Southend University Hospital NHS Foundation Trust
DAY SURGERY PRE-ADMISSION DOCUMENT

Please read carefully. All sections must be completed please.
NB: incomplete forms will be returned to you
Pre-operative Questionnaire

Patient name: Mr/Mrs/Ms/Miss/Other .....

Unit number: .....

Date of birth: ..... / ..... / .....

Address: .....

.....

FOR OFFICE USE ONLY

Admitting consultant: .....

Operation: .....

Admission date: ..... / ..... / .....

Operation date: ..... / ..... / .....

Pre-assessment date: ..... / ..... / .....

In order that we may prepare for your admission and provide you with the highest standard of care possible, we would ask you to complete this form **in full and return it, in the envelope provided, to us within 5 days**.

Please note: We wish to advise you that an admission date for your surgery will not be offered if you fail to complete this postal questionnaire in full. Forms that are incomplete result in delays and the possible cancellation of your procedure on the day of surgery.

The medical information you supply will be kept confidential by the hospital and will only be disclosed to others on a **strictly confidential basis** in connection with, and for the purpose of treatment.

Are there any dates when you will not be available?

.....

.....

Contact details

Home .....

Work .....

Mobile .....

Email .....

Patient's signature: .....

Date: ..... / ..... / .....

Form No: SOU419

Day Surgery Pre-Admission Document

Tick as appropriate

On the day of your procedure you must be collected by a member of your family or a friend and accompanied home by CAR or TAXI. NB: not public transport.

You must also arrange for someone to stay with you for 24 hours following surgery. Please provide their details below (you may provide this information on the day of your admisssion):

Name and contact number of person collecting you .....

Name of the person staying with you .....

		Yes	No
	Please confirm that you have transport and 24 hour care in place.	☐	☐
1	Do you have any special communication needs?	☐	☐
2	Are you fully mobile?	☐	☐
3	Do you use a wheelchair or hoist at home?	☐	☐
4	Do you have any special dietary requirements?	☐	☐

I understand that it would be dangerous to drive, operate machinery (including kitchen equipment) for at least 24 hours following surgery. I have arranged for somebody to accompany me home and stay with me for 24 hours after my operation.

Patient's signature .....

Communication Box (Please use for any further information)

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IMPORTANT

What is your weight? *Kg or stones/lb (please state which)* .....

What is your height? *Metres or feet/inches (please state which)* .....

		Yes	No	Comments
Have you ever had				
9	A serious illness (cancer/heart attack/stroke/angina/any other)	☐	☐	.....
10	Allergy or reaction to medicines, elastoplast or food/latex **(PLEASE LIST)**	☐	☐	.....
Have you ever suffered from any of the following				
	(Please tick/circle as appropriate)			
11	Chest pain on exercise or at night	☐	☐	.....
12	Breathlessness - walking/lying flat/climbing stairs	☐	☐	.....
13	Asthma (last attack) bronchitis, emphysema COPD	☐	☐	.....
14	High blood pressure - if YES do you know last reading?	☐	☐	.....
15	Heart murmur, rheumatic fever, tuberculosis (TB)	☐	☐	.....
16	Convulsions, fits, blackouts or fainting (last attack)	☐	☐	.....
17	Jaundice (yellowness) or liver disease (e.g. hepatitis)	☐	☐	.....
18	Indigestion, Acid Reflux, heartburn, hiatus hernia	☐	☐	.....
19	Kidney or urinary trouble	☐	☐	.....
20	Anaemia, blood clots or any other blood disorders	☐	☐	.....
21	Excessive bleeding or bruising	☐	☐	.....
22	Arthritis	☐	☐	.....
23	Muscle disease or progressive weakness, eg MS, Motor Neurone Disease	☐	☐	.....
24	Diabetes (sugar in urine)	☐	☐	.....
25	Thyroid disease	☐	☐	.....
26	Have you been diagnosed with sleep apnoea	☐	☐	.....
27	Have you been swabbed for MRSA	☐	☐	.....
28	Were you given body wash	☐	☐	.....

IMPORTANT

29	**Please list all medication, ie Prescription/Over the counter/Herbal, patches, injections, inhalers or recreational substances or please attach your repeat prescription list**	☐	☐	....
30	Do you take Warfarin/Clopidogrel or Aspirin or any other blood thinners/anti platelet medication	☐	☐	.....
31	Have you been screened for sickle cell/Thalassaemia Trait	☐	☐	.....
32	Smoke – per day	☐	☐	.....
33	If yes leaflet given	☐	☐	.....
34	Drink more than 1-2 pints of beer or 3 shorts a day	☐	☐	.....
35	If a woman are you pregnant or taking the pill or HRT	☐	☐	.....
36	Is there anything else the surgeon/anaesthetist should know	☐	☐	.....
37	What operations have you had before if any (please list)	☐	☐	....
38	Did you have any anaesthetic or surgical **complications** (please list)	☐	☐	.....
39	Has any member of your family had problems with anaesthetics	☐	☐	.....

NOTES