Sunshine Private Hospital
part of unitas healthcare

PREADMISSION HEALTH QUESTIONNAIRE - GENERAL

Patient Surname	
Patient First Name	
Unique Record Number	
Date of Birth	
Gender	

Write details or affix label here

TO BE COMPLETED BY THE PATIENT OR PERSON RESPONSIBLE | Please answer all questions to the best of your ability.
For assistance, ask your GP or call 1300 600 978 to speak with the Pre-admissions Nurse.
Email the completed form to surgicalandmedicalbookings@unitas.com.au at least 3 days prior to admission

Admission details

Admission Type: ☐ Surgical ☐ Endoscopy ☐ General Medicine ☐ Inpatient Mental Health ☐ ECT or TMS* ☐ Sleep Study**

Planned Admission Date: ……/……/…… **Reason for admission:** ……

Account Class: ☐ Private Insurance ☐ Uninsured ☐ Overseas ☐ DVA ☐ WCA ☐ TAC

Consent to be contacted prior to your admission

SPH may need to contact you to provide updates on your admission.
Do you consent to being contacted? ☐ No ☐ Yes → If yes, via ☐ Email ☐ SMS/Text ☐ Phone

Patient details

Patient Height: …… [cm] **Patient Weight:** …… [kg] **Patient BMI*:** ……

Do you have an Advanced Care Plan? ☐ No ☐ Yes → If yes, please provide a copy on admission.
Further details on ACPs can be found at https://www.health.vic.gov.au/patient-care/advance-care-planning-forms

Previous hospital admissions & operations

Have you had any previous admission or operations? ☐ No ☐ Yes → If yes, please provide details below.
If space is insufficient, please attach on separate sheet.

Date / Year [Approx.]	Reason for admission [Specify Illness, operation etc.]	Were there any complications? [If Yes*, Please specify]	*Doctor Notified?
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

Previous Anaesthesia

Have you or any family members ever experienced problems with or reactions to Anaesthetic? ☐ No ☐ Yes → If yes*, please provide details below.

Reactions: ……

*Theatre notified? Y / N

Alerts on Kyra? Y/N

Medication Management

Do you take or have you recently taken blood thinning medications (eg.aspirin/warfarin/clopidgrel)?
☐ No ☐ Yes → If yes, please provide further details below.

Type [brand name]: …… **Dose:** ……

If attending for surgery, have you been told to stop your blood thinning medications?
☐ No* ☐ Yes → If yes, what date were they ceased? ……/……/……

*Theatre notified if **not** ceased? Y / N

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*Preadmission nurse has notified ECT Co-Ordinator? Y / N

**Checked Manse Medical Schedule & Bookings List? Y / N

*Theatre notified if BMI >40? Y / N

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Medication Management [continued]

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Have you had any steroids or cortisone injections in the last 6 months? ☐ No ☐ Yes
→ If yes, please provide further details below.

Type [brand name]: ..... Dose: .....

Do you require assistance with taking medications [i.e. dosette, crushed, webster packs]? ☐ No ☐ Yes

Are you taking any prescription /non-prescription or complimentary medicines? ☐ No ☐ Yes
→ If yes, please bring these with you in their **original packaging.**

Current Medications

Do you have a Pharmacy Card? ☐ No ☐ Yes → If yes*, please provide.
Or, do you have a medications List from your GP? ☐ No ☐ Yes → If yes*, please provide.
If you have neither of the above, please provide a list of all your current medications in the space below.

*Printed/Scanned into Kyra? Y / N

Medication Name	Dose	Frequency	Reason for taking [if known]

Allergies and sensitivities

Do you have any allergies/sensitivities? ☐ No ☐ Yes →If yes*, please provide further details below

Medication ☐ No ☐ Yes →If yes please specify .....

Latex ☐ No ☐ Yes →If yes please specify .....

Tapes ☐ No ☐ Yes →If yes please specify .....

Food ☐ No ☐ Yes →If yes please specify .....

Other [please specify] .....

.....

* Red alert bands?

Y/N

Adverse reaction & medication chart completed?

Y/N

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General Health & Pre-surgical Information

Have you had recent blood or urine tests/pathology?	☐ No	☐ Yes→	If yes, please bring with you
Have x-rays/CT scan/MRI been taken for this admission?	☐ No	☐ Yes→	If yes, please bring with you
Females – are you pregnant or breastfeeding?	☐ No	☐ Yes	
Do you have sleep apnoea?	☐ No	☐ Yes	
Do you use a CPAP machine?	☐ No	☐ Yes→	If yes*, please bring your machine with you
Special Diet/Cultural Needs?*	☐ No	☐ Yes→	☐ Halal ☐ Gluten Free ☐ Vegetarian ☐ Vegan ☐ Dairy/Lactose Free ☐ Diabetic ☐ Other.....[please state]
Do you drink alcohol?	☐ No	☐ Yes→	If yes, how many per week?
Are you a smoker?	☐ No	☐ Yes	☐ I quit.....months/years ago
Have you ever used any illicit or recreational drugs?	☐ No	☐ Yes	
Dental Issues/Implants?	☐ No	☐ Yes→	☐ Chipped/broken teeth ☐ Loose teeth ☐ Dentures ☐ Crowns/plates/caps
Do you have any of the following? [tick those that apply] ☐ Prothesei/Artificial Joints ☐ Metal pins/plates ☐ Stent/valves ☐ Pacemaker/defib ☐ Stent/valves ☐ Other Implant/s			
Do you have Mobility issues?*	☐ No	☐ Yes→	Due to ☐ Being bed bound ☐ Injury ☐ Medication ☐ Other .....
Do you require a mobility aid?	☐ No	☐ Yes→	☐Stick ☐Walking frame ☐Wheelchair ☐Other
Have you had a fall in the last 12 months?	☐ No	☐ Yes	
Frequent headaches/migraines/neurological issues?	☐ No	☐ Yes	
CVA/Stroke/TIAs/Head Injury?	☐ No	☐ Yes→	If yes, any residual effects? .....
Epilepsy/Seizures?	☐ No	☐ Yes→	If yes, type and onset .....
Parkinson's/Multiple Sclerosis/Motor Neurone Disease?	☐ No	☐ Yes→	If yes, circle which applies
Short term memory loss/confusion/Alzheimers/Dementia?	☐ No	☐ Yes→	If yes, circle which applies
Had or having treatment for a mental health condition?	☐ No	☐ Yes→	If yes, name of condition.....
Previous suicide attempt?	☐ No	☐ Yes	
Aggressive tendency or behaviour?	☐ No	☐ Yes	
Do you have Thyroid problems?	☐ No	☐ Yes	
Do you have Diabetes?*	☐ No	☐ Yes→	☐ Type 1 ☐Type 2 ☐ Unknown ☐Gestational
Is it being treated/controlled?	☐ No	☐ Yes→	☐Diet ☐ Insulin ☐ Tablets .....
Difficulty swallowing/eating/speech impairment?	☐ No	☐ Yes→	If yes, due to stroke? ☐ No ☐ Yes
Blood pressure issues?	☐ No	☐ Yes→	☐ High blood pressure ☐ Low blood pressure
Heart disease/rheumatic fever/palpitations/irregular heart beat/heart murmur/heart attack?	☐ No	☐ Yes→	If yes, circle which applies
Lung disease/Asthma/COPD/bronchitis/emphysema/ pneumonia/shortness of breath?*	☐ No	☐ Yes→	If yes, circle which applies
Blood disorder/blood clot/DVT/PE?*	☐ No	☐ Yes→	If yes, name of condition.....
Blood Transfusion/or blood products?	☐ No	☐ Yes→	If yes, any reactions? .....
Kidney Disease/Bladder problems/Stoma/Incontinence?	☐ No	☐ Yes→	If yes, name of condition.....
Skin Issues/Wound/Broken Skin/Pressure Sores?*	☐ No	☐ Yes→	If yes, circle which applies
Arthritis/Osteoathritis?	☐ No	☐ Yes→	If yes, circle which applies
Gastric Band/Sleeve Gastrectomy/Gastric Bypass?	☐ No	☐ Yes→	If yes, circle which applies
Recent unintentional weight loss in last 6 months? *	☐ No	☐ Yes→	If yes, ...kgs
Have you been eating poorly due to a decrease in appetite?	☐ No	☐ Yes	
Are there any other health conditions you think we should know about?	☐ No	☐ Yes→	If yes, list here:

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Received Y/N

Dr Notified Y/N

*CPAP in hospital Y/N

*Kitchen Notified Y/N

*Aids labelled Y/N

Falls chart Completed Y/N

*Diabetic chart Y/N

BSL on admission Y/N

*CXR required? Y/N

*TEDS required Y/N

*Wound chart completed Y/N

L-QMC report completed Y/N

*Malnutrition assessment completed Y/N

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Home situation & discharge planning

What is your living arrangement?

☐ **I live at home with**.....

☐ **I live in a care facility** .....[name facility] ☐ Low Care ☐High Care

If you live in Nursing Home, do you have ambulance cover? ☐ No ☐Yes→ ..... [Cover No.]

☐ **I live alone** → Who will care for you in the 24hrs post-surgery? Name: .....

Relationship: ..... Contact number: .....

Do you anticipate difficulties returning to your place of residence? ☐ No ☐ Yes→.....

Are you already receiving assistance at home? ☐ No ☐ Yes

Please be aware that on discharge, it is in your best interest to:

1. Have a responsible adult to accompany you home.
2. Understand the importance of following instructions regarding your ongoing care.
3. Be aware of the danger to yourself/others and not drive a motor vehicle or operate machinery for 24 hours following any sedation, anaesthetic or strong pain medication.

..../...../.....

Patient/Carer/Relative/Guardian Signature (circle) Contact Phone number Date

Infection Control

Have you recently had or been exposed to COVID19?	☐ No	☐ Yes→	If yes, when? ...../...../.....
Have you been directly transferred from any overseas Health Care Facility (HCF)?	☐ No	☐ Yes→	Country: Admission Reason:
Have you been admitted overnight to any overseas HCF in the past 12 months?	☐ No	☐ Yes→	Country: Admission Reason:
Have you resided in an overseas Residential Aged Care Facility in the past 12 months?	☐ No	☐ Yes→	Country:
Have you been identified as a CRE contact in the past AND was there evidence of post-contact negative pathology cultures?	☐ No	☐ Yes→	If yes, Please provide post contact negative pathology
Have you had a past diagnosis of CRE colonisation or infection?	☐ No	☐ Yes	
Do you currently have symptoms of a respiratory infection (fever, cough)?	☐ No	☐ Yes	
Do you currently have symptoms of gastro-enteritis (Vomiting & or diarrhoea)?	☐ No	☐ Yes	
Are you currently being treated for any infections?	☐ No	☐ Yes	
Have you ever been diagnosed with having a Multi Resistant Infection?	☐ No	☐ Yes	

CJD Risk Screening [Ophthalmic Surgery Only]

Have you had investigations or procedures involving any of the following higher-infectivity tissues?		
Brain, pituitary, or dura mater	☐ No	☐ Yes
Cranial and dorsal root ganglia	☐ No	☐ Yes
Spinal cord	☐ No	☐ Yes
Eye (Retina/Optic Nerve)	☐ No	☐ Yes
Olfactory Epithelium	☐ No	☐ Yes
Have you had two or more first or second-degree relatives with CJD?	☐ No	☐ Yes
Do you have an unexplained progressive neurological illness of less than 12 months?	☐ No	☐ Yes
Received human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)?	☐ No	☐ Yes
Previous surgery on the brain or spinal cord with a dura mater graft (prior to 1990)?	☐ No	☐ Yes

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Do you think the patient may have CJD? ☐ No ☐Yes

Has the patient been screened - regarding their risk for CJD and is the patient clear for surgery? ☐ No ☐Yes

●If an infection risk noted or the patient answers YES to CJD questions, staff must contact the Hospital Co-ordinator (AH) or Infection Control Manager to report this information and gain advice on their care in the clinical area●

I have reviewed the Patient Health History and taken necessary actions

.....	.....	.....	...../...../.....
Preadmission Nurse Signature	**Print Name**	**Designation**	**Date**
.....	.....	.....	...../...../.....
Admission Nurse Signature	**Print Name**	**Designation**	**Date**

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Submit Form

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