Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

Patients – Please fill out this form so your Health Care Team can better meet your needs.

Date *(yyyy-Mon-dd)* _____

1. Legal Name _____ *(Surname)* _____ *(First)* _____ *(Middle)*

2. How old are you? _____ Date of Birth *(yyyy-Mon-dd)* _____

3. Home # _____ Cell # _____ Alternate # _____
   Email _____

4. Contact Person _____ Relationship _____
   Phone # _____ Cell # _____ Alternate # _____
   Contact Person _____ Relationship _____
   Phone # _____ Cell # _____ Alternate # _____

5. Who will pick you up from the hospital on discharge?
   Name _____ Relationship _____
   Phone # _____ Cell # _____ Alternate # _____

6. a) What language do you speak/understand?
   ☐ English ☐ Other _____
   b) Will you need an interpreter? ☐ No ☐ Yes

7. a) Do you have a Health Care/Personal Directive? ☐ No ☐ Yes
   ☐ Copy attached ☐ Enacted
   b) Do you have Advance Care Planning? ☐ No ☐ Yes
   c) Do you have a Legal Guardian? ☐ No ☐ Yes

8. Family Doctor's Name _____
   Date of last visit *(yyyy-Mon-dd)* _____ Reason _____

9. Do you see a Specialist Doctor regularly *(heart, lung, blood, etc)*?
   ☐ No ☐ Yes
   Doctor's Name _____
   Date of last visit *(yyyy-Mon-dd)* _____
   Reason _____

Hospital Use Only
Interview Information

Vital Signs for Anesthetic Consults

T _____

P _____

RR _____

BP _____ *(Right Arm)*

_____ *(Left Arm)*

SpO_2 _____

Height _____

Weight _____

BMI _____

☐ Goals of Care

_____

_____

Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

10. Reason for admission/surgery _____

11. Do you have any pain? 0 1 2 3 4 5 6 7 8 9 10
☐ No ☐ Yes *(no pain)* *(worst possible)*
Specify _____

12. Height _____ ☐ inches ☐ cm Weight _____ ☐ lbs ☐ kgs

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

14. **Allergies/Reactions** **Indicate Reaction**

Food ☐ No ☐ Yes ☐ Lactose ☐ Gluten
☐ Other Foods *(Specify)*

Medication ☐ No ☐ Yes *(Specify)*

Latex ☐ No ☐ Yes *(Specify)*

Other ☐ No ☐ Yes *(Specify)*

15. List Home Medications or attach a copy of your medications list.

☐ Copy Attached

- Prescription medications *(i.e. birth control pills, creams, eye drops, inhalers, insulin, patches, sleeping pills, etc.)*
- Over the counter medications *(e.g. aspirins, cold/allergy drugs, laxatives, vitamins, etc.)*
- Herbs or others *(i.e. garlic, ginkgo biloba, St. John's Wort, Glucosamine, etc.)*

Drug Name	Dose *(grams or mg)*	How Often	Reason

If coming to the Pre Admission Clinic / Hospital please bring all containers of prescriptions and over the counter medications with you.

Hospital Use Only
Interview Information

_____

☐ Urine hCG

☐ Latex Form Completed

☐ Medication Reconciliation Completed

_____

_____

_____

_____

_____

_____

Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

16. Do you have Obstructive Sleep Apnea (OSA)? ☐ No ☐ Yes

17. Do you use CPAP? ☐ No ☐ Yes

18. a) Do you snore loudly (loud enough to be heard through closed doors)? ☐ No ☐ Yes
    b) Do you think you have abnormal or excessive sleepiness during the day? ☐ No ☐ Yes
    c) Has anyone noticed that you momentarily stop breathing during your sleep? ☐ No ☐ Yes
    d) Do you have or are you being treated for high blood pressure? ☐ No ☐ Yes

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

20. Do you drink beer/wine/liquor? ☐ No ☐ Yes
    Number of drinks per week? _____

21. Do you use recreational drugs? ☐ No ☐ Yes
    Type _____ How Often? _____

22. Do you have:
    ☐ Capped or loose Teeth
    ☐ Dentures ☐ Upper ☐ Lower
    ☐ Eyeglasses
    ☐ Contact Lenses
    ☐ Hearing Aid ☐ Right ☐ Left
    ☐ Body Piercing *(Specify)* _____
    ☐ Intraocular Lens Implant ☐ Right ☐ Left
    ☐ Prosthesis/Implants _____
    ☐ None

23. Do any of these things make you feel short of breath or give you tightness in your chest or are you unable to complete them for any reason?
    a) Lying flat in bed ☐ No ☐ Yes
    b) Climbing 1 flight of stairs ☐ No ☐ Yes
    c) Walking 1 block ☐ No ☐ Yes
    d) Housework, getting dressed ☐ No ☐ Yes

Hospital Use Only
Interview Information

☐ Known Obstructive Sleep Apnea

OSA Risk Indicators:
- ☐ Snores Loudly
- ☐ Tired *(excessive sleepiness during day)*
- ☐ Observed *(stopped breathing during sleep)*
- ☐ Pressure *(has or being treated for high blood pressure)*
- ☐ BMI *(greater than 35 kg/m²)*
- ☐ Age *(over 50)*
- ☐ Neck circumference *(greater than 40 cm)*
- ☐ Gender *(male)*

OSA Risk Indicators:
_____ / 8

- ☐ High Clinical Suspicion if 3 or more risk indicators
- ☐ Anesthetic consult completed if High Clinical Suspicion and Major Surgery
- ☐ Note on Kardex
- ☐ OSA Information Sheet

Pre-Admission Use Only:

Exercise Tolerance in metabolic equivalents (METS) as reported by patient

- ☐ ET 4 METs or higher *(Patient has checked 'no' to all boxes)*
- ☐ ET *less than* 4 METs *(Patient has checked yes to any box)*

Alberta Health Services

Patient Assessment

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

24. List any Operations you have had:

Operation	Date *(yyyy-Mon-dd)*

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

Have you ever had anesthetic? ..... ☐ No ☐ Yes

Have you ever had a problem with the anesthetic?

Explain _____

Has anyone in your family ever had a problem with an anesthetic? ..... ☐ No ☐ Yes

Explain _____

25. Transfusion History:

Have you ever received blood or blood products? ..... ☐ No ☐ Yes

a) Did you have any problems? ..... ☐ No ☐ Yes

b) Do you have a rare blood type or been told that you have antibodies? ..... ☐ No ☐ Yes

c) Do you have an antibody card? ..... ☐ No ☐ Yes

d) Do you object to blood or blood product transfusion for any reason? ..... ☐ No ☐ Yes

Hospital Use Only
Interview Information

For patients older than 65 years of age, flag at risk for delirium if:

- ☐ older than 80 years of age
- ☐ benzodiazepines and/or alcohol more than 3 x/week
- ☐ glasses and/or hearing aides
- ☐ Previous Delirium
- ☐ assistance with any activities or daily living

Delirium Risk Flags: _____ /5

Delirium Risk if greater than 2 flags. Implement facility protocol.

- ☐ Information pamphlet given
- ☐ Delirium watch noted on PAC Checklist
- ☐ Confusion Assessment Method Score (CAM) on chart
- ☐ Note on Kardex
- ☐ N/A – less than 65 years of age

- ☐ Known antibodies – notify Blood Bank by calling 403.343.4827

Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

26. Nutrition Status ☐ No Concerns
If answered No Concerns proceed to question 27
a) Special 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

27. Elimination Status ☐ No Concerns
If answered No concerns proceed to question 28
a) Urinary pattern? ☐ Urgency ☐ Incontinent ☐ Frequency
☐ Get up During the night
Describe urinary pattern _____
b) Bowel pattern? ☐ Diarrhea ☐ Constipation ☐ Incontinent ☐ Ostomy
Describe bowel pattern _____
c) Other? ☐ No ☐ Yes
Describe _____

28. Functional Status ☐ No Concerns
If answered No concerns proceed to question 29
a) Any changes in activities of daily living? ☐ No ☐ Yes
Explain _____
b) Do you require assistance with toileting, bathing, dressing, walking, feeding? ☐ No ☐ Yes
Explain _____
c) Do you use any of these? ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Mechanical Lifts ☐ Bathroom Assists
Explain _____
d) Any changes in Sleep pattern? ☐ No ☐ Yes
Explain _____

29. Are you using any community services right now? ..... ☐ No ☐ Yes
If answered No proceed to question 30
☐ Home Care ☐ Physiotherapy ☐ No Services
☐ Dietitian ☐ Occupational Therapy ☐ Lifeline
☐ Handi-transit ☐ Other
☐ Treaty Number _____ ☐ Band Name _____
☐ Social Assistance Case Worker Name _____
Phone # _____ Case # _____

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

Hospital Use Only
Interview Information

☐ Discharge Planning Required
Reason:
_____
_____

☐ Home Care Notified

☐ Hospital Environmental Information Given
☐ Personal Care Items
☐ Valuables
☐ TV/telephone/radio
☐ Electrical appliances
☐ Smoking
☐ Visiting Policy
☐ Pastoral Care
☐ Unit Orientation
☐ Nurse call system
☐ Meal and snack times
☐ CCTV
☐ Name Placard on door

* Tell patient their name will be placed on a placard outside the room. If patient objects to this, the placard must be removed.
* Note same on Kardex

Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

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

- ☐ Chest Pain
- ☐ Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart beats fast, Skipped beats
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Persistent swelling in legs and/or feet
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)/Mini-Stroke
- ☐ Blood Clots *(legs, lungs, pelvis)*
- ☐ Bleeding Problems
- ☐ Anemia/Low iron
- ☐ Blood Transfusion
  Date _____ *(yyyy-Mon-dd)*
- ☐ Implanted Electronic Devices *(i.e. pacemaker, Internal defibrillator)*
- ☐ C. Difficile
- ☐ MRSA
- ☐ VRE
- ☐ Lung Problems
- ☐ Shortness of Breath, Cough, Wheeze
- ☐ Asthma
- ☐ Home Oxygen
- ☐ CPAP/BiPAP Machine
- ☐ Diabetic *(takes insulin)*
- ☐ Diabetic *(no insulin)*
  Usual blood sugar Range _____
- ☐ Thyroid problems
- ☐ Glaucoma
- ☐ Blindness
- ☐ Frequent Heart Burn
- ☐ Ulcers
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Bowel Disease
- ☐ Kidney/Bladder Problems
- ☐ Hemodialysis
- ☐ Peritoneal Dialysis
- ☐ Open Wounds
- ☐ Skin Rashes
- ☐ Migraines/Headaches
- ☐ Blackouts/Fainting spells in last year
- ☐ Seizures
- ☐ Recent Memory Loss
- ☐ Mental Health Issues
- ☐ Anxiety/Panic Attacks
- ☐ Depression
- ☐ Dementia
- ☐ Chronic Pain
- ☐ Disease of Nervous System *(i.e. MS)*
  _____
- ☐ Parkinson's Disease Tremors
- ☐ Muscle Disease
- ☐ Joint/Bone Problems *(i.e. Arthritis)*
  _____
- ☐ Falls within 6 months
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Malignant Hyperthermia
- ☐ Pseudocholinesterase Deficiency
- ☐ Cancer
  _____
- ☐ Hearing Deficit

Other _____

_____

_____

32. Who completed this form?
- ☐ Patient
- ☐ Other Name/Relationship _____

Signature _____ Date *(yyyy-Mon-dd)* _____

Reviewed by _____ Date *(yyyy-Mon-dd)* _____
(Nurse Signature)