

Risk assessment

MEDICAL HISTORY

List previous operations, hospital admissions or any major/serious illness

Have you, or any of your family, experienced an adverse reaction during anaesthesia general or local? YES NO If yes, please specify.

Have you, or any of your family, had a history of malignant hyperthermia? YES NO

MEDICATIONS / ALLERGIES

Please list current medications including any non-prescribed medications such as vitamins, herbs, natural or traditional therapies

MEDICATION/DRUG OR VITAMIN NAME	STRENGTH	NO. TAKEN	HOW OFTEN

Have you used steroid/cortisone medication in the past 6 months? YES NO

BLOOD THINNERS Have you taken any blood thinning medication this week? eg Aspirin, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix, Brufen, Nurofen, Indocid) or **Natural Thinners** (eg Vitamin E, Chinese herbs, Ginkgo, Fish Oil, Garlic)? YES NO

DIABETES Do you use insulin YES NO
 Are you tablet controlled? YES NO
 Are you diet controlled? YES NO
 Please bring ALL diabetic tablet medications AS WELL as your INSULIN on day of admission.

ALLERGIES Do you have any known allergies to any medications, dressings, latex or food? If yes, please list

HEIGHT in cms _____ WEIGHT in kgs _____
If 150kgs or over please contact day hospital reception. A pre admit anaesthetic assessment will be conducted over the phone to ensure your utmost safety.

DO YOU HAVE, NOW OR IN THE PAST, ANY OF THE FOLLOWING? YES NO

CIRCULATION	SEVERE HEART PROBLEMS Heart attack, heart failure, acute myocardial infarction. Any recent hospitalisation for heart disease. If YES, please contact the Day Hospital		
	A PACEMAKER OR DEFIBRILLATOR Please bring your Pacemaker/Defibrillator card with you		
	BLOOD CLOTS (DVT/PE) Have you ever received blood/blood product (eg anti D). If YES, did you have a reaction?		
	STROKE (TIA) Malignancy or recent fracture Blood pressure NORMAL <input type="checkbox"/> HIGH <input type="checkbox"/> LOW <input type="checkbox"/> Anaemia		
RESPIRATORY	SEVERE LUNG DISEASE Asthma. If YES, please bring your medication		
	Recent respiratory infection (cold or flu) or signs or symptoms with a temperature over 38 degrees? If YES, please contact the Clinical Services Manager at your nominated hospital.		
	Sleep apnoea		
SYSTEMS	Vision impairment		
	Hearing impairment		
	Cochlear implant		
	Bladder / kidney problems Anxiety / depression / panic attack Epilepsy / seizures / fits / dizzy spells		
INFECTION	Tick if any apply to you Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/>		
	Tick if any apply to you TB <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CRE <input type="checkbox"/>		
	In the last 2 weeks, have you had, or been in contact with, anyone with Chicken Pox or German Measles?		
DENTAL	Do you or any of your family suffer from or had exposure to Creutzfeldt jakob disease (CJD)?		
	Received human pituitary hormone or had a dura mater graft between 1972 and 1989?		
	Crowns, bridges, dentures, caps		
	Dental problems (eg gum disease, loose teeth, cracks)		
MOBILITY	Fallen in the past 12 months		
	Medication in the past 24 hours that impairs your co-ordination/ mental function		
	Cognitive impairment (eg disorientation, dizziness, confusion, memory loss, inability to follow instructions)		
SKIN	Back pain or injury / mobility problems Bed or wheel chair bound		
	Skin rash, eczema, skin tear		
	History of pressure areas		
LIFESTYLE	Alcohol: How much each day? _____ Standard drinks		
	Tobacco: How many each day? _____		
OTHER	Have you ever used IV or recreational drugs?		
	If female, are you pregnant? If no, date of last period ___/___/___		
	Needle phobia: If YES, please inform reception staff upon arrival		
	Do you have an Advanced Care Plan/Health Care Directive?		
	Any medical conditions/physical disability that may affect your procedure with us? If YES, please list		
	I have read and agree with the Day Hospital's Privacy statement.		

PATIENT/GUARDIAN SIGNATURE

DATE

ADMISSION NURSE If YES to any of the above, record in COMMENTS section of Theatre Checklist

NURSE SIGNATURE

DATE