MR/132

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?	☐ Yes ☐ No	If **YES**, language required?
Do you have any religious/cultural needs?	☐ Yes ☐ No	Details:
*Do you have an appointed medical decision maker or POA?	☐ Yes ☐ No	
*Do you have an Advance Care Directive/Plan?	☐ Yes ☐ No	
*If **YES**, have you provided a copy to the hospital?	☐ Yes ☐ No	
Do you have dietary restrictions/special diet?	☐ Yes ☐ 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?	☐ Yes ☐ No	Number per day	Ex smoker- when stopped
Do you vape?	☐ Yes ☐ No		
Do you use recreational drugs?	☐ Yes ☐ No	What	How often
Do you drink alcohol?	☐ Yes ☐ 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

VER 4
MAY
2025

Surgical Pre-Admission Checklist MR/132

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

CURRENT MEDICATIONS - bring them with you in their original boxes when you come to hospital

Name of pharmacist: .....

Are you taking blood thinners? ☐ **Yes** ☐ **No** **Name:** .....

Current medications please list **ALL** medications - herbal, prescribed, over the counter OR ☐ No Current Medications

DRUG/MEDICATION	DOSE & FREQUENCY	REASON (E.G. BLOOD PRESSURE)

ANAESTHETIC BACKGROUND		DETAILS
Have you or a blood relative had a problem with an anaesthetic?	☐ Yes ☐ No	
Have you ever been told that you have a difficult airway?	☐ Yes ☐ No	
Have you ever been told that you had a difficult spinal or epidural	☐ Yes ☐ No	
Any difficulty swallowing, or cough when swallowing, opening your mouth or moving your neck?	☐ Yes ☐ No	
Can you walk 1 kilometre without having to stop?	☐ Yes ☐ No	
Difficulty walking up more than two flights of stairs?	☐ Yes ☐ No	If **YES**, what stops you walking further? .....
Tick what you can do		Your: ☐ Housework ☐ Shopping ☐ Gardening ☐ Personal hygiene
Do you use a mobility aid?	☐ Yes ☐ No	If **YES**: ☐ Walking stick ☐ Frame ☐ Scooter
Can you lie flat?	☐ Yes ☐ No	
How many pillows do you sleep on?		

ENDOCRINE / METABOLIC		DETAILS
Diabetes	☐ Yes ☐ No	Usual blood sugar level: ..... ☐ Prediabetic ☐ Diet controlled ☐ Tablets ☐ Insulin
Thyroid disease	☐ Yes ☐ No	
Surgery/treatment for thyroid disease	☐ Yes ☐ No	When? .....
Endocrine or hormonal conditions	☐ Yes ☐ No	

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

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

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

CENTRAL NERVOUS SYSTEM		DETAILS
Stroke or ministroke (TIA)	☐ Yes ☐ No	When: .....
Epilepsy or fits - how often	☐ Yes ☐ No	Last one: .....
Parkinson's disease	☐ Yes ☐ No	
Other condition affecting nerve or muscle function	☐ Yes ☐ No	
Dementia or memory problems	☐ Yes ☐ No	
Confusion after an anaesthetic	☐ Yes ☐ No	
MUSCULOSKELETAL		**DETAILS**
Problems with bones or joints	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	Details: .....
Lupus or scleroderma	☐ Yes ☐ No	
PAIN		**DETAILS**
Do you have a history of chronic pain?	☐ Yes ☐ No	Details: .....
OTHER		**DETAILS**
Other medical conditions not specified	☐ Yes ☐ No	Details: .....
Have you had your spleen removed?	☐ Yes ☐ No	When: .....
Are you immunocompromised?	☐ Yes ☐ No	Details: .....
INFECTION CONTROL		**DETAILS**
Infected with a multi resistant organism eg: MRSA, VRE, CRE	☐ Yes ☐ No	
Currently have known or suspected infectious disease, TB, shingles, influenza	☐ Yes ☐ No	
History of chronic or serious infection - hepatitis, HIV, TB	☐ Yes ☐ No	
Have received a dura mater graft before 1989	☐ Yes ☐ No	
Have received human pituitary hormone therapy prior to 1985	☐ Yes ☐ No	
Do you or your family have a history of Creutzfeldt-Jacob disease (CJD)	☐ Yes ☐ No	
FEMALE PATIENTS ONLY		**DETAILS**
Are you pregnant	☐ Yes ☐ No	If **YES**, due date: .....
Are you breast feeding	☐ Yes ☐ No	
Other		

DISCHARGE PLANNING

Do you have caring responsibilities for another person? ☐ Yes ☐ No Details: .....

Do you have concerns about being able to cope when you go home? ☐ Yes ☐ 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? ☐ Yes ☐ No

Who is your carer /support person? Name: .....

Phone number: .....

OFFICE USE ONLY

Test requirements

☐ ECG ☐ Pathology ☐ Over 90 kgs ☐ Over 120kgs ☐ Mirena ☐ Anaesthetist visit ☐ Anaesthetic clinic

☐ POC appointment ☐ F2F or ☐ phone ☐ PAAC ☐ GPA ☐ F2F ☐ phone

☐ Reports required: ☐ Cardiology ☐ Pathology ☐ Other: .....

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