



Echuca Regional Health

SURGICAL PRE-ADMISSION CHECKLIST

SURNAME: _____ UR NO: _____

GIVEN NAME: _____

DOB: _____ SEX: _____ WARD: _____

DOCTOR: _____

USE LABEL IF AVAILABLE

Please complete this form immediately and return to your Surgeon's Rooms

Surgeon Name: _____ Planned Date of Procedure if known: ____ / ____ / ____

Home phone: _____ Work phone: _____

Mobile: _____

Email address: _____

GENERAL INFORMATION

Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, language required?
Do you have any religious/cultural needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
*Do you have an appointed medical decision maker or POA?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
*Do you have an Advance Care Directive/Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
*If YES, have you provided a copy to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have dietary restrictions/special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

ALLERGIES: Get details from your doctor if you are not sure

Do you have any allergies (Food, medications, tapes, Iodine or latex) Yes Nil known

If YES, provide details: _____

SOCIAL

DETAILS

Do you currently smoke tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number per day	Ex smoker- when stopped
Do you vape?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What	How often
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, how many standard drinks per week?	

Height _____ cm Weight _____ Kgs BMI _____

Have you had unplanned weight loss in the last 6 months Yes No If YES, how much _____ kgs

ILLNESS/SURGICAL HISTORY

Have you seen a specialist doctor (e.g. cardiologist) Yes No Provide details below:

MAJOR ILLNESS	DATE OF LAST VISIT	HOSPITAL/CLINIC	DOCTOR/SPECIALIST	REASON

SURGICAL HISTORY/ OPERATIONS	DATE	HOSPITAL/CLINIC	DOCTOR/SPECIALIST	OPERATION

PATIENT NAME: D.O.B.: / / UR NO:

CARDIOVASCULAR		DETAILS
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES , controlled with medication <input type="checkbox"/> Yes <input type="checkbox"/> No
Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest pain/angina	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	How often: Last episode:
Heart attack	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	When:
Palpitations, irregular heart beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart failure/cardiomyopathy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Murmur/heart valve disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Peripheral vascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart surgery/pacemaker/ implantable defibrillator	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Type: Device last checked: When: Where:
Have you ever had any heart investigations?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
• Stress test	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: Where:
• Angiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: Where:
• Heart ultrasound (echo)	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: Where:
RESPIRATORY		DETAILS
COPD/emphysema/lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent/recent infection/exacerbation: Details:
Asthma	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	How frequent? Attacks requiring hospitalisation <input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep apnoea	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If YES - CPAP machine <input type="checkbox"/> Yes <input type="checkbox"/> No (bring on day)
Do you use home oxygen	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If YES <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally
GASTROINTESTINAL		DETAILS
Acid reflux or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES , well controlled on medication <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery for weight loss or reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Bowel disease, Crohns, ulcerative colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver disease or abnormal liver tests/ hepatitis/jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coeliac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
GENITOURINARY		DETAILS
Kidney disease or abnormal kidney function tests	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ONCOLOGICAL		DETAILS
Do you have cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Been treated for cancer in the past	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES , what and treatment:
Do you have lymphoedema	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES , where:
HAEMATOLOGICAL		DETAILS
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: Why:
Anaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding or bruising disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	In: <input type="checkbox"/> Lungs <input type="checkbox"/> Legs <input type="checkbox"/> Arms
MENTAL HEALTH		DETAILS
Do you suffer from anxiety, depression or emotional disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

PATIENT NAME: D.O.B.: / / UR NO:

CENTRAL NERVOUS SYSTEM		DETAILS
Stroke or ministroke (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	When:
Epilepsy or fits - how often	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last one:
Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other condition affecting nerve or muscle function	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dementia or memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Confusion after an anaesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MUSCULOSKELETAL		DETAILS
Problems with bones or joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Lupus or scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PAIN		DETAILS
Do you have a history of chronic pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

OTHER		DETAILS
Other medical conditions not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Have you had your spleen removed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When:
Are you immunocompromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

INFECTION CONTROL		DETAILS
Infected with a multi resistant organism eg: MRSA, VRE, CRE	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently have known or suspected infectious disease, TB, shingles, influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of chronic or serious infection - hepatitis, HIV, TB	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have received a dura mater graft before 1989	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have received human pituitary hormone therapy prior to 1985	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you or your family have a history of Creutzfeldt-Jacob disease (CJD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FEMALE PATIENTS ONLY		DETAILS
Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, due date:
Are you breast feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other		

DISCHARGE PLANNING	
Do you have caring responsibilities for another person?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Do you have concerns about being able to cope when you go home?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
For a same day stay, it is essential that you have a support person to stay with you after discharge until the next day. Has this been organised? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who is your carer /support person? Name:	
Phone number:	

OFFICE USE ONLY	Test requirements
	<input type="checkbox"/> ECG <input type="checkbox"/> Pathology <input type="checkbox"/> Over 90 kgs <input type="checkbox"/> Over 120kgs <input type="checkbox"/> Mirena <input type="checkbox"/> Anaesthetist visit <input type="checkbox"/> Anaesthetic clinic <input type="checkbox"/> POC appointment <input type="checkbox"/> F2F or <input type="checkbox"/> phone <input type="checkbox"/> PAAC <input type="checkbox"/> GPA <input type="checkbox"/> F2F <input type="checkbox"/> phone <input type="checkbox"/> Reports required: <input type="checkbox"/> Cardiology <input type="checkbox"/> Pathology <input type="checkbox"/> Other:

Person completing form: Signature: Date: / /20.....