# F FAXING OR SCANNING SEND BOTH SIDES OF BOTH PAGES.

## PATIENT HEALTH QUESTIONNAIRE



## PLEASE RETURN THIS FORM TO ASCOT HOSPITAL AT LEAST ONE WEEK PRIOR TO YOUR OPERATION/PROCEDURE DATE

Dear Patient

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

When answering the questions, please do not write 'see my notes' or words to that affect because we do not have 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 the hospital on 09 520 9500.

We look forward to helping you prepare for your operation/procedure.

Regards,

Admissions Unit Nurses

### **YOUR DETAILS**

Full Name:	Date of Birth: / /
Planned Procedure:	
Home Phone Number: ( )	Mobile Number: ( )
NHI No: (if known)	Date of Surgery: / /
FOR HOSPITAL USE ONLY Pre-Admission Review:	
Action Taken: Date:	/ /
Date unable to contact (1st Attempt): / /	
Date unable to contact (2nd Attempt): / /	
Investigations required (please review any existing results)  FBC Renal Coaq G+H LFT INR	CXR MDRO swabs ECG ECHO
	CAR MUNICOSWADS ECG ECHO
Other tests (specify):	
Name:	Designation:
Signature:	
1 of 4 – contin	nue next page

# PATIENT HEALTH QUESTIONNAIRE



Heart Attack Heart Murmurs Diet controlled Heart Murmurs Diet controlled Artificial Heart Valve Insulin controlled Chest Pains/Angina Coronary Angiogram or Stents Renal/Kidney Disease Rheumatic Fever AF/Palpitations/Arrhythmias Ashma Heart Disease  CORD (Chronic Obstructive Respiratory Disease) Femphysema/Bronchitis Persistent Cough Problems opening your mouth or with neck stiffness? Persistent Cough Shortness of Breath Obstructive Sleep Apnoea Does lying flat make you breathless? Blood Clots Anaemia/Bleeding Disorders Blood Clots Are you or could you be pregnant? Blood Clots Epilepsy/Seizure Blackouts/Fainting Blackouts/Fainting Have you used boove then please give details, including treatment. If you require more space, attach	in tells	Yes No	Yes I		Yes	IN
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# IF FAXING OR SCANNING SEND BOTH SIDES OF BOTH PAGES.

# PATIENT HEALTH QUESTIONNAIRE



Full Name:							
Have you lived or worked overseas in the six months prior to your admission?	Yes	No					
Have you ever had MRSA , ESBL or VRE infection?	Yes	No					
Have you been in a hospital in NZ, including MercyAscot, or overseas within the last six month	ns? Yes	No					
Do you work in a health care facility?	Yes	No					
Height m Weight kg							
This information is important. <b>Do not leave this blank.</b> If you do not know, an estimate is acc	ceptable.						
Are you allergic/sensitive to any :  Yes  No  If 'yes' please name the items and describe rea	action:						
Medications Foods							
Latex							
Plasters/tape/skin preparations (e.g. iodine, chlorhexidine)							
Other							
Please list <b>all</b> previous admissions to hospital for operations/procedures and/or medical reasons <b>(Estimate if unsure)</b> . <b>If you require more space, attach an additional sheet</b> .	s. Please in	clude where	and when.				
Reason for admission Hos	spital		Month/Year				
Please list <b>all</b> medicines – tablets, inhalers, patches etc. prescribed by your doctor or <b>over the c</b> remedies or dietary supplements). <b>If you require more space, attach an additional sheet</b> .	counter (in	iclude any h	erbal or natural				
Name of Drug Stre	ength	Dose	Frequency				
Does anyone assist you with administration of your own medication?	Yes	No					
If 'yes' please give details:							
Is your medication packed in "compliance" (blister) packaging?	Yes	No VOLLTO	HOCDITAL				
PLEASE BRING ALL YOUR MEDICATIONS, IN ORIGINAL PACKETS, WITH YOU TO HOSPITAL.  3 of 4 – continue next page							

# PATIENT HEALTH QUESTIONNAIRE



## **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 help relieve your anxiety and prepare you for your discharge home.

You will need someone to stay with you for at least 24 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? Tick one.						
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 up to five days after your discharge or as advised by your surgeon.						
Who will be caring for <b>you</b> following your discharge?:						
Name: Relationship:						
Address:						
Phone Number (mobile/landline):						
FORMAL SUPPORTS:  Do you currently receive any formal supports (i.e. home help, meals on wheels)?  Yes  No						
If 'yes', please state who, and for how many hours per week.						
You will need to notify your formal supports of your hospital admission date and proposed discharge date.						
If you think that you will require respite care for a period of time after discharge, please discuss this with your surgeon. 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 <b>10am</b> .						
Name: Contact Phone Number (mobile/landline):						
Please feel free to add any further comments/concerns regarding discharge:						
It is important to know <b>who</b> has <b>completed this form</b> . Please <b>print and sign your name</b> .						
Print Name (in full:)  Date: / /						
Signature:						
I am the patient legal guardian parent other (specify)						

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