



NCN Health | Nathalia
Cobram
Numurkah

**Elective Admissions Booklet /
Consent for operation
MR17**

Cobram and Numurkah Only

Surname _____ UR Number _____

Given Name _____

Date of Birth _____ Sex M / F / O

VMO _____

Use UR Label if available

Health Assessment

Please complete the following		Yes	No	Please provide details if answer is YES	
What is your occupation?					
Have you had a serious illness?				Please describe:	
Do you have a medical enduring power of attorney?					
Do you have an Advanced Care Directive?					
Height:		Weight:		BMI:	
ALLERGIES					
Medication allergy? (only list these) (such as Penicillin)					
Food?					
Tapes?					
Latex allergy?					
Other					
Do you have special dietary needs?					
Do you have diabetes ?					
If Yes, which type? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure				If yes, how long have you had diabetes?	
Have you ever had any of the following?		Yes	No	Please provide details if answer is YES	
Asthma?				Please state puffers on med sheet (page 8)	
Unplanned rapid weight loss?				How much?	
Headaches, migraines?					
Hepatitis, jaundice or other liver disease?					
Kidney/bladder problems?					
Joint or valve replacement surgery?					
Steroids use, such as prednisolone?					
Anaemia?					
Used blood thinning medications?				Current?	Warfarin Aspirin Plavix
Bleeding disorders or blood clots?					
Dizzy spells or fainting?					
Stroke, TIA or other head injury?					
Epilepsy, fitting or blackouts?					
Bronchitis or pneumonia?					
Infectious disease such as TB?					
Gastrointestinal or bowel problems?					
Arthritis?					
A blood transfusion?					
Chest pain/angina?					
Pacemaker?					
Thyroid problems?					
Rheumatic fever?					
Heart palpitations/murmur?					
High Blood Pressure?					
Sleep apnoea?				Do you need to bring equipment?	
Stress test, cardiogram or heart surgery?				When & Where?	
Heart Specialists Name					
When did you last visit this doctor?					



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	Yes	No	
Long term swelling of the arms/legs (Lymphoedema)?			
If female, could you be pregnant?			
Do you smoke?			How many per day?
Do you use "recreational" drugs?			
Did you smoke in the past?			When did you stop?
Do you drink alcohol?			How much per day?
Anaesthetics		If YES, please comment.	
Have you or a blood relative ever had a problem with a general anaesthetic?			
Have you suffered from severe nausea after anaesthetic?			
Do you have problems with neck or jaw movement?			
Do you suffer from heartburn, indigestion or reflux?			
Do you have any capped teeth, loose teeth or dentures?			
Do you easily become breathless?			
Infection Control			
Are you aware of yourself or family member being a carrier of Creutzfeldt-Jakob Disease (CJD)?			
Have you had MRSA (Methicillin Resistant <i>Staphylococcus aureas</i>) or Golden Staph ?			
Have you had an VRE (Vancomycin Resistant <i>Enterococci</i>) infection?			
Discharge Planning			
Do you use community services such as District Nurse Home Help or Meals On Wheels?			Which service
Do you live in residential care accommodation?			Which facility
Do you normally need help with day to day activities such as showering, bathing or making meals?			
Are you solely responsible for the care of another person at home?			
Do you live alone?			
Do you have family/friends close by who can help you after hospital if needed?			Name of person
Will your address be the same after discharge?			
Do you have transport problems when you need to attend medical appointments?			
Will you require a Medical Certificate for absence from Work or carer's duties?			
Do you have any concerns about your admission which are causing you concern or distress?			
Would you like to speak to a social worker about these issues?			

