SPRING HILL SPECIALIST DAY HOSPITAL

Levels 1 and 4, St Andrew's Place
33 North Street, Spring Hill Qld 4000
Phone: [07] 3307 3243
Fax: [07] 3832 3247

PATIENT I.D. LABEL

PRE-OPERATIVE FORM

PRE-OPERATIVE ASSESSMENT FORM

PLEASE COMPLETE THIS FORM IN BLACK PEN AND RETURN IT TO THE DAY SURGERY UNIT AS SOON AS POSSIBLE IF TIME IS INADEQUATE, PLEASE BRING IT WITH YOU ON THE DAY OF SURGERY.

Name: **Ht:** cm **Wt:** kg

Females Only
Date of last menstrual cycle: / / Are you currently breastfeeding? ☐ Yes ☐ No

Details of previous surgery: _____

Have you had an anaesthetic previously? ☐ Yes ☐ No

If yes, please give details of any problems: _____

Do you have or have ever had any of the following?	Yes	No	Additional information
Allergies to medication / tapes / dyes	☐	☐	
A cough or cold at present	☐	☐	
Heart Disease, Rheumatic Fever, Heart Murmur	☐	☐	
Chest Pain / Angina / Heart Attack / High Blood Pressure	☐	☐	
Bronchitis, Asthma, or any other chest problems	☐	☐	
Do you smoke? For how long?	☐	☐	
Faint easily	☐	☐	
Epilepsy or other fits	☐	☐	
Hepatitis or Jaundice	☐	☐	
Arthritis or Muscle Disease	☐	☐	
Kidney problems	☐	☐	
Heartburn / Reflux	☐	☐	
Anaemia or other blood problems	☐	☐	
Bruise or bleed easily	☐	☐	
Diabetes	☐	☐	
Have you taken aspirin in the last 2 weeks	☐	☐	
Other serious illnesses or disabling conditions	☐	☐	

List of current medications (including alternative / recreational drugs): _____

Special diet? If yes please give details: _____

PRE-OPERATIVE FORM

CONSENT FORM

PLEASE READ AND COMPLETE FORM BELOW

I, _____

of _____

accept that for 24 hours following a General Anaesthetic or Intravenous Sedation I should not:

- **DRIVE A CAR OR OPERATE MACHINERY**
- **DRINK ALCOHOL**
- **SIGN ANY LEGAL DOCUMENT OR MAKE IMPORTANT DECISIONS**
- **TAKE HEAVY EXERCISE**

and that I must arrange for a responsible adult to drive me home and stay with me overnight following my surgery.

I am aware that failure to do so may result in my procedure being cancelled.

Signature: Parent / Guardian: Date: / /

Patient Notes: _____

Follow up Phone No.

Problems Identified / Action Taken: Date / Time: