

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to MercyAscot. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to that affect because we do not have your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you, along with any mobility aids, CPAP machines etc., to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact the hospital on 09 520 9500.

We look forward to helping you prepare for your operation/procedure.

Regards,

Admissions Unit Nurses

YOUR DETAILS

Legal Name: Date of Birth: / /

Planned Procedure:

Home Phone Number: () Mobile Number: ()

NHI No: (if known) Date of Surgery: / /

FOR HOSPITAL USE ONLY

Pre-Admission Review:

Reviewed; no further action required

Reviewed; patient contacted

Action Taken:

Date unable to contact (1st Attempt): / /

Date unable to contact (2nd Attempt): / /

Investigations required (please review any existing results)

FBC Renal Coag G+H LFT INR CXR MDRO swabs ECG ECHO

Other tests (specify):

Name: Designation:

Signature: Date: / /

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? If yes, please give details below

| | Yes | No | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Reflux | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Implants or Metalware | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmurs | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is it | | | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | Diet controlled? | <input type="checkbox"/> | | Mobility: | | |
| Chest Pains/Angina | <input type="checkbox"/> | <input type="checkbox"/> | Tablet controlled? | <input type="checkbox"/> | | Use Equipment | <input type="checkbox"/> | <input type="checkbox"/> |
| Coronary Angiogram or Stents | <input type="checkbox"/> | <input type="checkbox"/> | Insulin controlled? | <input type="checkbox"/> | | (e.g. crutches/frame/wheelchair) | | |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Renal/Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | History of Falls | <input type="checkbox"/> | <input type="checkbox"/> |
| AF/Palpitations/Arrhythmias | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Is activity restricted by: | | |
| Ischaemic Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | | | Shortness of Breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| CORD (Chronic Obstructive Respiratory Disease) | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Current Skin Problems (e.g. ulcers, wounds, eczema, boils) | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema/Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Have you or a blood relative ever had any problems during or after anaesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses/contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Problems opening your mouth or with neck stiffness? | <input type="checkbox"/> | <input type="checkbox"/> | Other vision impairments? | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Malignant Hyperthermia | <input type="checkbox"/> | <input type="checkbox"/> | Hearing difficulties | <input type="checkbox"/> | <input type="checkbox"/> |
| Obstructive Sleep Apnoea | <input type="checkbox"/> | <input type="checkbox"/> | Taken Human Growth Hormones prior to '92 | <input type="checkbox"/> | <input type="checkbox"/> | Do you or have you ever smoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does lying flat make you breathless? | <input type="checkbox"/> | <input type="checkbox"/> | Brain or spinal surgery which included the use of a dura mater graft? | <input type="checkbox"/> | <input type="checkbox"/> | If 'yes', how much? <input type="text"/> | | |
| Stroke/CVA/TIA | <input type="checkbox"/> | <input type="checkbox"/> | Are you or could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | If 'yes', for how long? <input type="text"/> | | |
| Anaemia/Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Have you suffered motion sickness or post-op nausea and vomiting? | <input type="checkbox"/> | <input type="checkbox"/> | When did you give up? <input type="text"/> | | |
| Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | History of Cancer? | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Seizure | <input type="checkbox"/> | <input type="checkbox"/> | | | | If yes, how many units weekly <input type="text"/> | | |
| Blackouts/Fainting | <input type="checkbox"/> | <input type="checkbox"/> | | | | (Units/Weekly) | | |
| | | | | | | (1 standard glass wine or 1/2 glass beer = 1 unit) | | |
| | | | | | | Recreational Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Special Dietary Requirements | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered 'yes' to any of the questions above then please give details, including treatment. **If you require more space, attach an additional sheet.**

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, mental illness, Alzheimer's, muscle/nerve disease? Yes No

If 'yes' please give details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes No

If 'yes' please give details:

If you have a body part removed during surgery, would you like it returned to you? Yes No

Are you waiting to see (or have recently seen) your doctor or hospital specialist about a health condition unrelated to the proposed operation/procedure you are currently being assessed for? Yes No

If 'yes' please give details:

Legal Name:

Have you lived or worked overseas in the six months prior to your admission? Yes No

Have you ever had MRSA, ESBL or VRE infection? Yes No

Have you been a patient in a hospital (in NZ, including MercyAscot, or overseas) **within the last six months?** Yes No

Do you work in a health care facility? Yes No

Height m Weight kg

This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

| Are you allergic/sensitive to any : | Yes | No | If 'yes' please name the items and describe reaction: | |
|---|--------------------------|--------------------------|---|----------------------|
| | | | Name | Reaction |
| Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |
| Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |
| Plasters/tape/skin preparations (e.g. iodine, chlorhexidine) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |

Please list **all** previous admissions to hospital for operations/procedures and/or medical reasons. Please include where and when. **(Estimate if unsure). If you require more space, attach an additional sheet.**

| Previous admissions/surgery | Hospital | Month/Year |
|-----------------------------|----------|------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list **all** medicines – tablets, inhalers, patches etc. prescribed by your doctor or **over the counter** (include any herbal or natural remedies or dietary supplements). **If you require more space, attach an additional sheet.**

| Name of Drug | Strength | Dose | Frequency |
|--------------|----------|------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does anyone assist you with administration of your own medication? Yes No

If 'yes' please give details:

Is your medication packed in "compliance" (blister) packaging? Yes No

PLEASE BRING ALL YOUR MEDICATIONS, IN ORIGINAL PACKETS, WITH YOU TO HOSPITAL.

DISCHARGE PLANNING

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will help relieve your anxiety and prepare you for your discharge home.

You will need someone to stay with you for at least 24 hours after discharge. This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

CARER SUPPORT:

Current living arrangements? Tick one.

Live alone Live with others i.e. partner/children

Have caring responsibilities for others at home. Please specify:

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and up to five days after your discharge or as advised by your surgeon.

Who will be caring for **you** following your discharge?:

Name: Relationship:

Address:

Phone Number (mobile/landline):

FORMAL SUPPORTS:

Do you currently receive any formal supports (i.e. home help, meals on wheels)? Yes No

If 'yes', please state who, and for how many hours per week.

You will need to notify your formal supports of your hospital admission date and proposed discharge date.

If you think that you will require respite care for a period of time after discharge, please discuss this with your surgeon. You may be responsible for any costs associated with this arrangement. These arrangements should be organised by you prior to your admission.

DISCHARGE/TRANSPORT:

Please advise the person collecting you that the discharge time is **10am**.

Name: Contact Phone Number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know **who** has **completed this form**. Please **print and sign your name**.

Print Name (in full): Date: / /

Signature:

I am the patient legal guardian parent other (specify)

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(csascot@mercyascot.co.nz or SEE PAGE 12 OF PATIENT INFORMATION BOOKLET)