



# ECHUCA REGIONAL HEALTH

## PRE-SURGICAL HEALTH ASSESSMENT

SURNAME: \_\_\_\_\_ UR NUMBER: \_\_\_\_\_  
 GIVEN NAME: \_\_\_\_\_  
 D.O.B: \_\_\_\_\_ SEX: \_\_\_\_\_ WARD: \_\_\_\_\_  
 V.M.O: \_\_\_\_\_

USE LABEL IF AVAILABLE

### GENERAL HEALTH INFORMATION

	YES	NO	DON'T KNOW	COMMENTS
Have you been admitted to a hospital in the last three months?				Provide details-
Do you smoke?				Provide details-
Previous smoker?				Quit Date -
Do you drink alcohol?				How much per week?
Do you use recreational drugs?				What?
Do you have caps, crowns, loose, damaged teeth or dentures?				What/where?
Do you have any reason to believe that you have been exposed to HIV/AIDS?				
<b>Female patients only:</b> Are you pregnant?				Estimated delivery date-
Are you allergic to any drugs, adhesive tapes, latex/rubber or foods?				Product/Reaction

HEIGHT- \_\_\_\_\_ CM      WEIGHT- \_\_\_\_\_ KG

### SURGICAL HISTORY

Have you ever had any operations? (If yes please provide details)	YES	NO	YEAR

### MEDICATIONS

Current medications including inhalers, patches, vitamins, alternative and unprescribed medications	DOSE	FREQUENCY

Are you taking Warfarin, Aspirin or other blood thinning medications?      YES      NO

Do you need an Interpreter?      YES      NO      If yes, what language? \_\_\_\_\_

PRE-SURGICAL HEALTH ASSESSMENT

MR/10C

## ANAESTHETIC HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?	YES	NO	DON'T KNOW	DETAILS
Diabetes				How is it controlled?
High Blood Pressure				
Heart Attack				When?
Angina/Chest Pain				When?
Palpitations or irregular heart beat				
Congestive Heart Failure				
Insertion of heart valve, stent or pacemaker				When? Type?
Rheumatic fever				
Asthma or shortness of Breath				
Bronchitis or emphysema				
Pneumonia or Tuberculosis				
Stroke or Mini Stroke				
Neurological condition				
Epilepsy, fits, fainting or "funny turns"				Which/when?
Organ Transplant				What/when?
Kidney disorders-dialysis, infections, stones or failure				
Liver disease- jaundice, hepatitis or cirrhosis				
Bruise or bleed easily				
Blood disorder- anaemia, leukaemia				What type?
Blood transfusion				When?
Clots in the legs or lungs				When?
Gastric reflux, heart burn or indigestion				
Psychiatric problems				
Significant back or neck injury?				What/when?
Have you ever had a general anaesthetic?				When?
Have you ever had any problems with an anaesthetic or surgery- nausea, temperature or prolonged drowsiness?				What?
Do you have any family members who have had problems with anaesthetics?				What relation?
Any serious illnesses- eg. cancer, thyroid disease, adrenal or gastrointestinal disorders?				What?
Have you received a Dura Mater graft before 1989?				
Do you have 2 or more first-degree relatives who have had Creutzfeldt-Jakob Disease?				
Have you received Human Pituitary Hormone Therapy prior to 1985?				

The answers I have given are true to the best of my knowledge.

Full name of the person completing the form. Please print.

Signature of the person completing the form.

Date:

# ECHUCA REGIONAL HEALTH

## ADMISSION REQUEST FORM

Surname..... UR No.....  
 Given Names.....  
 DOB ...../...../..... Sex ..... Ward.....  
 Doctor.....

USE LABEL IF AVAILABLE

**SURGEON:** .....

**DATE OF ADMISSION:** ..... / ..... / ..... **DATE OF OPERATION:** ..... / ..... / ..... AM / PM

**LENGTH OF STAY:**  Day Case  Overnight  Longer Stay (..... nights)

**INTENTION:**  Public  Private Insured  Self Funded  Repat/DVA  WC  TAC

**MR, MRS, Ms, MISS:** .....  
(Surname) (Given Name)

**ADDRESS:** ..... **POST CODE:** .....

**DATE OF BIRTH:** ..... / ..... / ..... **PHONE: AH** ..... **BH** .....

**PROVISIONAL DIAGNOSIS / INDICATION:** .....

**PROPOSED OPERATION:** .....

**ANAESTHETIST:** ..... **ANAESTHETIC CHECK REQUIRED:**  Yes  No

**PLANNED ANAESTHETIC:**  General  Local  Spinal  Sedation  Regional

**PRE-OPERATIVE CLINIC VISIT:**  Yes  No (Required for all overnight cases)

**DATE:** ..... / ..... / ..... **TIME:** ..... **POTENTIAL ACU POST-OPERATIVELY:**  Yes  No

**SPECIAL REQUIREMENTS (IMAGE INTENSIFIER, EQUIPMENT):** .....

**MEDICAL HISTORY:**

- NIDDM  IDDM  Pacemaker  Warfarin  Other Anticoagulant Therapy  
 Other Medical History (Specify): .....

**OTHER RELEVANT INFORMATION:**(Border baby, Significant past history): .....

**ALLERGIES / DRUG REACTIONS:** .....

DRUG ORDERS DATE / TIME	DOSE	ROUTE	FREQUENCY DURATION	DOCTOR'S SIGNATURE	RECORD OF ADMINISTRATION DATE / TIME GIVEN / GIVEN BY

**REQUESTING DOCTOR'S SIGNATURE:** ..... **DATE:** ..... / ..... / .....

ADMISSION REQUEST FORM

MR/10B