PLEASE RETURN THIS FORM **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

PATIENT HEALTH QUESTIONNAIRE
HE UIUINGA HAUORA TŪRORO

Kākāriki Hospital

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to Kākāriki Hospital. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to the same effect because we will not have all your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant x-rays / CT / MRI scans (CD discs) with you along with any mobility aids, CPAP machines etc. to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact your specialist prior to your admission.

Please ensure you are aware of when you should stop eating and drinking prior to your admission. Your specialist should advise you of these times. Please note this includes chewing gum, lollies, sugar etc. If you do not follow these instructions you risk having your surgery cancelled.

We look forward to helping you prepare for your operation.

Admissions Unit Nurses

YOUR DETAILS

Legal Name: Date of Birth: / /

Planned Procedure:

Date of Surgery: / / Best Contact Phone Number: ( )

FOR HOSPITAL USE ONLY

Pre-Admission Review: ☐ Reviewed; no further action required ☐ Reviewed; patient contacted

Action Taken:

Date unable to contact (1st Attempt): / /

Date unable to contact (2nd Attempt): / /

Name: Designation:

Signature: Date: / /

To be filed in the Clinical Record

PATIENT HEALTH QUESTIONNAIRE
HE UIUINGA HAUORA TŪRORO

Kākāriki Hospital

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No
High Blood Pressure controlled with medication	☐	☐
Heart Attack	☐	☐
Heart Murmurs	☐	☐
Artificial Heart Valve	☐	☐
Chest Pains/Angina	☐	☐
Coronary Angiogram or Stents in heart	☐	☐
Rheumatic Fever	☐	☐
AF / Palpitations / Arrhythmias	☐	☐
Cardiac devices e.g. pacemaker, ICD	☐	☐
COPD / Emphysema	☐	☐
Asthma	☐	☐
Have you had a 'headcold', throat/chest infection or bronchitis in last 4 weeks	☐	☐
Persistent Cough	☐	☐
Shortness of Breath	☐	☐
Obstructive Sleep Apnoea	☐	☐
Stroke / TIA	☐	☐
Anaemia / Bleeding disorders	☐	☐
Blood clots in legs or lungs (DVT/PE)	☐	☐
Epilepsy/Seizure	☐	☐
Blackouts/fainting	☐	☐
Heartburn/reflux	☐	☐
Diabetes: Type 1	☐	☐
Type 2	☐	☐

	Yes	No
Kidney problems	☐	☐
Hepatitis	☐	☐
Cirrhosis	☐	☐
HIV / AIDS	☐	☐
Tuberculosis	☐	☐
Do you have a history of CJD or other prion disease in your family (including 1st & 2nd degree relatives)?	☐	☐
Have you received human growth hormone or gonadotrophin treatment prior to 1986?	☐	☐
Have you received a dura mater graft before 1990?	☐	☐
Mental Illness	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Dementia/Alzheimer's	☐	☐
Arthritis	☐	☐
Joint implants or metalware	☐	☐
Do you currently use:		
Crutches, walking stick	☐	☐
Walker, frame	☐	☐
Wheelchair	☐	☐
Have you had any falls in the last 6 months?	☐	☐
Is your activity currently restricted by pain?	☐	☐

	Yes	No
Have you suffered post-op nausea and vomiting with recent surgeries?	☐	☐
Have you or a blood relative ever had any problems during or after anaesthesia? e.g. Malignant Hyperthermia, muscular dystrophy	☐	☐
Problems opening your mouth?	☐	☐
Are you or could you be pregnant?	☐	☐
Current Skin problems e.g. ulcers, wounds, eczema, boils	☐	☐
Do you or have you ever smoked?	☐	☐
If yes, how much?		
For how long?		
When did you give up?		
Do you drink alcohol?	☐	☐
If yes, how many units weekly (1 standard glass wine or ½ glass beer = 1 unit)		*Units a week*
Do you use recreational drugs?	☐	☐
Wear glasses / contact lenses	☐	☐
Other eye conditions	☐	☐
Hearing difficulties	☐	☐
Any special dietary requirements?	☐	☐
Bowel conditions	☐	☐
Bladder conditions	☐	☐

If you answered 'yes' to any of the questions above then please give details, including treatment, dietary requirements etc.

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, muscle / nerve disease? Yes ☐ No ☐

If '**yes**' please give details:

Are you under medical specialist care e.g. cardiologist, oncologist, rheumatologist? Yes ☐ No ☐

If '**yes**' please specify:

When did you last see them:

Do you have any religious beliefs / practices or cultural needs we should be aware of? Yes ☐ No ☐

If '**yes**' please give details:

2 of 4 – continue next page

PATIENT HEALTH QUESTIONNAIRE
HE UIUINGA HAUORA TŪRORO

Kākāriki Hospital

Legal Name:

Have you ever had MRSA, ESBL, VRE or CRE infection? Yes ☐ No ☐

If '**yes**', Which One: Approximate Date:

Have you lived or travelled overseas in the last 12 months? Yes ☐ No ☐

Have you worked in a healthcare facility in the last 12 months with hands-on patient care? Yes ☐ No ☐

Have you been a patient in ANY hospital within last 12 months? Yes ☐ No ☐

If '**yes**', When: Hospital: Number of Nights Stay:

Height: cm **Weight:** kg This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Are you allergic/sensitive to any: (circle which and describe below)
Medications **Foods** **Latex** **Plasters/tape/skin preparations** (e.g. iodine, chlorhexidine) **Other**

Substance	Reaction

Please list **ALL** previous admissions to hospital for surgical procedures. Please include where and when (estimate if unsure).
If you require more space, attach an additional sheet.

Previous surgery	Hospital	Year

Please list **ALL** medicines - tablets, inhalers, patches etc prescribed by your doctor or over the counter (include any herbal or natural remedies).
If you require more space, attach an additional sheet.

Name of medication	Dose	Frequency

Does anyone assist you with administration of your own medication? Yes ☐ No ☐

If '**yes**' please specify

PLEASE BRING ALL YOUR MEDICATIONS, IN ORIGINAL PACKETS, WITH YOU TO HOSPITAL.

To be filed in the Clinical Record

DISCHARGE PLANNING

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will relieve your anxiety and help you be ready for your discharge home.

You will need someone to stay with you for 24-48 hours after discharge. This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

CARER SUPPORT

Current living arrangements

☐ Live alone ☐ Live with others i.e. partner / children

☐ Have caring responsibilities for others at home. Please specify:

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and after your discharge or as advised by your specialist.

Who will be caring for you following your discharge?:

Name: Relationship:

Address:

Phone number (mobile/landline):

HOME SUPPORTS

Do you currently receive any supports at home (i.e. home help, meals on wheels)? Yes ☐ No ☐

If 'yes', please state what, and for how many hours per week.

If you think that you will require respite care after discharge, please discuss this with your specialist. You may be responsible for any costs associated with this arrangement. **These arrangements should be organised by you prior to your admission.**

DISCHARGE/TRANSPORT

Please advise the person collecting you that the discharge time is 10am.

Name: Contact phone number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know who has completed this form. Please print and sign your name.

Name (print): Date: / /

Signature:

I am the ☐ patient ☐ legal guardian ☐ parent ☐ other, specify:

PLEASE RETURN THESE FORMS **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE
You can email these forms to bookings@kakarikihospital.co.nz or see page 11 of Patient Information Booklet

To be filed in the Clinical Record