UR

Alfred Sandringham Caulfield

PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

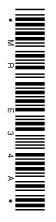
Family Name*	Given Na	me*		
Date of Birth*	Gender:		emale	□ Male
				*mandatory fields

Steps to completing this questionnaire,

- **1.** Save questionnaire to your computer
- 2. Answer questions
- 3. email to electiveservices@alfred.org.au
- **4. or** post to: Patient Services Centre, Alfred Health,
 - PO Box 315, PRAHRAN VIC 3181
- To help identify any health problems that may need treatment before your procedure, it is important to select all conditions relevant to you and provide correct information.
- Alfred Health must receive this document within the next 7 days, to ensure no delay or cancellation with your procedure.
- If you have questions call 9076 0359 between 8:00am & 4:30pm Monday to Friday
- Your GP may be able to provide assistance if you are unable to complete this questionnaire.

Clinic / Speciality attending	

Home Address				Posto	code		
Phone Mobile		Home		e			
Email				1			
Medicare Number	Medicare Number			Expiry			
Do you need an inte	rpreter to assist	in discus	ssing medica	al infori	mation	□ Yes □ No	
If yes, language							
Aboriginal or Torres Strait Islander		□ Yes	□ Yes				
	□ No □ Not specified						
Do you have an advance care direct		ve □ Yes □ No If yes, provide a copy			provide a copy		
Do you have a Medical Treatment Decision Maker		□ Yes □ No If yes, name					
Are you available at short notice		□ Yes □ No					
Alternative Contact Person name							
Contact Person address							
Relationship				F	Phone		
GP Name			GP F	hone			
GP Address							



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Any recent decrease in appetite

Migraines / blackouts / fainting

Blood clots / bleeding disorders / anaemia

Bowel / bladder problems / incontinence

Reflux / indigestion / hiatus hernia / ulcers

Mental health problems/depression/anxiety

Short term memory loss/previous confusion

Dementia / delirium / wandering

Skin conditions / existing wounds

Have you taken any prednisolone,

Other medical conditions or health

problems (eg family history of cancer, arthritis)

Chronic or acute pain

Cancer

Females

cortisone or steroids in the last 6 months

Stroke / mini strokes (TIAs)

Epilepsy / seizures

Blood transfusions

Kidney conditions

Liver disease

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IONS y additional details relevant				
y additional details relevant				
Managed by				
isers 🛛 Puffers 🛛 Home oxygen				
Yes 🗆 No				
Has your OSA been diagnosed with a Sleep Study?				
ype 2 🛛 Unsure				
isulin 🛛 Tablets 🗌 Diet				
Γ				

Specify

Specify

Specify

Specify

Specify

Specify

Specify

Specify

Describe

Describe

Describe

Name of medication

Date last taken

Body Location

Date diagnosed

Could you be pregnant? Are you breast feeding?

Describe

Last seizure

Managed by

Any weakness / symptoms

List

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EMR: Perioperative / Procedure_Preadmission_Patient Information and Health Questionnaire

or still taking
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Family Name*			Given Name*			
PREVIOUS OPERATIONS / PROCEDURES / HOSPITAL STAYS List any operations or procedures including dates and hospital where surgery was performed.						
(attach a separat		duing dates and nospital	where surgery was	penonned.		
ANAESTHETIC	mily member reacted	to an anaesthetic?	es 🗆 No Details			
Do you have any	questions relating to	an anaesthetic?	□ No List			
	4					
Do you regularly	see any specialists e	g. Cardiologist. List nan	ne/s and address/s			
MEDICATIONS						
	blood thinning medica					
Do you take any	other medications?)			
If yes, list all medication / tablets / puffers / eye drops / vitamins / herbal medicine that you currently take						
		ers / eye drops / vitamir	s / nerbai medicine	inat you currently take		
(attach separate lis	t if required)					
	t if required)	How much (do		often each day (frequency)		
(attach separate lis	t if required)					
(attach separate lis	t if required)					
(attach separate lis	t if required)					
(attach separate lis	t if required)					
(attach separate lis	t if required)					
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(attach separate lis	t if required)					
(attach separate lis	t if required)					
(attach separate lis	t if required)					
(attach separate lis Medication Nam	it if required)					
(attach separate lis	MATION	How much (do	se) How (
(attach separate lis Medication Nam HEALTH INFOR What is your heig	MATION pht in cms	How much (do	se) How of the second s	often each day (frequency)		
(attach separate lis Medication Nam HEALTH INFOR What is your heig	MATION ght in cms you have any allergie	How much (do	se) How (often each day (frequency)		
(attach separate lis Medication Nam HEALTH INFOR What is your heig ALLERGIES Do Latex / rubbe	MATION ght in cms you have any allergie	How much (do	se) How of the second s	often each day (frequency)		

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Family Name*		Given Name*					
LIFESTYLE							
Do you drink alcohol?	Amount Current amount						
Have you ever smoked?		Current amount					
		Date ceased					
Do you use recreational drugs?		Amount					
Do you use recreational drugs?		Туре					
Special diet required							
Impairment – vision		Aids used					
Impairment – hearing		Aids used					
Do you current have assistance with							
Walking		Stick 🛛 Frame 🔲 Crutches 🖾 Wheelchair 🗆 Other					
Hygiene		Council 🛛 Other					
Meals		Council 🗆 Other					
Medication		Dosette / webster □ Family □ Other					
		topping?					
PLANNING FOR YOUR DISCHARGE FROM HOSPITAL ↔ You must have a responsible adult to collect you on discharge from hospital ↔							
DISCHARGE DETAILS							
Who will collect you from hospital?	Nan	ne					
	Pho	one					
Who do you live with?							
	□ With others*						
	□ In care facility or hostel*						
If you live with *others or in a *care	Name						
facility, provide details	Phone						
Do you care for others at home							
Do you receive community support		Specify					
service							
Do you have someone to stay with		Name					
you the night you leave hospital?	Phone						
Where will you go on discharge							
In the last twelve months have you? Received treatment in an overseas healthcare facility Been informed that you have been a contact of someone with CPE*? Been informed that you have been a contact with someone with C. auris**? Yes □ No Have you ever been told you have CPE/ C.auris? Carbapenemase-Producing enterobacteriacaea *Candida auris							
I have provided complete and accurate answers to this questionnaire to the best of my knowledge.							
Name of person Date							
completing form							
Person/s completing this form							

Email completed questionnaire to <u>electiveservices@alfred.org.au</u>

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