Queensland Government

Adult Integrated Pre-Procedure Screening Tool

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Patient to complete this section

Please complete and return this form to avoid any unnecessary delays in booking your surgery

General information

Interpreter required?	☐ Yes ☐ No	If *yes*, preferred language:
Do you have any religious / cultural needs?	☐ Yes ☐ No	If *yes*, provide details:
Are you a Jehovah Witness?	☐ Yes ☐ No	
Are you of Aboriginal or Torres Strait Islander origin?	☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	
Do you have an Advance Care Plan?	☐ Yes ☐ No	
Do you have an Advance Health Directive (AHD)?	☐ Yes ☐ No	If *yes*, has the AHD been sighted and a copy in the medical record? ☐ Yes ☐ No
Do you have an Enduring Power of Attorney?	☐ Yes ☐ No	

Local doctor's (GP) name: Phone (if known):

Medical centre name:

Allergies

Do you have any allergies (medicines, sticking plaster, iodine, latex, food etc.)? ☐ Yes (provide details) ☐ Nil known

Details:

Illness / Surgical history

Have you seen a specialist doctor (e.g. cardiologist) or had surgery? ☐ Yes (provide details) ☐ No

Major illness

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

Surgical history

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

Current medications taken (bring medications with you whenever you come to hospital)

Please list all medications below. Include: **blood thinners**, **steroids**, **diabetic medications**, over the counter medications, inhalers, topical, eye drops, pain relievers, herbal medication. If you have a medication list, please attach it to this form.

☐ **I am on blood thinners**

	Medication name	Dose	Reason (e.g. blood pressure)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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ADULT INTEGRATED PRE-PROCEDURE SCREENING TOOL

v4.00 - 12/2017
Mat. no.: 10262762
SW269

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Please complete the following sections to help us to plan your care for your hospital stay

Health questionnaire

What is your weight? ..... kg | What is your height? ..... cm

Do you have, or have you ever had, any of the following?		If ***yes***, provide further details:
1 Have you, or any of your blood relatives ever had a problem with an anaesthetic	☐ Yes ☐ No	Details:
2 Difficulty swallowing, opening your mouth or moving 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	Frequent / recent infection / exacerbations? ☐ Yes ☐ No Details: .....
19 Sleep apnoea	☐ Yes ☐ No	CPAP Machine? ☐ Yes ☐ No
20 Stroke or TIA	☐ Yes ☐ No	Details:
21 Epilepsy or fits	☐ Yes ☐ No	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?	☐ Yes ☐ No	Have you smoked in last 30 days? ☐ Yes ☐ No If *yes*, please complete Smoking Cessation Clinical Pathway SW321.
26 Do you drink alcohol?	☐ Yes ☐ No	How often?
27 Do you take recreational (party) drugs?	☐ Yes ☐ No	What do you take and how often?
28 Could you be pregnant?	☐ Yes ☐ No	How many weeks?
29 Do you suffer from anxiety, depression or emotional disorders?	☐ Yes ☐ No	Details:
30 Other medical conditions or disabilities not already mentioned	☐ Yes ☐ No	Details:

Office use only (staff to complete)

Referral pathways: ☐ Refer to Anaesthetist ☐ Quitline ☐ AODS ☐ Social Worker ☐ GP ☐ My Age Care ☐ Other: .....

Weight: kg	Height: cm	BMI:	Pulse:	Blood pressure: /	Temp: °C	Resps:	O_2 sats: %	BGL: mmol/L

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Planning for your care

Accommodation: ☐ House / Unit ☐ Hostel ☐ Boarding ☐ Retirement village ☐ Nursing home ☐ Other: .....
Number of stairs / steps – Front / Back: ..... Internal: .....

Please answer the following questions		Office use (if *yes*, complete the following)
1 Do you live alone?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to: .....
2 Do you have friends or family to help you when you leave hospital?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to: .....
3 Do you have care responsibilities for others?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to: .....
4 Do you have difficulty managing day to day activities?	☐ Mobility ☐ Bathing ☐ Dressing ☐ Other:	☐ Consider anaesthetist referral ☐ Communicate with ward
5 Do you have any special dietary requirements (list)?	☐ Yes ☐ No If *yes*, details:	☐ Discuss with patient
6 Do you have any bowel or urine problems (e.g. bleeding or incontinence)?	☐ Yes ☐ No If *yes*, details:	☐ Communicate with ward
7 Do you have Community support services?	☐ Community nursing ☐ Other / Name of provider: ☐ Home help ..... ☐ Meals on wheels	☐ Consider anaesthetist referral ☐ Refer to: .....
8 Do you have difficulties with any of the following?	☐ Speech ☐ Hearing ☐ Touch ☐ Vision If *yes*, details:	☐ Consider anaesthetist referral ☐ Communicate with ward
9 Will your occupation affect your recovery / or do you need a Medical Certificate?	☐ Yes ☐ No	☐ Discuss with patient
10 How do you intend to arrive for your admission and discharge?	Admission: ..... Discharge:	☐ 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 If *yes*, details:	☐ Discuss with patient / consultant / GP ☐ OPD review ☐ Consider anaesthetist referral
12 **Infection alert:** Have you ever been placed in a private room during your hospital stay due to an infection?	☐ Yes ☐ No If *yes*, details:	☐ 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)	Total score: ..... ☐ If *yes* or *unsure*, contact dietitian or refer to Malnutrition Action Flowchart
15 Have you been eating poorly because of a decreased appetite?	☐ Yes (1) ☐ No (0)	

Patient signature:	**Date:**

Nurse comments

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Staff to complete this section

Surgery details

Date of assessment:	Consultant:
Procedure:	

	Confirmed with the patient		Confirmed / Action taken
1	Patient still requires / wants surgery?	☐ Yes ☐ No, reason:	☐ Discussed with the team ☐ Removed from ESWL
2	Patient has not had any changes in condition or health since completion of last health assessment for this procedure?	☐ Yes ☐ No If *yes*, what has changed?	☐ Discussed with the team ☐ Surgery delayed ☐ Consider anaesthetist referral
3	Allergies recorded on AIST checked with patient?	☐ Yes ☐ No	☐ Consider anaesthetist referral ☐ HBCIS updated
4	MRO status checked with patient?	☐ Yes ☐ No	
5	Weight recorded on AIST checked with patient?	☐ Yes ☐ No	
6	Patient is currently well (cough, cold or other illness)?	☐ Yes ☐ No, reason:	☐ Discussed with the team ☐ Surgery delayed ☐ Consider anaesthetist referral
7	Patients skin is intact – free from cuts scratches and signs of infection (redness, oozing, purulent)	☐ Yes ☐ No, describe:	☐ Discussed with the team ☐ Surgery delayed ☐ Consider anaesthetist referral
8	Patient's medication on AIST has been confirmed / patient has not recently started taking any new medications?	☐ Yes ☐ No List new medications:	☐ Discussed with the team ☐ Consider anaesthetist referral
9	Patient is on blood thinning medication?	☐ Yes ☐ No If *yes*, name of medication: ..... Patient advised to cease medication from: ..... / ..... / ..... Other:	
10	Vitamins or natural supplements have been discussed?	☐ Yes ☐ No Patient advised to cease medication from: ..... / ..... / ..... Other:	
11	Transport for admission and discharge has been arranged by the patient?	Admission: ☐ Yes ☐ No Discharge: ☐ Yes ☐ No	☐ Refer to Social Worker ☐ Refer to other: ..... ☐ Surgery delayed
12	Somebody is available to assist with ADL's as necessary after discharge?	☐ Yes ☐ No	

Patient education

Admission information	☐ Admission time (subject to change - confirmed when patients phones 3 days prior for health check)		☐ Admission location ☐ Fasting time	☐ Morning medication instructions
Pre-operative education	☐ Patient journey explained *(DSU → Holding bay → Theatre → Recovery → Day surgery or ward)* ☐ Expected length of stay is between ..... and ..... days ☐ Showering – the night before and morning of your surgery ☐ Males – use an electric shaver or take extra care when using a blade to prevent cutting skin, trim beards		☐ 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 home, minimal money to be brought into hospital	
Discharge restrictions / requirements discussed	☐ Driving ☐ Lifting ☐ Responsible adult for 24hours for day case (over 18) ☐ N/A		☐ Post-operative visit ☐ House hold chores ☐ Pre-prepared foods	
Information / Education given by	Name:	Designation:	Signature:	Date:
Review by nursing / medical staff	Suitable for anaesthetic review on day of procedure? ☐ Yes ☐ No Requires referral to anaesthetic clinic? ☐ Yes ☐ No Requires specialist anaesthetic assessment? ☐ Yes ☐ No			
	Name:	Designation:	Signature:	Date:

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