐	☐	....
Someone to drive you home?	☐	☐	....
Do you have dependants at home?	☐	☐	....
Do you anticipate any problems on discharge? If yes, please explain	☐	☐	....

Do you currently receive assistance or have you arranged any Community Services?	YES	NO	COMMENTS
ACC Home Care	☐	☐	....
Home Help services	☐	☐	....
District Nurses	☐	☐	....
Other	☐	☐	....

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 *Signature* ________ *Date* / /

NOTE: If within 7 days prior to your admission you have any of the following: flu, cold, broken or infected areas of the skin, vomiting/ diarrheoa – **please contact your surgeon**.

FOR HOSPITAL USE ONLY (prior to admission)

Phone Pre-assessment

YES ☐ NO ☐

Date Pre-assessed ___ / ___ / ___

Anaesthetic Issues:

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Medical History:

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Medications:

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Other:

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	YES	NO	COMMENTS
Sensitivites: on TRAK	☐	☐	....
Allergies: On TRAK	☐	☐	....
Needs confirmation with patient	☐	☐	....
Alerts: On TRAK	☐	☐	
Medical staff informed	☐	☐	....
Request for information from other Health Providers	☐	☐	From..
			....

Pre-assessment Nurse *Signature* ____________________ *Date* ___ / ___ / ___

FOR HOSPITAL USE ONLY

Admission Assessment

Action required by admitting nurse (after reviewing questionnaire with patient)

✔ If action appropriate ✘ If action not required

- [ ] Discuss possible need for night special if patient has known history of confusion / memory loss
- [ ] MRSA swabs if patient admitted overnight to (or employed in) a hospital or rest home in last 6 months
- [ ] ESBL swab if patient has been admitted for more than 2 days to (or employed in) a hospital or rest home in last 6 months
- [ ] Anaesthetist notified of any issues or concerns
- [ ] Patients own medications locked in ward drug room / safe
- [ ] Pharmacist required to check medication blister packs
- [ ] Theatre notified of a latex allergy or patient weight ≥100kgs
- [ ] Allergies and alerts updated in TRAK
- [ ] Skin assessment completed
- [ ] Wound assessment chart commenced
- [ ] Dietary requirements / food allergies updated in TrendCare
- [ ] Physiotherapist referral for mobility risk assessment

Day Case patients only

- [ ] Transport home has been arranged ie: not driving self home or catching a bus
- [ ] There will be a responsible person at home with patient overnight

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
- [ ] Patient's own medications to be returned
- [ ] A phone follow up is requested by the patient
- [ ] ACC/Medical Certificate will be required on discharge

Other actions taken:

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Admitting Nurse Signature ____________________ Date / /