Patient's Questionnaire and Pre-Admission Form

FORT WHYTE ORTHOPEDICS

RESTORING *motion* FOR LIFE

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The following paperwork is to be filled out by the patient:

- ❑ WRHA SURGERY PROGRAM PRE-Operative Assessment Patient Questionnaire (4 pages)

- ❑ PRE-ADMISSION FORM (1 page)

- ➔ The forms mentioned above can be sent back to the office by email or fax (see letterhead)

Please submit the completed forms minimum **TWO MONTHS prior to your surgery date** ***(unless told otherwise).***

If you have any questions please contact your surgeon's office assistant (SOA):

SOA:
Phone:
Email:

The completed forms are DUE on: _____

- *Patients who have any missing pieces of the surgical package will be contacted.*
- *Failure to submit your completed surgical package by the due date will result in delaying surgery.*

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM
PREoperative Assessment
Patient Questionnaire

DATE COMPLETED (DD/MMM/YYYY): _____
PHIN: _____

Please fill out this form (questions 1 - 33) to help our Health Care Team meet your medical needs.
Print your answers in black ink; you will need to mail or drop off your completed form to your surgeon's office.
This information is needed at least 3 weeks before your surgery date.

1. Legal Name: _____ (SURNAME) _____ (MIDDLE) _____ (FIRST) _____ (PREFERRED NAME)
2. How old are you? _____
3. Home #: _____ Cell #: _____ Alternate #: _____
4. Date of Surgery (DD/MMM/YYYY) _____ Surgeon's Name: _____
   Type of Surgery: _____
5. Do you have a Health Care Directive? ☐ No ☐ Yes ☐ Copy attached
   Power of Attorney: _____ Phone #: _____
6. a) What language do you speak/understand? ☐ English ☐ French ☐ Other _____
   b) Will you need an interpreter? ☐ No ☐ Yes
7. Contact Person: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
8. Who will pick you up from the hospital on discharge?
   Name: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
9. a) Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months:
   ☐ In an acute care hospital outside Manitoba ☐ In an acute care hospital within Winnipeg
   b) Have you been hospitalized or investigated for the following in the past 6 months?
   ☐ Tuberculosis (TB) ☐ *C. difficile* ☐ MRSA
   ☐ Other Describe: _____ ☐ Do not know
10. Do you have Allergies and/or intolerances (i.e. medication, latex, tape,dust/pollen,food,etc.)
    ☐ No ☐ Yes List below:

Allergic to:	Reaction:

11. Do you wear a **Medic Alert® Bracelet** . . . . . ☐ No ☐ Yes
    What does it say? _____
12. List Home Medications or attach a copy of your medication list ☐ Copy attached
    - Prescription medications (i.e. birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills, etc.)
    - Over the counter medications (i.e. aspirins, cold/allergy drugs, laxatives, vitamins)
    - Herbs or others (i.e. garlic, gingko biloba, St. John's Wort)

Drug Name	Dose (grams or mg)	How Often	Reason

If coming to the PREoperative Assessment Clinic, please bring the containers of all prescription and over the counter medications with you.

Hospital Use Only

Interview Information

T _____ P _____ RR _____

☐ Right Arm
BP _____ ☐ Left Arm

O_2 SATS _____

Weight _____ Height _____

BMI _____

☐ Surveillance swab sent (if indicated)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Medication Reconciliation Completed for Same Day Admission

☐ Best Possible Medication History Completed for Day Surgery Patient with Chronic Renal Failure on Hemodialysis

_____

Patient Name: _____ **PHIN:** _____

13. Family Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

14. Do you see a Specialist Doctor (heart, lung, blood, etc.) ☐ No ☐ Yes
List below:
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

15. Is it possible that you could be pregnant? . . . . . ☐ No ☐ Yes

16. How tall are you? _____ How much do you weigh? _____ lbs or kgs

17. a) Do you have Obstructive Sleep Apnea (OSA)? . . . . . ☐ No ☐ Yes
b) Have you had a sleep study? . . . . . ☐ No ☐ Yes
c) Do you use a CPAP/BiPAP machine? . . . . . ☐ No ☐ Yes
d) Do you snore loudly (loud enough to be heard through closed doors)? . . . ☐ No ☐ Yes
e) Do you think you have abnormal or excessive sleepiness during the day? . . ☐ No ☐ Yes
f) Has anyone noticed that you momentarily stop breathing during your sleep?. . ☐ No ☐ Yes
g) Is your neck measurement greater than 40 cm/16 inches? . . . . . ☐ No ☐ Yes

18. a) Do you get short of breath or tightness in your chest lying flat in bed or getting dressed? . . . . . ☐ No ☐ Yes
b) Can you climb 1 flight of stairs without stopping to rest? . . . . . ☐ No ☐ Yes ☐ Haven't tried this activity

19. Health History: Place a mark (X) if you have had any of these ☐ None

- ☐ Chest Pain
- ☐ Angina/Heart Related Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart beats fast, Skipped Beats
- ☐ Rheumatic fever
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Persistant swelling in legs and/or feet
- ☐ Lung Problems
- ☐ Shortness of Breath, Cough, Wheeze
- ☐ Asthma
- ☐ Home Oxygen
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)/Mini-stroke
- ☐ Migraines/Headaches
- ☐ Blackouts/Fainting spells in last year
- ☐ Seizures
- ☐ Recent Memory Loss
- ☐ Disease of Nervous System (i.e. MS)
- ☐ Parkinson's Disease/ Tremors
- ☐ Muscle Disease
- ☐ Joint/Bone Problems (i.e. Arthritis)
- ☐ Chronic Pain
- ☐ Gout
- ☐ Frequent Heart Burn/Acid Reflux
- ☐ Ulcers
- ☐ Open Wounds
- ☐ Skin/Rashes
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Bowel Disease (i.e. Crohn's Colitis)
- ☐ Kidney/Bladder Problems
- ☐ Hemodialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Peritoneal Dialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Anemia/Low Iron
- ☐ Blood Transfusion
  Date: _____ (DD/MMM/YYYY)
- ☐ Bleeding Disorders
- ☐ Sickle Cell Disease
- ☐ Blood Clots (legs, lungs, pelvis)
- ☐ Family History of Blood Clots
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Mental Health Issues
- ☐ Dementia
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Malignant Hyperthermia
- ☐ Pseudocholinesterase Deficiency
- ☐ Implanted Electronic Devices (i.e. pacemaker, internal defibrillator,interna pain stimulator)
  Date of Last Visit: _____ (DD/MMM/YYYY)
- ☐ Other

Hospital Use Only

Interview Information

_____

☐ Known OSA (PAC referral required)

☐ High Clinical Suspicion (PAC referral required)

☐ Low Clinical Suspicion

Patient Name: _____ **PHIN:** _____

Comments: _____

_____

Are there health problems that run in your family?
Explain: _____

Have you ever had an anesthetic? . . . . . ☐ No ☐ Yes
Have you ever had a problem with the anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____
Has anyone in your family ever had a problem with an anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____

_____

20. List any Operations you have had:

Operation	Date (DD/MMM/YYYY)	Hospital

The last time that you had surgery, did you experience confusion, hallucination or behaviour that was unusual for you? . . . . . ☐ No ☐ Yes

21. Have you been admitted to hospital for any reason other than for surgery:

Reason	Date (DD/MMM/YYYY)	Hospital

The last time that you were hospitalized, did you experience confusion, hallucination or behaviour that was unusual for you?. . . . . ☐ No ☐ Yes

22. List any special tests you have had:
☐ Stress Test ☐ Ultrasound ☐ Angiogram ☐ Other

Test	Date (DD/MMM/YYYY)	Hospital

23. Transfusion History:
a) Do you have a rare blood type or been told that you have antibodies? . . . . ☐ No ☐ Yes
b) Do you object to blood and blood product transfusion for any reason? . . . . ☐ No ☐ Yes
c) Have you ever received blood or blood products? . . . . . ☐ No ☐ Yes
d) Did you have any problems? . . . . . ☐ No ☐ Yes

24. Do you smoke? . . . . . ☐ No ☐ Yes Do you Vaporize? . . . . . ☐ No ☐ Yes
How many per day?_____ Number of years smoked/vaporized?_____
When did you quit _____

25. Do you drink beer/wine/liquor?B . . . . . ☐ No ☐ Yes
How much? _____ How often? _____

26. Do you use recreational drugs? . . . . . ☐ No ☐ Yes
Type _____ How often? _____

Hospital Use Only

Interview Information

Mini-Cog Score (if available):
_____ ☐ Not Available

B **For patients greater than 65 years of age, flag at risk for delirium if:**
- ☐ **greater than 80 years of age**
- ☐ **benzodiazipines and/or alcohol greater than 3 x/week**
- ☐ **glasses and/or hearing aids**
- ☐ **Mini Mental Status Exam less than 24 or previous delirium**
- ☐ **assistance with any activities of daily living**

Delirium Risk Flags:
_____ /5

B **If 2 (two) or more flags are present, implement facility protocol.**

☐ N/A patient less than 65 years of age

Patient Name: _____ **PHIN:** _____

27. Do you have: ☐ Capped or Loose Teeth
☐ Dentures/Removable Teeth or Bridge Work ☐ Upper ☐ Lower
☐ Contact Lenses ☐ Hearing Aid B ☐ Right ☐ Left
☐ Eyeglasses B ☐ Body Piercings _____
Prosthesis specify _____

28. Nutrition Status: ☐ Regular Diet
a) Special diet? . . . . . ☐ No ☐ Yes
Type of diet _____
Describe eating pattern: _____
b) Difficulty eating or swallowing? . . . . . ☐ No ☐ Yes
c) Weight pattern? ☐ Stable ☐ Gain ☐ Loss Amount:_____ Time period:_____
☐ Nausea ☐ Vomiting ☐ Choking ☐ Indigestion ☐ Reflux ☐ Anorexia

29. Elimination Status: ☐ Regular ☐ Ostomy ☐ No Concerns
a) Urinary pattern? ☐ Urgency ☐ Incontinent ☐ Frequency ☐ Get up During the Night
Describe urinary pattern: _____
b) Bowel pattern? ☐ Diarrhea ☐ Constipation ☐ Incontinent
Describe bowel pattern: _____
c) Other? . . . . . ☐ No ☐ Yes
Describe: _____

30. Functional Status: ☐ No Concerns
a) Any changes in activities of daily living: . . . . . ☐ No ☐ Yes
Explain: _____

For the Day Surgery Population, ***if one or more of the risk for falls questions [30(b)(c) or (d)] is checked yes, initiate facility falls prevention screening tool***

b) Falls within 12 months: . . . . . ☐ No ☐ Yes
c) Do you require assistance with toileting, bathing, dressing, walking, feeding: . . . . . ☐ No ☐ Yes B
Explain: _____
d) Do you use any of these: ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Mechanical Lifts ☐ Bathroom Assists
Explain: _____

e) Any changes in sleep pattern: . . . . . ☐ No ☐ Yes
Explain: _____
f) Do you have any pain: . . . . . ☐ No ☐ Yes
Explain: _____

31. What are your living arrangements? ☐ No Concerns
a) Lives: ☐ Alone ☐ Spouse/partner ☐ Child(ren) ☐ Pets ☐ Other _____
b) Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home
☐ Supportive Housing ☐ Assisted Living
☐ Other Explain: _____
c) Must use stairs: ☐ No ☐ Yes Number:_____
Is there a railing? ☐ No ☐ Yes

32. Are you using any community services right now? ☐ No Services
☐ Home Care ☐ Physiotherapy ☐ Occupational Therapy
☐ Dietitian ☐ Day Hospital ☐ Lifeline®
☐ Handi-transit ☐ Other
☐ Treaty Number_____ ☐ Band Name: _____
☐ Social Assistance Case Worker Name: _____
Phone# _____ Case # _____

33. Who completed this form? ☐ Patient
☐ Other Name/Relationship: _____

Hospital Use Only

Interview Information

☐ Consults Initiated

_____

☐ Facility Falls Prevention Screening Tool Initiated

_____

Screened by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

_____

Assessed by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

_____

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been no significant change in the patient's condition.

GRACE HOSPITAL

PRE-ADMISSION FORM

Please complete and return to your Surgeon's office as soon as possible.

If you must cancel your surgery, please CONTACT YOUR DOCTOR'S OFFICE immediately so the time can be given to another patient.

SURNAME	GIVEN NAME	GENDER	TITLE	MAIDEN/PREVIOUS NAME
		☐ Female ☐ Male	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	
ADDRESS		CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBERS: HOME	BUSINESS	MESSAGE	DATE OF BIRTH: DAY	MONTH	YEAR	AGE
( )	( )	( )				

ALLERGIES (MEDICATIONS AND FOOD)	DO YOU WISH TO STATE A RELIGION?

REGISTRANT'S SURNAME & GIVEN NAME (Name on front of MHSC card)	EMPLOYER OF REGISTRANT

HAVE YOU BEEN A PATIENT IN THIS HOSPITAL BEFORE?	PHIN:	FAMILY DOCTOR
☐ YES ☐ NO		

NAME OF SPOUSE, NEAREST RELATIVE, OR FRIEND	RELATIONSHIP

ADDRESS AND TELEPHONE NUMBER

IF YOU ARE NOT REGISTERED WITH MHSC, ARE YOU PLANNING TO STAY:	DATE OF ARRIVAL IN MANITOBA
☐ TEMPORARY IN MANITOBA OR ☐ PERMANENT IN MANITOBA	
OTHER PROVINCIAL PLAN NO. & EXPIRY DATE (if applicable)	PREVIOUS ADDRESS IN FULL

MHSC NUMBER	**Your MHSC # covers STANDARD accommodation only.**	ACCOMMODATION REQUESTED
		☐ Standard ☐ Semi-Private ☐ Private

PRIVATE INSURANCE	CONTRACT/POLICY NO.	GROUP NO.	POLICY HOLDER
☐ Blue Cross ☐ Other _____			

WCB CLAIM NO. (if applicable)	PATIENT'S EMPLOYER

I hereby request a private/semi-private room when available and agree to pay the additional charges either personally or with proceeds from an insurance assignment, or both, to Grace Hospital. I further authorize Grace Hospital to release such information as may be necessary for the completion of my hospitalization claim.

DATE	SIGNATURE OF APPLICANT