PATIENT IDENTIFICATION LABEL

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Reception	To: Admission Nurse
Patient ID& Procedure Match		
Alerts		
Medicare status		
Special requirements-including language		
Initial to indicate Clinical Handover at this Point of Care		

PATIENT ADMISSION DETAILS

Admitting Doctor/Surgeon:		
Date of Admission:	**Arrival Time** (**Office use only**)	**Discharge Time** (**Office use only**):
Operation/Procedure:		
Have you been hospitalized anywhere in the last seven days? Yes□ No□ If yes, where		

PATIENT DETAILS – Please print as your name appears on Medicare Card

Title:	Surname:	Previous Surname:
Given Name:		
Address:		Postcode:
Phone (H)	(M) Email:	(B)
Sex: Male□ Female□	**Date of Birth:**	Marital Status:
Country of Birth (if Australia, which state) Religion:	Are you an Australian Resident? Yes□ No□ Are you of Aboriginal/Torres Strait Island Descent? Yes□ No□	

Medicare number:	Reference No:	Expiry Date:	Ambulance Membership Number: Y/N
Pension No. Health Care Card			Expiry Date:
Do you have Private Health Insurance? Yes□ No□ Private Health Fund Name:			Membership Number: Do you wish to use your PHF for this admission? Yes□ No□

Next of KIN (Person to contact in case of Emergency)
Name: Relationship:
Contact No.
ESCORT CONTACT DETAILS (who will be taking you home?)
Name: Relationship:
Contact No.
Charter of Rights: I have read and understand my rights as per Rights & Responsibilities Information provided by IVE **Patient Signature:**

PRE-ANAESTHETIC ASSESSMENT

Patient to complete. Admission Nurse to review with patient at time of pre-operative assessment, then handover to Doctors prior to consultation.

1. Medical History

Have you ever had any of the following complaints?

	Yes	No
High Blood Pressure		
Heart Attack		
Angina		
Stroke		
Rheumatic Fever		
Blood clot in legs or lungs		
Kidney Disease		
Diabetes	Type 1/ Type 2	
Anaemia		
Pneumonia or Tuberculosis		
Asthma		
Emphysema or chronic obstructive lung disease		
Hepatitis or Jaundice		
Hay Fever		
Nervous Breakdown		
Epilepsy or fitting		
Prosthetic Joints		
Heart Valve Replacement		
Recent Cold		

2. Surgical History

Have you had any previous operations? Yes No

Details:

Operation	Year

	Yes	No
Have you got bleeding tendency?		
Do you bruise easily?		
Have you had blood transfusions? Date:_____		
Any reaction to transfusion?		

Have you had blood thinner in the past week? Yes No

HEIGHT: _____ **WEIGHT:** _____

WHAT IS YOUR GOAL FOR TODAY'S ADMISSION:

_____

HOW WOULD YOU DESCRIBE YOUR MOOD:

WORST MOOD *BEST MOOD*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10

FOR STAFF ONLY: FALLS RISK: YES ☐ NO ☐

Nursing Notes: _____

Time of last food: _____ **Time of last drink:** _____

TEMP: _____ RAT TEST ☐ PCR TEST ☐ INITIAL: _____

PREP: _____ STOOLS CLEAR ☐

Nurse Name: _____ **Date:** _____

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Admission Nurse	To: Doctors
Patient ID& Procedure Match		
Alerts		
Fasted/Preparation completed correctly		
Relevant Medical History		
Special requirements-including language/translator		
Initial to indicate Clinical Handover at this Point of Care		

3. Anaesthetic History

Have you or a family member had an anaesthetic complication?

Yes No

If Yes,_____

_____

4. Medications

Please list your current Medications

_____

_____

_____

_____

5. Allergies

Do you have any allergies?Yes No

If Yes, _____

_____

_____

6. Other:

	Yes	No
Do you smoke? How Many?		
Do you drink Alcohol? How much per day?		
Have you used intravenous drugs?		
Have you had a recent overseas hospital stay?		
Have you had a temperature in last week?		
Females, Are you Pregnant? If Yes, EDC		
Do you require any assistance with mobility or use any aids such as walking stick, frame?		
Do you have any issues with skin integrity such as ulcers, skin tears, lesions or wounds?		
Do you require assistance to communicate? Hearing or vision deficit, cognitive impairment?		
Do you require an interpreter? If so what language?		
Any loose or capped teeth or denture in place?		

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