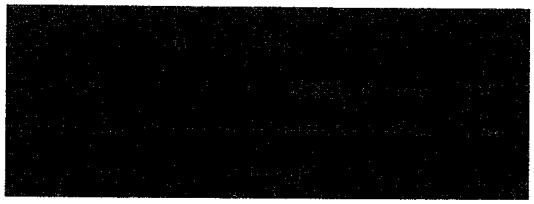
the Mater

Patient Label



Patient Pre - Admission Questionnaire

The patient must complete front page and pages 1- 4

It is important that you return this document at least 5 days prior to your surgery.

Name: _____

Day of Admission: _____ **Day of Surgery:** _____

Surgeon: _____

Have you been in a hospital in the last 12 months?

☐ No ☐ Yes Where: .....

How long where you admitted: .....

If you have, any queries ask your doctor or contact the

Pre Admission Clinic 9900 7494

Pre –Admission Questionnaire

Re-Order No. 28580

Instructions for completing this form

Pre Admission Questionnaire

1. It is very important that you complete this with as much information as possible.

2. This Questionnaire must be completed for each admission.

    - If the patient has been admitted within the last 3 months to the Mater the medical history does not need to be re done. If there has been no change in your medical history you will only need to complete the discharge section on page 4.

3. These details help us with your background information so that we can properly prepare for your admission.

4. Complete the pages with the blue headings, not the shaded green area.

Nursing Pre Admission Assessment – at the end of the Questionnaire

1. This section is for staff use only. Nursing staff are required to check the assessment and to complete the green shaded area where applicable.

2. Also, nursing staff must complete the Pre Admission Assessment Nursing Summary in the green section.

To be completed by the admitting Doctor

Relevant History or Specific Pre Operative Instructions:

.....

.....

.....

.....

.....

.....

.....

.....

.....

the Mater

Mater Hospital & Day Surgery Booking Form

Patient Details

Patient to Complete

Have you ever been a patient at the Mater before No ☐ Yes ☐ Year? _____

Mr. Mrs. Miss. Ms. Other _____

Surname: _____ **Given Names:** _____

Date of Birth: _____ Age: _____ Male/Female Religion: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____ Country _____

Telephone: (H) _____ (W) _____ (M) _____

Family Doctor: _____ Phone: _____

Address: _____

Next of Kin or Person to Notify: _____ Relationship: _____

Address: _____

Suburb: _____ Postcode: _____

Telephone: (H) _____ (W) _____ (M) _____

Accommodation Preference: Single Room ☐ **Shared Room** ☐ **We will make every effort to provide you with your preference; however, rooms cannot be guaranteed and are allocated according to clinical need and availability.**

Hospital Booking Details

Doctor to Complete

Admitting Doctor _____

Admission Date: _____ Time: _____ Procedure Date _____

Transfer From: _____ MRSA Swabs taken date _____

☐ Day Only ☐ Overnight, No nights _____ If length of stay longer than DRG please give reason

_____

Diagnosis: _____

Surgery /Procedure: _____

_____

Estimated length of Surgery _____ ☐ Image Intensifier

Item No/s MBSN(s): _____

Prosthesis – Product Name/Code: _____

☐ **Level I ICU (HDU)** ☐ **ICU Post Op No days** _____ ☐ **Cardiac Cath Lab**

Health Insurance

Patient to Complete

Health Fund Name: _____ Member No: _____

DVA Number: _____ White / Gold DVA transport required: Yes / No / NA

Pension No: _____ Pharmacy Concession/Safety Net No: _____

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Number beside your name on the Medicare Card: ☐

Expiry Date: _____

Workers Comp Insurance Company: _____ Workers Comp Claim No: _____

Copy of Workers Compensation approval letter to be attached

the Mater **Surgical Consent**

Operation / Procedure

Patient Label

Patients 14 years and older are able to consent, and parents on behalf of their children.

Provision of information to the patient

I, Dr ..... A/PROF LEO PINCZEWSKI ..... have discussed with my patient /parent / guardian

Patient's Name: .....
the patient's present condition, the alternative treatments available, and explained the benefits and risks of the proposed procedure:

I acknowledge that I have explained to the patient all points and I am of the opinion that the decision maker has understood the information.

The proposed is: **Do not use abbreviations** .....

.....

.....

Medical Officer's Signature: ..... Date: .....

Patient Consent:

I .....

of .....

Consent to, and understand the following. The doctor has explained to me that:

- The administration of anaesthetics, medications, and/or other treatments which could be related to this procedure and their risks;
- I have had the opportunity to ask questions in relation to the above, and I am aware of the likely results, the risks and potential complications;
- other unexpected operations/procedures/treatments may be necessary and I request that these be undertaken as required;
- the operation/procedure/treatment may not give the expected result even though the operation/procedure/treatment is carried out with all due professional care.

Orthopaedic Patients only

1. Bone (allograft and non-irradiated allograft) from a TGA licensed approved Bone Bank may be necessary to fill defects in the bone during the procedure.
2. Bone tissue and (in the case of revision surgery) implants that are removed at the time of surgery may be used by researchers approved by the St Vincents & Mater Health Ethics Committee for investigating the cause of success or failure of joint replacement surgery.
3. As an additional precaution for myself, and the hospital, blood testing for Human Immunodeficiency Virus "HIV" and Hepatitis B&C prior to receiving a bone graft e is recommended /suggested.

☐ **Bone graft information given to patient if having a Bone graft.**

Blood Transfusion / Products:

- I understand why I may require a blood transfusion / blood product and have discussed other relevant options with the doctor. I have been informed of the risks and benefits, alternatives to a blood transfusion / product. I was given a Consumer Brochure
- ☐ **Yes I consent to a blood transfusion /product**
- ☐ **No I do not consent to a blood transfusion /product**

Dr ..... A/PROF LEO PINCZEWSKI ..... has explained as above and I am satisfied with the explanation and answers to my questions.

.....	.....	.....
Name of patient /parent/guardian	Signature	Date
.....	.....	.....
Print Name of Interpreter	Signature:	Date

Medical History must be completed by the patient

Interpreter Required ☐ No ☐ Yes Language: .....

Reason for Admission, Procedure or Presenting Illness: .....

.....

.....

.....

Do you see any other Specialist for any other conditions ☐ No ☐ Yes if yes List any Names and details:

(eg Cardiologist) .....

.....

.....

..... Phone: .....

Allergies: Do you have any allergies? No ☐ Yes ☐ If yes, specify what triggers the allergy & what reaction you have.	**Staff Use**
	☐ Allergies documented on Med Chart & Theatre Alert Form completed

Pathology / X-Rays or Other Test Results	**Staff Use**
Have blood tests/ pathology/ autologous blood been taken for this admission ☐ Yes ☐ No	Results available
Which Company? ..... When?	☐ In file
Have you had a recent ECG/ Echocardiogram? ☐ Yes ☐ No	☐ Online
Have ☐ X-rays ☐ CT scan ☐ MRI been taken for this admission? If yes, please bring with you for this admission ☐ Yes ☐ No	☐ Not available

Current Medications

Please list **All** medications including complimentary medications & bring these to hospital in their original container (attach a list if insufficient space).

Do you take or have recently taken blood-thinning medication eg. **Aspirin**, Warfarin,

Coumadin, Clopidogrel, Iscover, Plavix or natural blood thinning medication? ☐ Yes ☐ No

Have you been told to cease this? ☐ Yes ☐ No by who.....

Date to cease: ..... Date last taken:.....

Have you been told to start any other treatment eg Clexane ☐ Yes ☐ No

Drug Name	Dose	Frequency

Surgical History - list and date previous surgery & where. (attach list if insufficient space)		
General Medical History		**Comments & Further information**
Height: ..... Weight: ..... **(Circle)**	**Yes – No**	$\frac{\text{Weight}}{\text{Height}^{m2}}$ = ... BMI **> 120 kg** Notified ward / OT hover matt > 100 kg
Heart Conditions / Heart Attack / Chest Pain/ Angina (circle)	**Y – N**	Details
Cardiac Surgery / Pacemaker / Prosthetic Valve / Grafts / Stents / Angioplasty / Any other (circle)	**Y – N**	Bring ID information Is surgeon aware? ☐ Yes ☐ No Pacemaker last checked:.....
Heart Irregularities: Palpitations / Irregular Heart Beat / Heart Murmur (circle)	**Y – N**	Details
High Blood Pressure	**Y – N**	When was your BP last checked? .....
Blood clots in legs or lung (circle)	**Y – N**	Specify: Is Surgeon aware? ☐ Yes ☐ No
Have you had any Anaesthetic Reactions Any neck problems	**Y – N** **Y – N**	Details:
Diagnosed Sleep Apnoea	**Y – N**	Bring CPAP Machine to hospital
Asthma / Bronchitis /Emphysema / shortness of breath on exertion / Hay Fever / Pneumonia / TB / COPD (circle)	**Y – N**	Specify: ..... Do you use ☐ Oral Steroids ☐ Puffer ☐ Nebulisers ☐ Home oxygen Bring all Asthma medications
Diabetes: ☐Type 1 ☐ Type 2 (circle)	**Y – N**	Controlled by ☐Diet ☐Tablet ☐ Insulin ☐ Pump
Do you have instructions how to manage your diabetes before surgery	**Y – N**	Details
Blood Disorders/ Anaemia (circle)	**Y – N**	Details
Blood Transfusion Reaction	**Y – N**	Type of reaction .....
Stroke / Mini Stroke / MS Motor Neurone Disease (circle)	**Y – N**	Any residual weakness or symptoms?
Do you have Parkinson's Disease	**Y – N**	Treatment
Short Term Memory Loss / Confusion (circle)	**Y – N**	Details
Mental Illness /Anxiety / Depression /Psychosis (circle)	**Y – N**	Details
Epilepsy / Fits / Seizures (circle)	**Y – N**	Details: ..... Last seizure..... Treatment.....
Faints / Blackouts / Dizzy Spells / Migraine (circle)	**Y – N**	Details
History of falls	**Y – N**	Details
Do you have any prosthetics joint replacements Hip / Knee Mobility aid, eg frame / stick (circle)	**Y – N**	Specify Please bring to hospital
Have you been treated for chronic pain	**Y – N**	What medications were given? Was this medication effective? ☐ Yes ☐ No

General Medical History		Comments & Further information
Elimination issues: Bowel or bladder problems/ incontinence / stoma – colostomy (circle)	Y – N	Specify
Reflux / Hiatus Hernias / Gastric Ulcers / Gastric Banding (circle)	Y – N	Specify
Cancer - type	Y – N	Date diagnosed ..... ☐ Chemotherapy ☐ Radiotherapy
Skin Conditions: Wounds / ulcers broken skin Dermatitis (circle)	Y – N	Details of current treatment
☐ Pregnant ☐ Breastfeeding	Y – N	Due date Details
Do you wear glasses / contact lens or hearing aids (circle)	Y – N	Aid used
Do you have Glaucoma	Y – N	Treatment
If you have any other medical problems not listed – give details (attach list if insufficient space).		
Dentures **Upper** ☐ Partial ☐ Full **Lower** ☐ Partial ☐Full		☐ Crown /Bridges ☐ Loose teeth ☐ Implants☐ Caps

Infection Control Assessment			Staff Use
Infectious Disease: HIV / Hepatitis / or other infections	Y - N	Specify: Treatment:	Contact Infection Control Manager
Have you had a respiratory illness or cough recently?	Y - N	Currently taking antibiotics? ☐ Yes ☐ No Surgeon aware? ☐ Yes ☐ No	
Have you had any illness as such gastroenteritis or been in contact with someone who has Chicken Pox with in the last 14 days?	Y - N	Details	
Intravenous Antibiotic treatment > 4 wks	Y - N	Details:..... Why:..... When:	☐ VRE swabs
History of Intensive Care > 1 wk	Y - N	Details:..... Why:..... When:	☐ MRSA swabs ☐ VRE swabs
Transferred from an Overseas Hospital	Y - N	Details	☐ MRSA swabs ☐ VRE swabs
MRSA screening should be performed on patients with risk factors – ie history of MRSA, hospital or nursing home admissions in the past 12 months, existing wounds, ulcers, drains sites and catheter specimens if IDC in situ.			

Creutzeldt Jacob Disease			Staff Use
History of acute onset dementia or other progressive neurological conditions	Y - N		☐ Infection Control notified & Theatre ☐ If the patient is having Neuro Surgery a completed CJD Form should be completed/ attached from the Surgeon's room
Have you ever had neurological surgery: eg brain or spinal surgery	Y - N	Surgeon: ..... Hospital:..... When:	
Human pituitary hormones prior to 1985 for growth or infertility	Y - N		
Family history of CJD or progressive neurological disorder	Y - N		

Lifestyle		Comments & Further information
Do you smoke Have you ever smoked	Y – N Y – N	Amount Date ceased
Alcohol intake	Y - N	Amount Frequency: ☐ Any Free Days
Illicit Drugs use	Y - N	Type: .....Frequency: .....

Nutritional Score

Staff Use

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

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

If you have been eating poorly due to decrease in appetite ☐ Yes = **1** ☐ No = **0**

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

Special diet needs ☐ Yes ☐ No

☐ Diabetic ☐ Kosher ☐ Other specify: .....

☐ Texture modified ☐ Gluten Free ☐ Thickened Fluids

Do you require assistance with meals ? ☐ Yes ☐ No

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

Nutritional Assessment

Score of **> 2** above – refer to dietician ☐

☐ Hovermatt for **> 100kg or for under weight patients**

Day Surgery Discharge Plan

All patients undergoing Day Procedures must have an Escort home & a Carer overnight

How are you getting home?.....

Who is staying with you overnight? Name:..... Phone: .....

Overnight Patient Discharge Plan (note discharge time is 0930)

Staff use

Household Arrangement

☐ Alone ☐ With Carer ☐ With Family ☐ Other, specify .....

Home Environment

☐ House /Flat ☐ Retirement Village ☐ Nursing Home ☐ Hostel ☐ Other? .....

At home, are there ☐ Stairs internal /external, with / without rails: How many? .....

☐ Separate Shower ☐ Shower over bath

Activity assessment - do you cope independently with daily living eg showering, dressing?

☐ Yes ☐ No specify assistance required: .....

Support services:

☐ No services ☐ Family /Friends ☐ Personal Carer ☐ Delivered Meals ☐ Shopping

☐ Home Nursing ☐ Home Help ☐ Personal Alarm ☐ Care Package ☐ Case Manager

Issues Identified

Referred

☐ DVA Discharge Planner

☐ Social worker

☐ Occupational Therapist

☐ Breast Care Nurse

☐ Stoma Therapist

☐ Speech Therapist

Are you planning on going to Rehabilitation ☐ Yes ☐ No if yes where: .....

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

Do you care for others at home? ☐ Yes ☐ No:Specify: .....

Any additional patient information

Person collecting you from Hospital

Name ..... Phone .....

Patient Signature: _____ Date: _____

Pre Admission Clinic Assessment – Nursing staff only to complete

Pre Admission Form sighted, Date _____ ☐ No further Action Required

Phone Consult ☐ Date ☐ Clinic Consult _____

Medical 2 Points Each	Score	Surgical 1 Point Each	Score
Insulin dependent diabetic		Major Abdominal Surgery	
Ischeamic heart disease AMI & Angina stents recent history of stents (contact specialist and obtain letter)		Major Vascular / Cardiac Surgery	
Anticoagulants Warfarin or Clopidogrel (antiplatelets) Aspirin		Major Cancer Surgery	
Obstructive Sleep Apnoea		Shared Airway Surgery	
Dementia / Parkinson's Disease		Joint Replacement	
> 85 yrs – both medical & surgical pts		Revision Joint Replacement	
Medical 1 Points Each			**Score**
> 70 yrs – both medical & surgical pts		COPD / Asthma / Smoker =1 point for each condition	
BMI >30 Obesity		Deep Venous Thrombosis or Pulmonary Embolism	
Heart Valve Replacement / Arrhythmias Anaemia		Non Insulin Dependent Diabetes Mellitus	
Hypertension		Epilepsy	
Pre Admission Triage Score **Add up total Score as per Pre Admission Protocol**		**Total Points**	

Reference - **In addition use clinical judgment to triage patient accordingly if they do not fit the relevant criteria**

Less than 4 Continue all Cardiac medications, cease smoking, review by Anaesthetist in Hospital

Anaesthetist Problems - Contact Anaesthetist

4-6 Contact Anaesthetist **6-8** Contact Surgeon re referral to Physician or seek report & contact Anaesthetist

8 or more Contact Surgeon re referral to Physician & ICU / HDU bed

Discharge Risk Assessment Tool

Discharge Risk Factors		
Three or more medications & recently changed in last 2 wks		
Cognitive Impairment		
Multiple Chronic Conditions		
Falls History last 12 mths	Mobility Impairment	
Psychosocial Concerns eg emotional, financial, legal		
Multiple Hospital Admissions		
Living Alone		
Are they a carer?		
Do they have difficulties with activities of daily living?		Are they receiving or needing Community Services
Home Access and Safety Issues		
Lives Long Distance	Accommodation Issues	Requires Transport Services

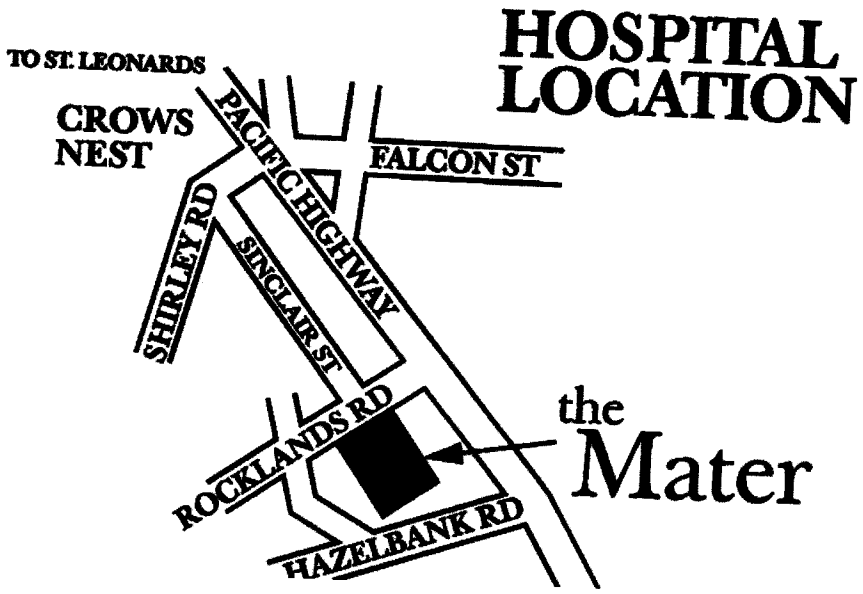
Contact Discharge Planner Social Worker, Occupational Therapist if any of the above risks are identified

Pre Admission Assessment Nursing & Allied Health Summary

☐ **Pathology as per surgeon protocol** State what pathology	☐ **Radiology as per surgeon protocol completed**
	☐ Request form ☐ Attended When
☐ Other	☐ Other

Outcome Referral	**Date**	**Signature**
Anaesthetist		
Physician		
Infection Control		
Dietician Score– (refer to dietician of **> 2** above)		
Referrals to Allied Health - Who and when?		
Nurse Unit Manager		
Clinical Pathway / Other		
Falls Risk commenced in Clinical Pathway		
VTE Risk assessment commenced in Clinical Pathway		

Date	**Comments**	**Signature**
	Note any Drugs to be ceased prior to surgery	



Mater Hospital
Admissions Office
Rocklands Road
North Sydney NSW 2060
Telephone (02) 9900 7396 Facsimile (02) 9900 7395
Email: admissions@matersydney.com.au
www.matersydney.com.au

Suite 2, The Mater Clinic
3 Gillies Street
Wollstonecraft NSW 2065
p 02 9437 5999

Appendix 1: Participant Information Sheet

LOCAL ANAESTHETIC ADMINISTERED BY THE "INJECTAMATIC" FOR PAIN MANAGEMENT FOLLOWING ELECTIVE KNEE SURGERY

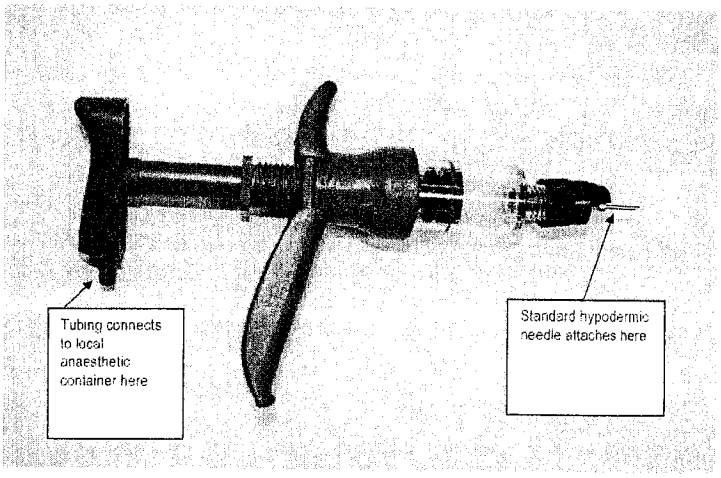
Dr Leo Pinczewski is seeking your permission to use a new device, the Injectamatic, which will be used to inject local anaesthetic into your knee during your operation. This new device, called an "Injectamatic" is being manufactured by Surgical Specialties Pty Limited, Australia.

The device is NOT currently registered or approved for use by the Australian Therapeutic Goods Administration

Administration of local anaesthetic forms part of Dr Pinczewski's routine pain management regime for his patients. Traditionally, 8 syringes have been used for this purpose. The new "injectamatic" device requires the use of only one syringe to deliver the same amount of medicine.

Giving your consent for Dr Pinczewski to use the new device is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect the treatment you receive now or in the future. Whatever your decision, it will not affect your relationship with the staff caring for you.

Figure 1: The "Injectamatic" Device



A photograph of the device is shown here.

Both before and after your knee surgery, your permission to use this device will not alter your pre-operative and post-operative care.

When you have read this information, Dr Lucy Salmon, Alison Kok or Dr Leo Pinczewski or your anaesthetist will be available to answer any queries you may have. If you would like to know more at any stage, please do not hesitate to contact them on 9437 5999.

If you wish to participate, please sign the attached consent form and return to Dr Leo Pinczewski, Suite 2, 3 Gillies St, Wollstonecraft, NSW 2065

This information sheet is for you to keep.

Suite 2, The Mater Clinic
3 Gillies Street
Wollstonecraft NSW 2065
p 02 9437 5999

Appendix 2: Patient Consent Form

Australian Government
Department of Health and Ageing
Therapeutic Goods Administration

AUTHORISATION OF SUPPLY UNDER s19(5) OR SECTION 41HC
THERAPEUTIC GOODS ACT 1989
Consent to Treatment and Indemnity for Use of
Products Derived from Biological Tissue Including Human Blood or Plasma

I, ...
(name of patient or parent/guardian)

understand that the Commonwealth can give no guarantee as to the quality, safety or efficacy of.....INJECTAMATIC.....(name of product),

particularly as regards any prion or viral inactivation procedures used in its manufacture. Accordingly, the Commonwealth can accept no liability for its use.

I understand that this product is not approved for use in Australia but that use of the product has been approved under the provisions of section 19(5) or section 41HC of the *Therapeutic Goods Act 1989*.

I confirm that the above statements have been explained to me and in this knowledge agree to administration of the product to me/my ward.

Patient's name: .....

Signature of patient: ..... **Date:** .....
(or parent/guardian)

Signature of witness: ..... **Date:** .....

I have explained the above statements to the patient or the patient's parent/guardian.

Treating physician: ...DR LEO PINCZEWSKI.....

Signature: ..... **Date:** .....

Do Not Send to TGA.
Should be kept on patient's file