Darwin Day Surgery

Short Stay Pre-Admission Health Screening Form
Form F.56

Affix Patient Label Sticker Here

When you complete this form there will be questions on both your physical and mental health. Please answer all questions so we can work together to plan the best care possible for you. We respect and support people from all cultures. If there are any specific cultural needs you have please let us know.
Please complete the following health questionnaire *(please circle the appropriate answer, tick where appropriate, and provide further information where indicated):*

Name: ______________________________ **Date of Birth**: ___ / ___ / ___ **Primary Phone No**: ______________

Planned Procedure: ____ **Admission Date:** ______________

Do you understand what your medical treatment/surgery **is**? **YES** **NO** **(please circle)**
Do you understand what your medical treatment/surgery **involves**? **YES** **NO**
If you **do not** understand, will someone be coming with you who can help explain? **YES** **NO**
Who is that person? ____ **Phone No**: ____________________

Height & Weight Details	Height (cm): Weight (kg): BMI: (kg/m^2)
Visual aids	**Y N** ☐ Glasses ☐ Contact Lenses ☐ Eye prosthesis
Hearing aids	**Y N** ☐ Left ☐ Right
Walking aids	**Y N** Specify:

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Do you have, or have you ever had:	**Yes No**	**Details**
Do you have any **ALLERGIES**? *Including **medications, latex, food** etc.* What are they and what kind of reaction do you have? Please list in next column **-------→**	**Y N**	
Heart trouble, palpitations, heart disease, heart attack, chest pain or pain on exertion (angina)	**Y N**	Specify: When:
Artificial heart valves, pacemakers, defibrillators	**Y N**	Specify:
Rheumatic fever	**Y N**	
High blood pressure	**Y N**	For how long?
Diabetes ☐ Type1 ☐ Type2	**Y N**	Controlled by: ☐ Diet ☐ Tablet ☐ Injection What are your usual blood sugars?
Blood clots (vein thrombosis, pulmonary embolus)	**Y N**	
Bleeding disorder / anaemia	**Y N**	
Have you ever had a blood transfusion?	**Y N**	Where and when:
Stroke / mini stroke / TIA / any residual weakness?	**Y N**	When:
Epilepsy / Seizures / Dizziness / Fainting (fear of needles?)	**Y N**	Specify: When:
Previous Falls or Unsteady on your feet	**Y N**	
Rheumatoid arthritis	**Y N**	Where:
Artificial joints / limbs or other body implants	**Y N**	Specify:
Back / neck injury or problems	**Y N**	Specify:
Do you have chronic pain?	**Y N**	Specify:
History of skin ulcers OR skin pressure injury	**Y N**	Specify:
Kidney problems / dialysis / kidney impairment	**Y N**	
Stomach ulcers or Heartburn or Reflux	**Y N**	Specify:
Jaundice (yellow skin/eyes) or other liver condition: **HIV or Hepatitis B or C?**	**Y N**	Specify:
Tuberculosis now or in the past?	**Y N**	When:

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Do you have, or have you ever had:	**Yes No**	**Details**
Do you have **MRSA** *or* **VRE**? (Antibiotic Resistant Bacteria's)	**Y N**	
Have you had Human Pituitary Growth Hormone prior to 1985?	**Y N**	
Have you had neurosurgery (brain/spinal cord) prior to 1985?	**Y N**	
Do you have **Creutzfeldt-Jakob Disease** (CJD)? *a rare brain disorder thought to be caused by an abnormal form of a protein called a 'prion'	**Y N**	Specify:
Have you been admitted overnight to any overseas hospital or resided in an overseas residential aged care facility within the past 12 months?	**Y N**	If ***YES*** have you been tested for **CRE**? **YES NO** ***carbapenem-resistant enterobacteriaceae* (a bacteria in the bowel)**
Sleep apnoea	**Y N**	What do you do about it?
Breathlessness on mild exertion or exercise	**Y N**	
Asthma or wheeziness; Hayfever or sinus problems	**Y N**	Specify:
Emphysema or bronchitis or frequent coughing	**Y N**	
Are you (could you be) pregnant?	**Y N**	If so, how many weeks?
Do you drink alcohol? **Y N** How many per week:		Do you smoke? **Y N** How many per day:
Have you taken any steroids (prednisolone or cortisone) in the last six months?	**Y N**	Specify:
Have you ever had an anaesthetic in the past?	**Y N**	Circle which: ***General*** ***Sedation*** ***Local***
Please list the procedures and year you have had anaesthetic in the past: ***e.g.: Appendix 2010 or Caesarian 2013***		
Have you (self or family) ever had any problems with anaesthetics? For example: Malignant hyperthermia (this is a rare reaction to certain types of anaesthetic drugs)	**Y N**	Specify:
Any other medical conditions or history not mentioned in this form, please specify:		

Please list **ALL REGULAR OR OCCASIONAL MEDICATIONS & VITAMINS & RECREATIONAL DRUGS you currently take in the table below**

Including: blood thinning medications, aspirin, warfarin, puffers/inhalers, patches, natural therapies or vitamins, oral contraceptive pill or implants, *AND* recreational drugs

Name of Medication	How much (dose)	How often (e.g.: daily)	**Name of Medication**	How much (dose)	How often (e.g.: daily)

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The following questions will help staff to better understand and be supportive of specific needs in regard to your mental health:

Do you have, or have you ever had:	Yes No	Details / Comments:
• Delirium • Post-Traumatic Stress Disorder • Depression • Bipolar Disorder • Acquired Brain Injury • ADHD (Attention Deficit Hyperactivity Disorder) • Autism/Asperger Syndrome • Anxiety • Eating Disorder • Dementia/Alzheimer's	**Y N** **Y N** **Y N** **Y N** **Y N** **Y N** **Y N** **Y N** **Y N** **Y N**	Please specify further:
Any episodes of confusion or memory loss?	**Y N**	Specify:
Any acute deterioration in your mental state?	**Y N**	Specify:
Episodes of aggressive or violent behaviour	**Y N**	Specify:
Episodes of self-harm or suicidal thoughts	**Y N**	Specify:

Throughout your admission at Darwin Day Surgery, do you need the support of a friend or relative? **Yes** **No**

If Yes, who will that be: ____

Are there specific signs that you would like us to be aware of that will alert our staff to a change in your mental state?

____

Are there any other factors that we need to be aware of that will:

a) Make you feel more supported? **Yes** **No**
- If Yes: ____

b) Make you feel more anxious or less supported? **Yes** **No**
- If Yes: ____

Who will be taking you home and be with you OVERNIGHT following your surgery? *GENERAL ANAESTHETIC & SEDATION SURGERY ONLY*		
Name:	Relationship:	Phone No:
Who is your emergency / Next of Kin contact?		
Name:	Relationship:	Phone No:

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature Patient / Carer: ______________________________ **Date:** ______________

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Pre-Admission and Admission Nurse Only:

Darwin Day Surgery Nursing Staff **only** to complete on all patients who are over 65 years of age:

Screening for Risk of Delirium:

Is the patient:

- >65 year old? **Yes** **No**
- Known to have dementia or cognitive impairment? **Yes** **No** **(if yes, see Theatre Manager)**
- Currently have an infection? **Yes** **No** **(if yes, see Theatre Manager)**

Using your Clinical judgement (please answer):

1. Is the patient orientated to Day / Time / Place? **Yes** **No**

   Comments: ______________________________

2. Does the patient understand the reason for their admission? **Yes** **No**

   Comments: ______________________________

Note: If you answered NO to either question 1) or 2) contact Theatre Manager as the patient may need further assessment or rescheduling

3. Is a Mini Mental required? **Yes** **No** **(if yes, see Form F.95)**

Assessing for Impaired Decision Making:

Impaired decision-making capacity means that person is **not capable** of:

- Understanding any information that may be relevant to the decision, including the consequences.
- Retaining such information, even for a short time.
- Using information to make decisions.
- Communicating the decision (in any way: verbal, written, sign language)

When assessing whether a person has the capacity to make medical or dental decisions, it is important that you:

- Ask open-ended questions
- Do not ask leading questions
- Try to identify whether a person needs support or help to make the decision or requires a "Substitute Decision-Maker" to make a decision for them. In some circumstances the person may need support from a neutral person such as an advocate or an interpreter.

Example questions: What is the treatment that you might be having? Can you explain it to me? What are the risks of having the treatment? How will the treatment help you? What are the good things about the treatment? What are the bad things about the treatment? How do you think you will be able to deal with these? What do your family and friends think of the treatment? What would happen if you didn't have any treatment at all?

From nurse assessment: Does the patient have decision making capacity? **YES / NO** **(if no, see GM/TM)**

***Pre-admission Nurse Use Only*:** Patient Meets Darwin Day Surgery Criteria: **YES / NO**

Patient has been informed of: Fasting Times: YES NO N/A Excess/Quote Amount: YES NO N/A

Arrival Time: YES NO Escort/Overnight Carer Confirmed: YES NO N/A

Other Notes: ……………………………………………………………………………………………

………

Nurse: ………………………… Signature: ………………………… Designation: ………… Date: …………………

*****Following health screening now complete Comprehensive Care Plan F.56A with patient &/or carer*****

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