PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

LIFESTYLE	YES (Please Tick)	NO (Please Tick)		Staff use
Do you smoke?			Daily amount: _____	Consider Nicotine patches
Have you ever smoked regularly?			Date ceased: ___ / ___ / ___	
Have you discussed nicotine replacement therapy or cessation with your Doctor?				
Alcohol intake			Amount: Frequency:	
Recreational drug use?			Type:	

NUTRITIONAL ASSESSMENT

Staff use

Height _____cms Weight: _____kgs

Have you lost weight recently without trying? ☐ Yes ☐ No = 0 ☐ Unsure = 2

If yes to weight loss: ☐ 1-5kg = 1 ☐ 6-10kg = 2 ☐ 11-15kg = 3 ☐ >15kg = 4

Have you been eating poorly due to a decrease in appetite? ☐ Yes = 1 ☐ No = 0

BMI=

Hovermat In IBA

☐ __/__/__

Nutritional Assessment

Score of 2 or above – refer to dietician

☐ __/__/__

Food intolerance or allergies ☐ Yes ☐ No Describe exact food and response

Special dietary needs ☐ Yes ☐ No

Please specify:

Do you require assistance with meals ☐ Yes ☐ No

☐ Cut up ☐ Packets opened ☐ Special utensils ☐ Assistance with eating

Day Surgery Patients Discharge Plan

ALL PATIENTS UNDERGOING DAY PROCEDURES MUST HAVE AN ESCORT HOME AND A CARER OVERNIGHT

Who is taking you home? Name: _____ Phone No: _____

Who is staying with you overnight? Name: _____ Phone No: _____

Overnight Patient Discharge Plan (NOTE – DISCHARGE TIME IS 9.30AM)

Staff use

Issues identified

Referred

☐ Home Health

☐ Social Work

__/__/__

☐ O.T.

☐ N/A

Living arrangements ☐ Alone ☐ Spouse/Partner with Carer ☐ With Family ☐ Other, specify

Home environment ☐ House/flat/apartment ☐ SRS ☐ Nursing Home ☐ Retirement Village ☐ Hostel ☐ Other, specify

At home there are ☐ Steps ☐ Ramps/rails ☐ External toilet ☐ Shower chair ☐ Separate shower ☐ Shower over bath ☐ Toilet Frame ☐ Bathroom handrails ☐ Toilet handrails ☐ Stairs Are the stairs available ☐ Yes ☐ No

Activity assessment – Do you cope independently with daily living activities eg showering, dressing?

☐ Yes ☐ No, specify assistance required _____

Support services at home ☐ No services ☐ Family / Friends ☐ Personal carer ☐ Delivered meals ☐ Shopping ☐ Home Nursing ☐ Home Help ☐ Personal alarm ☐ Care package Case Manager _____ Phone No: _____

Name of GP: _____ **Phone No:** _____ **Fax No:** _____

Do you plan to return to your current accommodation directly from hospital? ☐ Yes ☐ No

If No, specify plans:

Are you a carer for others at home? ☐ Yes ☐ No Specify:

Any additional patient information:

_____

_____

_____

Signature _____ Date ___ / ___ / ___ Time _____

Pre-Admission Form Sighted / Triage ☐ Green No - Further Action Required ☐ Orange ☐ Red

☐ Refer to MR2B Signed: _____ Date: ___ / ___ / ___

Unit Nurses Signature: _____ Date: ___ / ___ / ___ Time: _____