Queen	sland		(Af	fix identification label he	re)	
Govern		UR	URN:			
Queensland (Affix identification label here) Government URN: Adult Integrated Family name: Pre-Procedure Screening Tool Given name(s): Facility: Date of birth: Sex: Date of birth: Sex: Date of birth: Patient to complete this section Sex: Date of birth:						
	ult Integrated	Giv	ven name(s):			
Pre-Proce	dure Screening	1001	dress:			
F = 2016 at				0		
Facility:	_		te of birth:	Sex:	∐M ∐F ∐I	
			nplete this section			
General informa	ease complete and return	this form to avoi	id any unnecessary d	elays in booking your	surgery	
nterpreter required?		Yes No	b If yes, preferred langu	lage:		
	gious / cultural needs?	Yes No	· · · · · · · · · · · · · · · · · · ·			
Are you a Jehovah W	/itness?	Yes No)			
	or Torres Strait Islander origi			ait Islander 🗌 No		
Do you have an Adva						
Do you have an Adva	ince Health Directive (AHD)?	Yes No	 If yes, has the AHD b and a copy in the med 		No	
Do you have an Endu	ring Power of Attorney?	Yes No				
Local doctor's (GP) n	ame:		Pho	one (if known):		
Medical centre name	:		L			
Allergies						
	I history cialist doctor (e.g. cardiologis	st) or had surgery?	? Yes (provide details	s) 🗌 No		
Have you seen a spe Major illness	cialist doctor (e.g. cardiologis				or / type of surgery	
Have you seen a spe	-	st) or had surgery? Name of		s) No Reason for seeing doct (e.g. heart / lung prot	or / type of surgery plems, diabetes)	
Have you seen a spe Major illness	cialist doctor (e.g. cardiologis			Reason for seeing doct	or / type of surgery olems, diabetes)	
Have you seen a spe Major illness	cialist doctor (e.g. cardiologis			Reason for seeing doct	or / type of surgery blems, diabetes)	
Have you seen a spe Major illness Date of last visit	cialist doctor (e.g. cardiologis Hospital / Clinic			Reason for seeing doct	or / type of surgery blems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history	cialist doctor (e.g. cardiologis Hospital / Clinic	Name of	doctor	Reason for seeing doct (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit	cialist doctor (e.g. cardiologis Hospital / Clinic		doctor	Reason for seeing doct	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history	cialist doctor (e.g. cardiologis Hospital / Clinic	Name of	doctor	Reason for seeing doct (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history	cialist doctor (e.g. cardiologis Hospital / Clinic	Name of	doctor	Reason for seeing doct (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history	cialist doctor (e.g. cardiologis Hospital / Clinic	Name of	doctor	Reason for seeing doct (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit	cialist doctor (e.g. cardiologis Hospital / Clinic	Name of Name of	doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica	tions taken (bring medications below. Include: blood t	Name of Name of A	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica inhalers, topical, eye	tions taken (bring medica	Name of Name of A	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica inhalers, topical, eye	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica inhalers, topical, eye Medi	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica inhalers, topical, eye Medi 1	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot	olems, diabetes)	
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Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica inhalers, topical, eye Media 1 2 3	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot spital) , over the counter medic please attach it to this fo	olems, diabetes)	
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Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica inhalers, topical, eye Medica 1 2 3 4 5 6	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot spital) , over the counter medic please attach it to this fo	olems, diabetes)	
Have you seen a spe Major illness Date of last visit Surgical history Date of last visit Current medica Please list all medica inhalers, topical, eye Medi 1 2 3 4 5 6 7	tions taken (bring medica tions pain relievers, herbal	Name of Name of Name of ations with you wh hinners, steroids medication. If you	doctor doctor doctor	Reason for seeing doct (e.g. heart / lung prot Reason for seeing doct (e.g. heart / lung prot (e.g. heart / lung prot spital) , over the counter medic please attach it to this fo	olems, diabetes)	

Queensland		(Affix identification label here)			
Government		URN:			
		Family name:			
Adult Integrate	d				
Pre-Procedure Screen	ing Tool	Given name(s):			
		Address:			
		Date of birth: Sex: M F I			
	following sect	ions to help us to plan your care for your hospital stay			
Health questionnaire					
What is your weight? k		What is your height? cm			
Do you have, or have you ever had, any of 1 Have you, or any of your blood relatives	_	If yes, provide further details:			
ever had a problem with an anaesthetic					
Difficulty swallowing, opening your mouth or moving your neck Difficulty swallowing your neck	Yes No	Details:			
3 Difficulty walking up more than two flights of stairs	Yes No	What stops you from walking further?			
4 Dentures	Yes No	Upper only Lower only Both upper and lower			
5 Loose or chipped teeth	Yes No	Details:			
6 High blood pressure	Yes No	Is it controlled on medication? Yes No			
7 Angina	Yes No	How frequently: Details:			
8 Arrhythmia or palpitations	Yes No	Details:			
9 Heart attack	Yes No	When:			
10 Heart surgery / pacemaker / defibrillator inserted	Yes No	Details:			
11 Other heart problem	Yes No	Details:			
12 Heartburn or acid reflux	Yes No	Well controlled on medication? Yes No			
13 Liver disease / hepatitis / jaundice	Yes No	Details:			
14 Kidney disease	Yes No	Dialysis? Yes No Details:			
15 Blood clots in the legs or lungs	Yes No	Details:			
16 Diabetes	Yes No	Usual blood sugar level: Pre-diabetic Diet controlled Tablets Insulin			
17 Asthma	Yes No	How frequent are attacks? Daily Weekly Monthly Yearly Never Exacerbations requiring hospitalisation or close GP monitoring? Yes No			
18 COPD / Emphysema / Lung disease	Yes No				
19 Sleep apnoea	Yes No	CPAP Machine? Yes No			
20 Stroke or TIA	Yes No	Details:			
		How frequent are attacks? Daily Weekly Monthly Yearly Never Details:			
22 Arthritis Yes No /		Are you taking steroids? Yes No Details:			
23 Bleeding / bruising disorders	Yes No	Details:			
24 Anaemia / Previous blood transfusion	Yes No	Details:			
25 Have you ever smoked tobacco?		Have you smoked in last 30 days? Yes No If <i>yes</i> , please complete Smoking Cessation Clinical Pathway SW321.			
		How often?			
27 Do you take recreational (party) drugs?	Yes No	What do you take and how often?			
28 Could you be pregnant?		How many weeks?			
29 Do you suffer from anxiety, depression or emotional disorders?	 YesNo	Details:			
30 Other medical conditions or disabilities Yes No not already mentioned		Details:			
Office use only (staff to complete) Referral pathways: Refer to Anaesthetist	t Quitline	AODS Social Worker GP My Age Care Other:			
		AODS Social Worker GP My Age Care Other: ood pressure: Temp: Resps: O2 sats: BGL:			
kg cm		/ °C % mmol/L			

Government URN: Adult Integrated Family name: Pre-Procedure Screening Tool Given name(s): Address: Date of birth: Sex: M F I Planning for your care Adcress: Date of birth: Sex: M F I Please answer the following questions Internat: Internat: Office use (if yes, complete the following) 1 Do you live alone? Yes No Discuss with patient 2 Do you have care responsibilities Yes No Discuss with patient 3 Do you have difficulty managing day to day activities? Yes No Discuss with patient 4 Do you have any special dietary requirements (list)? Yes No Discuss with patient 5 Do you have any bowel or urine problems (e.g. bleeding or incontinence)? Yes No Inscuss with patient 6 Do you have community Community nursing Other / Name of provider: Consider anaesthetist referral	Queensland			(Affix identification label here)			
Adult Integrated Given name(s): Address: Date of birth: Sex: M F 1 Planning for your care Accommodation: House / Unit House Bearding Retirement village Nursing home Other: Immer of statist states - Front Back: Internal: Planning for your care Accommodation: House / Unit House Internal: Planning for you care Places answer the following questions Internal: Office use (f yes, complete the following) 1 Do you live alone? Yes No Discuss with patient 2 Do you have finds or family to help you when you leave hospital? Mobility Bathing Dressing Oressing 3 Do you have difficulty Mobility Bathing Dressing Communicate with ward Discuss with patient 6 Do you have difficulty? Mobility Bathing Dressing Communicate with ward Discuss with patient 7 Do you have difficulties with any of the yes No If yes, details: Discuss with patient Discuss with patient 8 Do you have difficulties with any of the following? Ochmunity nursing Other / Name of provider: Refer to: Refer to: 9 Mobili your occupation affect your refer on you head stite referral Refer to: Consider anaesthetist referral				URN:			
Pre-Procedure Screening Tool Given name(s): Address: Date of birth: Sex: M F I Planning for your care Address: Date of birth: Sex: M F I Accommodation: House / Unit Hostel Boarding Retirement village Number of stairs / steps - Front/ Back. Internal. Please answer the following questions Office use (if yes, complete the following) Discuss with patient Retire to: Biscuss with patient 2 Da you have franks or famkly to they achieve hospital? Yes No Biscuss with patient Biscuss with patient 3 Do you have franks or famkly to they difficulty Yes No Biscuss with patient Biscuss with patient 4 Do you have any special dietary Yes is No Biscuss with patient Biscuss with patient 5 Do you have any bowel or uniting problems (cg. Dieeding or they set No Biscuss with patient Biscuss with patient 6 Do you have any bowel or uniting they details: Communicate with ward Biscuss with patient Biscuss with patient 7 Do you have any bowel or uniting Community nursing Other / Name of provider: <th colspan="3"></th> <th>Family name:</th> <th></th>				Family name:			
Address: Date of birth: Sex: M F 1 Planning for your care Accommodator: House / Unit House / Unit House / Unit House / Unit Address: Number of stars / steps – Front / Back: Internat: Office use (if yes: complete the following) Please answer the following questions Office use (if yes: complete the following) 1 Do you have fiftends or family to help you when you leave hospita? Yes _ No Discuss with patient 2 Do you have are care responsibilities for others? Other: Communicate with ward 3 Do you have ary special dietary requirements (list)? Mobility _ Bathing _ Dressing _ Communicate with ward 5 Do you have any special dietary requirements (list)? Yes _ No _ If yes, details: _ Communicate with ward 6 Do you have any special dietary requirements (list)? _ Community runsing _ Other / Name of provider: _ Consider anaesthetist referral _ Refer to: 7 Do you have difficulties with any of the following? _ Community runsing _ Other / Name of provider: _ Consider anaesthetist referral _ Refer to: 8 Do you have difficulties with any of the following? _ Fee, details: _ Communicate with ward _ Pres_, details: 9 Wi				Given name(s):			
Date of birth: Sor: M F 1 Planning for your care Accommodation: House / Unit Hotel Internal: Mumber of stairs / steps = Front / Back: Internal: Please answer the following questions Office use (If yes, complete the following) Discuss with patient 2 Do you have friends or family to		Pre-Procedure Scre	ening lool				
Planning for your care Accommodation: House / Unit Hostel Boarding Retirement village Number of Saira's Jelps – From / Back: Number of saira's Jelps – From / Back: Internal. Office use (if yes, complete the following) 1 Do you live alone? Yes No Decuss with patient 2 Do you have friends or family to help ou when you leave hospita? Yes No Decuss with patient 3 Do you have difficulty Yes No Decuss with patient Refer to: 4 Do you have difficulty Mobility Bathing Dressing Consider anaesthetist referral 5 Do you have any special dietary res. Yes No Discuss with patient 6 Do you have any bowed or urine problemic (s.) Listoring or anaesthetist referral (s.) Listoring or the yes. details: Community mursing Other / Name of provider: Consider anaesthetist referral 8 Do you have difficulties with any of the following? Gonsider anaesthetist referral Refer to: 8 Do you have difficulties with any of the following? See No Consider anaesthetist referral 9 Will your occupation affect your recovery / or do you nead Admission: <th></th> <th></th> <th></th> <th></th> <th></th>							
Accommodation: House / Unit Hostel Boarding Retirement village Nursing home Other: Number of stars / steps – Front / Back. Internal. Office use (if yes, complete the following) 1 Do you live alone? Yes No Discuss with patient 2 Do you have fifends or family to help you when you leave hospital? Yes No Discuss with patient 3 Do you have care responsibilities for others? Yes No Discuss with patient 4 Do you have any special dietary requirements (ist)? Mobility Bathing Dressing Consider anaesthetist referral 5 Do you have any special dietary requirements (ist)? Mobility Bathing Other: Communicate with ward 6 Do you have any bowel or urine problems (e.g. bleding or incontinence)? Yes No Communicate with ward 7 Do you have Community Community nursing Other / Name of provider: Consider anaesthetist referral 8 Do you have difficulties with any of the following? Speech Hearing Touch Vision 9 Will your occupation affect your recovery / or do you need a modeclincte? Admission Discu		opping for your ooro					
Number of slairs / steps - Front / Back: Internal: Please answer the following questions Office use (if yes, complete the following) 1 Do you live alone? Yes No 2 Do you have finds or family to help you when you leave hospital? Yes No 3 Do you have care responsibilities for others? Yes No 4 Do you have any special dietary requirements (list)? Other: 5 Do you have any special dietary requirements (list)? Yes No 6 Do you have any special dietary requirements (list)? Yes No 7 Do you have community surging Other / Name of provider: Communicate with ward 9 Do you have community surging Other / Name of provider: Consider anaesthetist referral 10 Do you have community Community nursing Other / Name of provider: Consider anaesthetist referral 11 So you have difficulties with any of the following? Yes No Discuss with patient 11 So you have difficulties with any or recovery / or do you need a Media Media Communicate with ward 9 Will your occupation affect your recovery / or do you need a Media Communicate with ward Discus			lostel Boarding E	Retirement village 🗌 Nursing home	e 🗌 Other:		
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2 Do you have friends or family to help you when you leave hospital? Ves No 3 Do you have care responsibilities for others? Yes No Discuss with patient 4 Do you have care responsibilities for others? Yes No Discuss with patient 5 Do you have difficulty managing day to day activities? Other: Communicate with ward 6 Do you have any special dietary requirements (list)? Yes No Discuss with patient 7 Do you have community support services? Communicate with ward Communicate with ward 7 Do you have Community support services? Community nursing Other / Name of provider: Consider anaesthetist referral 8 Do you have difficulties with any of the following? Speech Hearing Touch Vision 9 Will your occupation affect your your admission and discharge? Yes No Discuss with patient 1 Skin Integrity: Do you have skin problems such as sores, skin teats, eccema or pressure sores? Admission: Discuss with patient / consultant / GP OPD review 1 Skin Integrity: Do you have skin problems such as sores, skin teats, eccema or pressure sores? Communicate with ward Discuss with patient /							
2 Do you have friends or family to help you when you leave hospital? Image: triangle t		Do you live alone?	Yes No				
for others? Image: Consider anaesthetist referral 4 Do you have difficulty managing day to day activities? Other: Consider anaesthetist referral 5 Do you have any special dietary requirements (list)? Yes [No If yes, details: Discuss with patient 6 Do you have any bowel or unine problems (e.g. bleeding or incontinence)? Yes [No If yes, details: Communicate with ward 7 Do you have community support services? Community nursing Home help Other / Name of provider: Home help Consider anaesthetist referral 8 Do you have difficulties with any of the following? Speech Hearing [Touch] Vision If yes, details: Consider anaesthetist referral 9 Will your occupation affect your recovery (or do you oned a Medical Certificate? Admission: Discuss with patient Discuss with patient 10 How do you intend to arrive for your admission and discharge? Admission: Discuss with patient / consultant / GP Discuss with patient / consultant / GP Discuss with patient / consultant / GP Discuss with patient / consultant / GP Derview 12 Infection alert: Have you ever been placed in a privete room during your hespital stup ue to an infector? Yes [No Communicate with ward 13 Falls in the last 6 months? Yes (2) [Insure (2) [No (0) Total score: If yes or unsure, contact diettian or refer to Malnutritio	2		Yes No				
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problems (e.g. bleeding or incontinence)? If yes, details:	5		Yes No		Discuss with patient		
support services? Home help Refer to: 8 Do you have difficulties with any of the following? Speech Hearing Touch Vision Consider anaesthetist referral 9 Will your occupation affect your recovery / or do you need a Medical Certificate? Image: Communicate with ward Discuss with patient 10 How do you intend to arrive for your admission and discharge? Admission: Discuss with patient suitability of mode 11 Skin integrity: Do you have skin problems such as sores, skin tears, bruises, blisters, rashes, dermatitis, ecarma or pressure sores? Yes No 12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection? Yes No 13 Falls history: Have you bad any falls in the last 6 months? Yes (2) Unsure (2) No (0) 14 Nutrition: Have you lost more than 6kg over the last 6 months? Yes (1) No (0) Total score: 14 Nutrition: Have you been eating poorly Yes (1) No (0) Total score: If yes or unsure, contact dicitian or refer to Mainutrition Action Flowchart	6	problems (e.g. bleeding or			Communicate with ward		
of the following? If yes, details: Communicate with ward 9 Will your occupation affect your recovery / or do you need a Medical Certificate? Discuss with patient 10 How do you intend to arrive for your admission and discharge? Admission: Discuss with patient suitability of mode PREAC review 11 Skin integrity: Do you have skin problems such as sores, skin tears, bruises, blisters, rashes, dermatitis, eczema or pressure sores? Yes No Discuss with patient / consultant / GP 12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection? Yes No Communicate with ward 13 Falls history: Have you had any falls in the last 6 months? Yes (1) No (0) Total score: If yes or unsure, contact dietitian or refer to Malnutrition Action Flowchart	7		Home help	Other / Name of provider:	Consider anaesthetist referral		
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11 Skin integrity: Do you have skin problems such as sores, skin tears, bruises, blisters, rashes, dermatitis, eczema or pressure sores? Discuss with patient / consultant / GP 12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection? Yes No 13 Falls history: Have you had any falls in the last 6 months? Yes (2) Unsure (2) No (0) Total score: 14 Nutrition: Have you lost more than 6kg over the last 6 months without trying? Yes (1) No (0) No (0)	10						
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bruises, blisters, rashes, dermatitis, eczema or pressure sores? If yes, details: OPD review 12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection? Yes No Communicate with ward 13 Falls history: Have you had any falls in the last 6 months? Yes No Complete full falls / frailty assessment 14 Nutrition: Have you lost more than 6kg over the last 6 months without trying? Yes (1) No (0) Total score: If yes or unsure, contact dietitian or refer to Malnutrition Action Flowchart	11						
12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection? Yes No Communicate with ward 13 Falls history: Have you had any falls in the last 6 months? Yes No Complete full falls / frailty assessment 14 Nutrition: Have you lost more than 6kg over the last 6 months without trying? Yes (2) Unsure (2) No (0) 15 Have you been eating poorly Yes (1) No (0) Total score: If yes or unsure, contact dietitian or refer to Malnutrition Action Flowchart		uises, blisters, rashes, dermatitis,	If yes, details:				
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15 Have you been eating poorly Yes (1) No (0)	14	Nutrition: Have you lost more than 6kg over the last 6 months	Yes (2) Unsure (2) 🗌 No (0)	If yes or unsure, contact dietitian or		
	15	Have you been eating poorly	Yes (1) No (0)				
Patient signature: Date:	Pat	ient signature:			Date:		
Nurse comments	Nu	irse comments					

Queensland Government		(Affix identification label here)					
		URN:					
			Family name:				
	Adult Integrate cedure Scree		Given name(s):				
FIG-FIU			Address:				
Facility:			Date of birth:		Sex:	M 🗌 F 🗌 I	
		Staff to c	omplete this secti	on			
Surgery detai	ils						
Date of assessme	ent:	Co	onsultant:				
Procedure:							
Confirmed with t					Confirmed	/ Action taken	
1 Patient still re	quires / wants surgery?	Yes No, rea	son:			ed with the team d from ESWL	
	ot had any changes in ealth since completion	Yes No	an and D			ed with the team	
	assessment for this	ir yes, what has ch	anged?		Surgery	r anaesthetist referral	
3 Allergies reco with patient?	rded on AIST checked	Yes No			Consider	r anaesthetist referral pdated	
	hecked with patient?	Yes No					
5 Weight record with patient?	led on AIST checked	Yes No					
6 Patient is curr or other illnes	rently well (cough, cold s)?	Yes No, rea	son:		Discusse	ed with the team delaved	
					Consider anaesthetist referral		
7 Patients skin is intact – free from cuts scratches and signs of infection (redness, oozing, purulent)			scribe:		Discussed with the team Surgery delayed Consider anaesthetist referral		
been confirme	ication on AIST has ed / patient has not ed taking any new	Yes No List new medicatio	IS:		Discussed with the team Consider anaesthetist referral		
9 Patient is on t medication?	Ŭ	Patient advised to	dication: cease medication from:		-		
10 Vitamins or natural supplements have been discussed? Patient advised to			cease medication from:				
	admission and discharge inged by the patient?		es 🗌 No es 🗌 No		Refer to Social Worker		
12 Somebody is	available to assist with				Surgery		
ADL's as necessary after discharge? Patient education							
Admission information	Admission time	(subject to change - prior for health check	confirmed when patients	Admission loca	ation	Morning medication instructions	
Pre-operative education □ Patient journey explained (DSU → Holding balk Recovery → Day surgery or ward) □ Expected length of stay is betweenand Showering – the night before and morning of y □ Males – use an electric shaver or take extra card balk at a prevent putting the parts.			and days orning of your surgery	in the cancella Nails – all nail must be remov	Skin care (e.g. gardening as cuts can result in the cancellation of your surgery) Nails – all nail polish and Acrylic / Gel nails must be removed Valuables – jewellery to be removed and left at		
a blade to prevent cutting skin, trim beards home, minimal Discharge restrictions Driving Post-operative			money to be brought into hospital visit				
/ requirements			House hold chores				
Information / Name: Education given by		Designation:	Signature:	Pre-prepared foods gnature: Date:			
Review by nursing medical staff	G / Suitable for anaesti Requires referral to	hetic review on day o anaesthetic clinic? anaesthetic assessr	Yes	s 🗌 No		Date:	