LADY BJELKE-PETERSEN COMMUNITY HOSPITAL	**Pre-Admission Health Questionnaire**	AFFIX PATIENT LABEL HERE

PLEASE COMPLETE AREAS IN WHITE ONLY – A PREADMISSION NURSE WILL CONTACT YOU PRIOR TO SURGERY

Patient's Name:			**Date of Birth:**		
Address:				**Post Code:**	
Telephone:		**Completed by**	Patient ☐ Carer ☐ Other ☐		
Surgeon:		**Type of surgery?**			
Admission Date:		**Informed consent explained by surgeon?**	Yes ☐ No ☐		
GP Details	**Name:**		**Phone:**		
Interpreter: Yes ☐ No ☐ Detail:		**Religious or Cultural needs? Please advise:**			
		Height:	**Weight:**	**BMI**	

Allergies & Sensitivities

Have you ever had an ALLERGIC or ADVERSE reaction to?

	YES	NO	PRODUCT NAME	TYPE OF REACTION
DRUG				
LATEX				
FOOD / OTHER				

Do you have any special dietary requirements	Yes ☐ No ☐	If yes, please give details?

Anaesthesia

	Yes	No	
Have you had anaesthesia before?			Have you had a previous admission to Lady Bjelke-Petersen Community Hospital? Yes ☐ No ☐ Date:_____
Have you or any blood relative had any problems with an anaesthetic?			

Previous operations

Please list previous operations:

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Cardiac	**Yes**	**No**	**HOSPITAL USE ONLY**	**Nurse initial**
Have you ever had a? Heart Attack ☐, Stroke ☐ Year:				
Have you ever had Heart Surgery? Which year:				
Do you have a? Pacemaker ☐, Internal Defibrillator ☐				
Do you have any? Cardiac Stents ☐, Prosthetic Heart Valve ☐				
Have you ever had? Angina ☐, Chest Pain ☐, High Blood Pressure ☐				
Do you have an Irregular? Heartbeat ☐, Palpitations ☐				
Have you ever had a? Blood Clot ☐, DVT ☐, Pulmonary Embolism ☐				
Do you have any other? Heart Problems ☐, Blood Disorders ☐				
Diabetes				
Do you have Diabetes? Type: Type 1 ☐ Type 2 ☐ Unsure ☐ Controlled by: Diet ☐ Tablet ☐ Insulin ☐				
Gastrointestinal				
Have you suffered from? Reflux ☐, Heartburn ☐				
Do you have a? Hiatus Hernia ☐ Gastro-Intestinal Ulcers ☐				
Do you have a Gastric Band in place?				
Skeletal / mobility				
Have you ever had? Back ☐, Neck ☐, Jaw Problems ☐				
Do you have Arthritis? If so state where:				
Have you experienced? Fainting ☐, Dizziness ☐, Fall ☐ In the last 3 months.			Complete falls risk tool Score:	
Do you use a? Walking Stick ☐, Crutches ☐, Walking Frame ☐				
Any problems bearing your weight? Details:				
Do you use a wheel chair?				
If Yes, can you stand to transfer independently?				
Respiratory				
Do you smoke? Amount per day?				
Do you have? Asthma ☐, Bronchitis ☐, Emphysema ☐, COPD ☐				
Are you able to Lie Flat for your procedure?				
Do you have? Sleep Apnoea ☐ EPAP☐ CPAP ☐ Oxygen ☐				

LADY BJELKE-PETERSEN COMMUNITY HOSPITAL	**Pre-Admission Health Questionnaire**	AFFIX PATIENT LABEL HERE

Infection Control	**Yes**	**No**	**HOSPITAL USE ONLY**	**Nurse initial**
Do you have a family history of, two or more First Degree Relatives with Creutzfeldt-Jakob disease or other unspecified Neurological Disorder?				
Have you had a Dura Mater Graft to the Brain or Spinal Cord prior to 1989?				
Have you received Human Pituitary ☐ Growth or Fertility Hormones ☐ prior to 1986?				
Have you ever tested positive for Hepatitis A ☐ B☐ C ☐ HIV ☐ TB ☐				
Have you ever had a hospital acquired infection? MRSA ☐ VRE ☐ Clostridium difficile ☐ CRE Bacteria ☐ If yes, when?				
Have you recently returned from overseas or had an overnight stay in an overseas Hospital in the last 12 months?			If yes, use contact precautions	
Have you had or been exposed to an infectious disease in the last 14 Days? Chicken Pox ☐ Measles ☐ Other ☐				
Prostheses/Aids				
Do you wear? Glasses ☐ Contact Lenses ☐				
Do you use a Hearing Aid or other Hearing Appliance?			Please wear your hearing aid to hospital	
Do you have? Dentures ☐, Caps ☐, Crowns ☐, Loose Teeth ☐				
Do you have an artificial? Joint ☐, Limbs ☐, Breasts ☐ If yes Where:				
Do you have implanted? Plates ☐, Pins ☐, Porta Cath ☐				
General Health and Wellbeing				
Have you been diagnosed with Cancer? If yes where: When?				
Do you experience Claustrophobia or other Phobias?				
Do you or have you ever had, Depression, Anxiety or any other Mental Health concerns?				
Do you have a Disability?				
Do you have? Alzheimer's ☐ Dementia ☐				
Are you Pregnant?				
Do you drink Alcohol? How many per day?				
Do you take Illicit Drugs? Details:				
Do you have, or have you ever, had a history of Heavy Drug or Alcohol use? If so, what and when?				
Any Skin Wounds, Pressure Sores or Ulcers?			(If yes, complete Norton Scale Risk Assessment tool) ❑ Low ❑ Mod ❑ High Score:	
Are there any other Surgical or Medical problems? Epilepsy ☐ , Liver Disease ☐, Psychiatric ☐, Other ☐				
Do you have any Body Piercing Jewellery?			Remove / Tape	

LADY BJELKE-PETERSEN COMMUNITY HOSPITAL

Pre-Admission Health Questionnaire

AFFIX PATIENT LABEL HERE

Medications

HOSPITAL USE ONLY

A printout from your GP is sufficient.
If not available then list all medications (prescription, non-prescription and herbal)

Drug Name	Dose	Frequency	

Do you take blood-thinning medication? Yes ☐ No ☐

e.g. Warfarin, Plavix, Aspirin, Fish Oil, Garlic Tablets, Anti-Inflammatory Medications, etc

Contact your Surgeon for advice concerning these medications

Have you ever taken FLOMAXTRA? (or any Alpha1 Blocking Antagonist Medications) Yes ☐ No ☐

INR result:
Date last taken / /

Patients receiving General Anaesthesia or IV Sedation

Following surgery, I will have a responsible adult drive me/accompany me home and stay with me for the 24 hours following discharge. I realise mental impairment may persist for several hours following the administration of anaesthesia.

The answers I have given are true to the best of my knowledge and no information has been withheld.

How can we support your care goals during your admission to LBPCH?

Patient Signed:		**Date:**	

Hospital use:

Patient Advised	**Arrival Time**	Time:	**Fasting Time**	Food:	Fluid:

Pre-Operative – Hair Washed and Showered ☐, No Makeup ☐, Nail Polish or Acrylic Nails ☐, Perfume ☐, Jewellery including Piercings and Watches ☐

Nurse Comments:

Nurse Signed:		**Date:**	

LADY BJELKE-PETERSEN
COMMUNITY HOSPITAL

AFFIX PATIENT LABEL HERE

Patient Admission Form

ADMISSION DETAILS

Admitting Doctor: Admission Date:

Planned Procedure: Item Number(s):

If the person completing this form is Not the patient or Under 18 Years of age please provide your
Name: Phone No: Relationship:

PATIENT DETAILS

Title: _____ Family name: _____
Given Name: Preferred Name:

Residential Address: _____
Suburb: State: Post Code:

Postal Address: _____
Suburb State: Post Code:

Telephone: Home: _____ Work: _____ Mobile: _____
If there is a message service, may we leave a message? Yes ☐ No ☐

Email Address:

Date of Birth: _____ Gender: Male ☐ Female ☐ Indeterminate ☐
Marital status: Defacto ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐
Employment: Employed ☐ Pensioner ☐ Retired ☐ Home Duties ☐ Unemployed ☐ Student ☐
Occupation:

Are you an Australian Resident? Yes ☐ No ☐ Country of Birth: _____
Are you of Aboriginal or Torres Strait Islander descent? Yes ☐ No ☐
If Yes; are you Aboriginal ☐, Torres Strait Islander ☐, both Aboriginal and Torres Strait Islander ☐

What language is spoken at home? Is an interpreter required? Yes ☐ No ☐

CONTACT PREFERENCES

Indicate your preferred method of contact; Home phone ☐ Mobile ☐ Email ☐ SMS ☐ Post ☐

NEXT OF KIN

Title: Family Name: Given Name: Relationship:

Address: _____
Suburb: State: Post Code:

Telephone Home: Work/Day: Mobile:

PERSON TO NOTIFY ON DISCHARGE (If different from Next Of Kin)

Title: Family Name: Given Name: Relationship:

Address: _____
Suburb: State: Post Code:

Telephone Home: Work/Day: Mobile:

ENDURING POWER OF ATTORNEY *If Yes; please provide a copy to the hospital.*

Do you have a current Advance Health Directive? Yes ☐ No ☐

Do you have a current Enduring Power of Attorney – Health and Medical Guardian? Yes ☐ No ☐

Name: Relationship: Telephone:

Do not write in this binding margin

Patient Admission Form

LADY BJELKE-PETERSEN
COMMUNITY HOSPITAL

Patient Admission Form

AFFIX PATIENT LABEL HERE

PERSON / ORGANISATION RESPONSIBLE FOR PAYMENT OF ACCOUNT

Self ☐, DDHHS ☐, Next of Kin ☐

Third Party ☐, Name:

Worker's Compensation ☐, Claim No: Employer:

DVA - Gold ☐, Orange ☐, White ☐, Card No: Expiry:

MEDICARE DETAILS

Medicare No: __ __ __ __- __ __ __ __ __-__ Reference Number on Card: __ Expiry Date:__ __/__ __

CARD DETAILS - CONCESSION

Do you have any type of Pension / Concessional Benefits Card? No ☐

Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card ☐

Card No: _____

Have you reached the Safety Net for Pharmaceuticals? Yes ☐ No ☐ Safety Net No: _____

HEALTH INSURANCE DETAILS

Name of Health Fund: _____ Type of cover: _____

Membership No: _____ Do you have an excess Yes ☐ No ☐ If Yes; Amount $ _____

Have you changed your cover in the last 12 months? Yes ☐ No ☐

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained therein

Hospital Booklet ☐ Private Patient's Charter of Rights ☐ My right to privacy under the Privacy Act ☐

CONSENT AND AGREEMENT

- I agree that I have read and understood these conditions of admission
- I accept responsibility for full payment of all hospital charges and associated fees, either self-funded or not covered by my insurer.
- I consent to the collection, use, and disclosure of my personal information as outlined in the hospital handbook and in accordance with the relevant provision of the Commonwealth Privacy Act.
- I consent to Lady Bjelke Petersen Community hospital staff contacting my next of kin with the outcome of treatment or to obtain consent to necessary treatment if I am not able to provide such consent.
- I have been advised that a responsible adult must accompany me home and stay with me for at least 24hrs following discharge.
- I will not drive a car, motorcycle, ride a bicycle or operate machinery for 24 hrs after my anaesthetic.
- I will not drink alcohol for 24hrs before and after my anaesthetic.
- I will not make any important decisions or sign a contract within 24hrs of my anaesthetic.
- I acknowledge that the hospital does not accept any responsibility for the loss of any money or valuables that I bring with me.
- I certify that the information I have provided on this admission form is true and correct to the best of my knowledge.
- I would like to consent to my records being uploaded to My Health record system. Yes ☐ No ☐

Patient / Guardian Name: _____ Date: _____

Signature:

Patient Admission Form