PATIENT HEALTH SUMMARY

A current GP summary & GP/Pharmacy medical list attached to this form would be much appreciated

Surname	MRN
Given name	
DOB ..../........../................	☐ Male ☐ Female
Ward:	
Complete all patient details or affix patient label here	

Expected admission date: ..../............../.................	Admitting Doctor:

(Please circle or tick the relevant answers & specify details where indicated)

Title	Surname	Given name (s)

Address	Post code

Do you have an: Advance Care Directive/Living will? ☐ No ☐ Yes OR Enduring Guardian ☐ No ☐ Yes
(if yes, please provide a copy or details to the hospital)

Reason for admission (*if this admission is for an injury, please indicate cause of injury & place of occurrence)*

Have you been referred by your surgeon to any other doctors that work at the Mater Hospital?
☐ No ☐ Yes If **yes**, Name & Date seen

Have you seen a specialist for other conditions?	N Y	*Name*	*Specialty*	*Contact no.*	*Last seen*
		Name	*Specialty*	*Contact no.*	*Last seen*

Have you had any test carried out prior to this admission?	N Y	***Please bring all results of test carried out for this admission to Pre-admission or on admission***

Test	*When*	*Company or where test carried out:*
Blood / pathology		
ECG / Echocardiogram / Stress test		
X- rays / CT scan / MRI		

Allergies

N Y ***Please document any known allergies or sensitivities eg. medications, latex plants, tape***

Allergy	**Reaction**

Your current Medications

*Please list **ALL** current medications (with strength of tablet & dosage) & **bring these to hospital in their original containers**. **(Webster packs cannot be used & will be re-dispensed)***

Do you take / have you taken **blood thinning medication**? ☐ Aspirin ☐ Warfarin ☐ Coumadin ☐ Clopidogrel ☐ Iscover ☐ Plavix ☐ Other (*specify*)	N Y	If **yes**, *note reason*
If **yes**, have you been asked to **stop** these?	N Y	**If *yes*, By whom:** **Date to cease:** **Date last taken:**
Have you been asked to **start** any other treatment eg. Clexane?	N Y	
Do you take or have you taken **steroids, chemotherapy, immunosuppressants**?	N Y	If **yes**, *specify*
Do you take **insulin**?	N Y	If **yes**, *specify*

Medication *(include complementary medication)*	**Route** (eg.Oral/Inhaled/topical)	**Strength** (mg/mcg/ units)	**Number per dose** (tablet/drops/sprays)	**Frequency of dosing** (eg. once/twice/three times daily)

Please take the time to complete all relevant sections and submit as soon as possible

Fax: (02) 99007395 **Address:** PO BOX 958 North Sydney NSW 2059 Australia

MATER HOSPITAL
A FACILITY OF
ST VINCENT'S
HEALTH AUSTRALIA

Medical history (continued)

Surname	MRN
Given name	
Complete all patient details or affix patient label here	

Please circle or tick the relevant answers & specify details where indicated

Previous surgical history? *(Attach list is insufficient space)*	N	Y	***Please specify below***
Hospital	Year	Specify type of surgery or operation	

Anaesthetic history Have you had any problems with anaesthetics in the past?	N	Y	***Please specify below & bring any letters detailing reaction to Pre-admission or on day of admission***
If ***yes***, please note reaction and complete the questions below to assist with your anaesthetic:			☐Dentures ☐partial ☐full ☐upper ☐lower ☐Loose teeth ☐Implants ☐Caps ☐Crowns ☐Bridges
Malignant hyperthermia or family history	N	Y	☐Self ☐Family
Difficult intubation	N	Y	When
Neck stiffness / surgery: Back stiffness / surgery	N	Y	
Recent respiratory illness / Gastro-oesophageal reflux	N	Y	
Are you pregnant or breastfeeding?	N	Y	No. of weeks?

Medical history *Please circle or tick the relevant answers & specify details where indicated*			
High blood pressure / low blood pressure	N	Y	
Heart failure / fluids on the lungs / leg swelling	N	Y	
Chest pain / angina / heart attack / / coronary angiography / coronary stent / Coronary artery bypass graft	N	Y	When?
Palpitations / atrial fibrillation / Pacemaker / implantable defibrillator	N	Y	
Rheumatic fever / Heart murmur / Cardiac valve disease / cardiac valve surgery	N	Y	
Stroke / ministroke (TIA) / limb weakness / paralysis	N	Y	
Peripheral vascular disease / leg ulcer / varicose veins	N	Y	
Risk factor for blood clot: Recent (or planned) air travel or prolonged journey	N	Y	
Risk factor for blood clot: Previous history of blood clot leg (DVT) / lung (pulmonary embolism) or family history of clots in legs or lungs?	N	Y	
Risk factor for blood clot: Are you on Hormone Replacement Therapy?	N	Y	
Recent upper respiratory tract infection	N	Y	
Bronchitis / Asthma / Emphysema / Chronic airway disease / / pneumonia	N	Y	Specify.. Do you use: ☐Nebulisers ☐Puffers ☐Home Oxygen
Shortness of breath (at rest, on exertion)	N	Y	
Obstructive sleep apnoea / CPAP machine in use	N	Y	***Bring CPAP machine on admission***
Diabetes	N	☐Type 1 ☐Type 2	Controlled by: ☐Diet ☐Injection ☐Tablet
Diabetic complications (kidney, eye, neuropathy)	N	Y	
Thyroid disorder / Addison's disease / Cushing's disease	N	Y	
Multiple sclerosis / Parkinson's / Motor Neurone disease	N	Y	
Paraplegia / quadriplegia / cerebral palsy	N	Y	
Epilepsy / seizures / fits / dizzy spells / blackouts	N	Y	

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Medical history (continued)

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Anaemia / bleeding disorder /leukaemia / lymphoma	N	Y	
Peptic ulcer disease / gastritis/ reflux	N	Y	
Hepatitis	N	Y	Year diagnosed / Type ☐A ☐B ☐C ☐D ☐E
Liver disease / liver failure / jaundice / Cirrhosis	N	Y	
Ulcerative colitis / Crohn's disease / diarrhoea / constipation / incontinence (bowel) / stoma	N	Y	
Bladder problems / incontinence (bladder) / catheter / kidney stones / prostate problems	N	Y	
Kidney problems / kidney failure	N	Y	
Dialysis	N	Y	How often? / Where?
Kidney transplant / other organ transplant	N	Y	Details:
Cancer Primary / Metastatic	N	Y	Year diagnosed / Type
Rheumatolgical disease / arthritis / muscle weakness / autoimmune disease / Myasthenia gravis	N	Y	Details
Back pain / injury / mobility problems	N	Y	
Do you have chronic pain?	N	Y	Site / Duration
Bed bound / wheelchair bound	N	Y	
Skin rash / eczema / skin tear or ulcer / history of pressure areas	N	Y	Specify
Previous head injury	N	Y	
Depression / anxiety / panic attacks / mental disorder / Psychosis	N	Y	
Short term memory loss / confusion / dementia	N	Y	
Glaucoma / cataracts / macular degeneration	N	Y	
Do you have a vision or hearing impairment?	N	Y	Aids used:
Have you had a fall in last 6 months? (if ***yes, indicate type of fall)***	N	Y	☐slip ☐trip ☐legs gave way ☐dizzy ☐lost balance
Do you use a mobility aid?	N	Y	☐stick ☐frame ☐chair
Infection Control Assessment			
History of / or current Multi Resistant Organism (MRO) eg. VRE or MRSA	N	Y	Specify:
Have you ever had intravenous antibiotics for more than 4 weeks?	N	Y	Why? Where? When?
Have you travelled to a country with a health alert in the past 3 months?	N	Y	Where? When?
Have you had a stay in any hospital in the last 12 months of greater than 24 hours?	N	Y	Where? When?
Have you been transferred from another facility	N	Y	Details:
Creutzfeldt-Jakob Disease (CJD)			
Have you suffered from a recent, progressive dementia the cause of which has not been identified?	N	Y	
Have you had surgery (spinal or brain) that involved a dura mata graft or a corneal graft prior to 1990?	N	Y	
Have you been involved in a 'Look Back' study for CJD or are in the possession of a 'Medical in Confidence Letter' regarding CJD?	N	Y	
Have you had a first degree relative with CJD (or other prion disease)?	N	Y	
Have you had treatment with Human Pituitary Hormones (for infertility or growth) before 1986?	N	Y	Details:

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Medical history (continued)

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Lifestyle

Question	N	Y	Details		
Do you have any Cultural or Religious requirements while in hospital?	N	Y	If **yes** *(specify)*		
Do you smoke?	N	Y	Amount/ day	Number of years	Date / year ceased
Have you ever smoked?	N	Y			
Do you drink alcohol?	N	Y	Type & amount	Frequency	Any free days?
Have you a history of alcohol withdrawal or do you anticipate problems with stopping alcohol?	N	Y	If **yes** *(specify)*		
Do you take any recreational / illicit drugs	N	Y	Type:	Frequency:	

Nutritional details

Weight kg | Height cm | BMI

Question	N	Y	Details
Would you like to see a Dietitian?	N	Y	*(Specify)*
Have you **lost weight** recently without trying?	N	Y	If **yes**, ☐ **1-5 kg** =*(1)* ☐ **6-10 kg** =*(2)* ☐ **11-15 kg** =*(3)* ☐ **> 15 kg** =*(4)*
Have you been eating poorly due to decreased appetite? *(score No=0 Yes=1)*	N	Y	
Do you have a **food intolerance or allergy**?	N	Y	If **yes** *(specify exact food & response)*
Do you have special **dietary needs?**	N	Y	☐ Diabetes ☐ Kosher ☐ Texture modified ☐ Gluten free ☐ Vegetarian/Vegan ☐ Halal ☐ Thickened fluids ☐ Other *(specify)*
Do you require **assistance with meals**?	N	Y	☐ Special utensils ☐ Cut up ☐ Packaged opened ☐ Help with eating

Day Surgery Discharge Planning

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

How are you getting home?

	Relationship:	Best contact phone no.	Other contact details:
Person collecting you from hospital: **Name:**			
Who is staying with you overnight? **Name:**	Relationship:	Best contact phone no.	Other contact details:

Inpatient Discharge Planning

Note: discharge time 0930

Household arrangement: ☐ Lives alone ☐ With Carer ☐ With family Other *(specify)*
☐ I care for others at home *(specify)*

Home environment: ☐ House/flat ☐ Hotel ☐ Other *(specify)*
☐ Retirement Village/Nursing Home *(Facility name)* *(Contact no.)*

At home, do you have?	No. of stairs	
☐ Internal stairs with rails ☐ Internal stairs without rails ☐ External stairs with rails ☐ External stairs without rails		☐ Separate shower ☐ Shower over bath

Question	N	Y	Details
Do you struggle with **Activities of Daily Living**? eg. showering, dressing	N	Y	If **yes**, *specify assistance required*
Do you have **Support Services** at home?	N	Y	☐ Family & Friends ☐ Delivered meals ☐ Case manager ☐ Home help ☐ Carer ☐ Shopping ☐ Home nursing ☐ Personal alarm ☐ Care package
Are you planning to go to **Rehabilitation**?	N	Y	If **yes**, where?
Are you returning to your usual home on discharge?	N	Y	If **no**, where?

Have you supplied additional patient information? N Y *(specify)*

SIGNATURE PATIENT / CARER

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature ....

Date ..../.........../..................

Form completed by:

....
Print name

☐ **Patient** ☐ **Carer**
☐ **Admitting Nurse**

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