ALEXANDRA
DISTRICT HEALTH

ELECTIVE SURGICAL MANAGEMENT PLAN
Section A
HEALTH QUESTIONNAIRE

AFFIX PATIENT IDENTIFICATION LABEL HERE

First Name:

Surname:

D.O.B.

What is your height? _____

What is your weight? _____

Do you require an interpreter ❒ **No** ❒ **Yes**

Language required: _____

Interpreter booked ❒ **No** ❒ **Yes**

Medical History	**No**	**Yes**	**Comments**
Have you: Seen a heart specialist or needed treatment for a heart (cardiac) problem?	❒	❒	⇨
Had a heart attack?	❒	❒	⇨
Had discomfort in the chest when you are stressed or emotionally upset?	❒	❒	⇨
Ever had discomfort in the chest, arm or jaw when you are exercising?	❒	❒	⇨
Been diagnosed with high blood pressure (hypertension)?	❒	❒	⇨
A pacemaker or internal defibrillator?	❒	❒	⇨
Had asthma, bronchitis or any problem with your breathing?	❒	❒	⇨
– Has it interfered with your sleep?	❒	❒	⇨
Been coughing up phlegm (sputum) from your chest?	❒	❒	⇨
Had a cold or flu in the last month?	❒	❒	⇨
Been short of breath while – Walking from room to room?	❒	❒	⇨
– Carrying shopping?	❒	❒	⇨
– Walking up one flight of stairs?	❒	❒	⇨
Do you snore?	❒	❒	⇨
– Is your sleep affected by snoring?	❒	❒	⇨
– Do you use a CPAP machine when you sleep?	❒	❒	⇨
– Have you had a sleep study conducted?	❒	❒	⇨
Had fainting, blackouts, dizzy spells, a fit or seizure or suffer from epilepsy?	❒	❒	⇨
Had a stroke or mini-stroke (TIA)?	❒	❒	⇨
Had depression, anxiety, panic attacks or memory loss?	❒	❒	⇨
Had problems with your thyroid?	❒	❒	⇨
Been diagnosed with diabetes?	❒	❒	⇨
Had problems with your liver or hepatitis (yellow jaundice)?	❒	❒	⇨
Had problems with your kidneys (renal disease) or kidney stones?	❒	❒	⇨
Had a blood clot in the leg (DVT) or on the lung (PE) which has required treatment?	❒	❒	⇨
Do you use or have you ever used recreational drugs?	❒	❒	⇨
Had a blood transfusion? – Did it cause you any problems?	❒	❒	⇨
Do you suffer with chronic pain?	❒	❒	⇨
Do you smoke?	❒	❒	⇨ How many each day?_____ ⇨ How long have you been smoking_____? ⇨ If you have quit, when did you quit? _____
Have you or any members of your family:			
Had any problems with your blood including Anaemia, unexplained bruising or excessive bleeding or do any illnesses run in your family e.g. Muscular disease?	❒	❒	⇨
Had any problems with anaesthetics?	❒	❒	⇨

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	No	Yes	Comments
How many glasses of alcohol do you drink per week?	NUMBER OF GLASSES_____		When was the last time you had more than four on the one day? _____
Do you get heartburn, reflux or does food, acid or bile ever come up from your stomach?	❒	❒	⇨
Have you had problems with stomach ulcers or hiatus hernia?	❒	❒	⇨
Do you think you could be pregnant?	❒	❒	⇨ Date of last period _____
Do you have any skin conditions such as shingles, psoriasis, eczema or ulcers?	❒	❒	⇨

Past operations: (Please list operations from past to present)

Type of operation	Year	Hospital

Medications: ATTACH A WRITTEN LIST IF NECESSARY
Please list all prescribed and over the counter medications, herbal remedies, tablets, pills, sprays, injections, patches and eyedrops

Name of medication	Dose	When? (morning, evening, etc)

	No	Yes	Reaction
Are you taking Clopidogrel (Plavix or Iscover)?	❒	❒	
Are you taking warfarin?	❒	❒	
Are you taking anti inflammatory drugs or aspirin?	❒	❒	

Allergies (adverse reactions):

Are you allergic or have reactions to:	No	Yes	Reaction
Drugs (medicines, injections) please state.	❒	❒	
Surgical tapes	❒	❒	
Food (specify)	❒	❒	
X-ray / contrast dyes	❒	❒	
Anaesthetics	❒	❒	
Rubber / Latex	❒	❒	
Other (please state)	❒	❒	

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ALEXANDRA DISTRICT HEALTH

ELECTIVE SURGICAL MANAGEMENT PLAN
Section B
CARE ASSESSMENT AND DISCHARGE PLANNING

AFFIX PATIENT IDENTIFICATION LABEL HERE

First Name:

Surname:

D.O.B.

General Health Information:	No	Yes	If YES, please give details
Has your bowel pattern changed recently?	❒	❒	⇨
Do you suffer from any of the following: (eg constipation, leaking, diarrhoea, haemorrhoids, bleeding)?	❒	❒	⇨
Do you have a stoma (eg Colostomy, Ileostomy, Ileal conduit)	❒	❒	⇨
Has your bladder pattern changed recently?	❒	❒	⇨
Do you suffer from or have: (eg a need to go to the toilet at night, frequency, burning, urgency, catheter)	❒	❒	⇨
Do you use continence pads?	❒	❒	⇨
Have you unintentionally lost weight in the past three months?	❒	❒	⇨
Have you had any difficulty swallowing?	❒	❒	⇨
Do you have problems with your hearing? (eg wear hearing aides, impaired hearing, deaf)	❒	❒	⇨
Do you have problems with your eyesight? (eg wear contact lens, glasses)	❒	❒	⇨
Do you wear dentures?	❒	❒	⇨
Do you have caps / crowns / loose teeth?	❒	❒	⇨
Other prosthesis?	❒	❒	⇨
Discharge Planning Information:	**No**	**Yes**	
Do you use any community services? (eg Royal District Nursing Service (RDNS), Personal Alarm, Linkages, Meals on Wheels, Home Help)	❒	❒	⇨
Do you have, or use any aides or devices to help with your everyday life? (eg. Walking stick, Sleep apnoea machine, Frame, Home oxygen, Wheelchair, Shower chair *(Please bring any walking aids in with you to hospital on admission)*	❒	❒	⇨

	No	Yes	Office Use Only Admission	 Comments
Do you have, or are you likely to have self care problems? (eg. washing, meal preparation, shopping)	❒	❒	❒	⇨
Do you live alone?	❒	❒	❒	⇨
• If yes, are you 70 years of age or older?	❒	❒	❒	⇨
Do you have any caring responsibilities for others (including pets)?	❒	❒	❒	⇨
Are there any unsafe aspects at home (eg steps) that may be a problem on discharge?	❒	❒	❒	⇨
Have you been admitted to hospital two or more times in the last year?	❒	❒	❒	⇨

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Other Discharge Considerations

Certificate required:
❒ Medical certificate ❒ Workcover certificate ❒ TAC ❒ Centrelink

I live with (please tick): Friends ☐ / Parents ☐ / Family ☐ / Alone ☐

Usual accommodation (please tick):

House ☐	Flat ☐	Unit ☐	Special Residential Service ☐	Nursing Home ☐	Hostel ☐	Other _____

Transport home and overnight care (for patients whose time in hospital will be 1 day only)

Are you aware that you must be accompanied home and travel by private care or taxi after your operation / procedure? Yes ❒ No ❒

Who will be responsible for your transport home and care overnight? Please fill in details below.

Name: _____ Phone (H) _____ (BH) _____ Mob _____

Transport home (for patients whose time in hospital will be longer than 1 day)

Who will be responsible for your transport home and care overnight? Please fill in details below.

Name: _____ Phone (H) _____ (BH) _____ Mob _____

These forms were completed by (tick): ☐ Yourself ☐ Friend ☐ Relative ☐ Local Doctor (GP) ☐ Other _____

I consent to relevant clinical information about my care being sent to my nominated GP, referring specialists, and / or other relevant health care professionals that will be involved in my ongoing care. If you do not want this to happen please let us know.

To the best of my knowledge I have given complete and accurate information

Signature _____ Name (print) _____ Date _____

OFFICE USE ONLY (WHEN ADDED TO THE WAITING LIST)

TYPE OF PREADMISSION REQUIRED (please circle): PHONE APPOINTMENT VMO GP ANAESTHETIC CONSULT

TESTS REQUIRED (please circle): FBE U&E LFT TFT BSL HBA1C INR APPT ECG CXR OTHER .....

FORMS SENT YES ❒ NO ❒

COMPLETED BY: NAME: ..... DESIGNATION: ..... DATE: .....

OFFICE USE ONLY (ON ADMISSION)

Information confirmed by a nurse on admission (Section B only):

Signature _____ **Name (print) & Designation** _____ **Date** _____

INFORMATION BELOW TO BE COMPLETED FOR DAY CASES AND OVERNIGHT STAY PATIENTS ONLY

REFERRALS	Date of referral	Name & Designation of person making referral	**Mode** Fax=F Mail=M Verbal=V	Service referred to	Date service to be commenced	Spoke to: Name & Designation
HITH						
Medical Imaging						
Outpatients						
Pathology						
Physiotherapy						
Post Acute Care						
RDNS						
Social Work						
Other (describe)						

Completed by:

Signature ..... **Name (print) & Designation** ..... **Date** .....