SPRING HILL SPECIALIST DAY HOSPITAL

Levels 1 and 4, St Andrew's Place
33 North Street, Spring Hill QLD 4000

Phone: [07] 3307 3243
Fax: [07] 3832 3247

PATIENT I.D. LABEL

PRE-OPERATIVE FORM

PRE-OPERATIVE ASSESSMENT FORM

PLEASE COMPLETE THIS FORM IN BLACK PEN AND RETURN IT TO THE DAY SURGERY UNIT AS SOON AS POSSIBLE.
IF TIME IS INADEQUATE, PLEASE BRING IT WITH YOU ON THE DAY OF SURGERY.

Name: **Ht:** cm **Wt:** kg

Details of previous surgery:

Have you had an anaesthetic previously? ☐ Yes ☐ No

If Yes please give details of any problems:

Gyn/IVF patient only

Date of last menstrual cycle: / /

Are you currently breast feeding? ☐ Yes ☐ No

Do you have or have ever had any of the following? *(Circle answer where there are options)*	Yes	No	Additional information
Allergies to medication / tapes / dyes / latex / food	☐	☐	
Malignant hyperthermia (you or your family)	☐	☐	
A cough or cold at present	☐	☐	
Heart disease, Rheumatic fever, Heart Murmur	☐	☐	
Chest Pain / Angina / Heart Attack / High Blood Pressure	☐	☐	
Bronchitis, Asthma, or any other chest problems	☐	☐	
Do you smoke? How long?	☐	☐	
Faint easily	☐	☐	
Epilepsy or other seizures	☐	☐	
Hepatitis or jaundice	☐	☐	
Arthritis or muscle disease	☐	☐	
Kidney problems	☐	☐	
Heartburn / reflux	☐	☐	
Anaemia or other blood problems	☐	☐	
Bruise or bleed easily	☐	☐	
Diabetes Type 1 Type 2	☐	☐	
Have you taken Aspirin in the last 2 weeks	☐	☐	
Other serious illnesses or disabling conditions	☐	☐	

List of current medications (including alternative / recreational drugs):

Special diet? If yes please give details:

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RISK MANAGEMENT

CLINICAL RISKS: Patient self-assessment - please complete boxes 1 - 4

ADMISSION NURSE: if yes to any of the following, document and handover as per policy

PATIENT TO COMPLETE

1 FALLS RISK	Have you fallen in the last year	YES	NO
	Do you have any cognitive impairment? (Disoriented, dizzy, confused, memory impairment, unable to follow instructions)	YES	NO
	Do you require supervision or assistance with ambulation or have any restricted mobility?	YES	NO
	Have you received medications in the last 24 hours that impair co-ordination / mental function?	YES	NO
	Do you have presence of sensory or motor impairment?	YES	NO
2 SKIN INTEGRITY RISK	Do you have a history of poor skin integrity – broken skin area / fragile skin?	YES	NO
	Do you have a history of incontinence? COMMENTS:	YES	NO
	Are you a known insulin dependant diabetic? (Not gestational)	YES	NO
3 THROMBOSIS RISK	Do you have a history of deep vein thrombosis / pulmonary embolism?	YES	NO
	Do you have a history of previous stroke/ heart failure / acute myocardial infarction?	YES	NO
	Do you have a history of malignancy?		
	Have you sustained a recent fracture?	YES	NO
	Is your planned procedure / operation time greater than 2 hours? (Check with nurse)	YES	NO
4 INFECTION CONTROL/CJD	Do you or a family member suffer from or been exposed to CJD (Creutzfeld Jakob Disease)	YES	NO
	Have you received human pituitary hormone or had a dura mater graft between 1972 & 1989?	YES	NO
	Have you ever had a mutli-resistant infection?	YES	NO
	Do you have or have you ever had Tuberculosis (TB)?	YES	NO
	Do you have or have you ever had blood borne infection (e.g. Hepatitis HIV)?	YES	NO
	Do you have a respiratory infection or signs & symptoms of a respiratory infection with a temperature over 38 degrees?	YES	NO

CLINICAL RISKS

Assessment is required upon admission and re-assessment must be undertaken if changes are noted to any of the risk factors above during admission.

ACKNOWLEDGEMENT OF REQUIREMENTS FOR DISCHARGE

I ______________________________ acknowledge that I have been informed by hospital staff of the following requirements relating to my discharge from the Day Hospital.

- I must be collected by a responsible adult/family member/carer when I have been discharged
- I have arranged for a responsible adult to stay with me for the first 24 hours post procedure or at least over night.
- For the first 24hours post procedure I will;
  - Take medications only prescribed by my doctor
  - Not drink alcohol
  - Not drive a motor vehicle or take control of machinery or hazardous appliances
  - Avoid tasks that involve concentration or responsible decision making

Patient Signature ______________________________ Date ____/____/____

Nurse Signature ______________________________ Date ____/____/____