

PRE-ADMISSION FORM

Doctor's Information

Name of Dr: Practice No:
Diagnosis: ICD Code:
Procedure:
Date of Procedure:

Please FAX or E-MAIL 48 hours prior to admission

Please complete - Full details of patient

Surname: Full names:
Sex: Male Female Date of birth:
Preferred language: English Afrikaans Dependant code:
ID No: Cell No:

Person responsible for account (Main member of Medical Aid)

Medical Fund: Option:
Title: Mr Mrs Ms Child Dr Prof Member No:
ID of Main member: Authorization No:
Main member's surname: Initials:
Postal address: Physical address:
Code: Code: Email:
Tel: (H) Cell:

Employer's Detail (Main member/Person responsible for account)

Company name: Tel No: (W)
Postal address of employer: Occupation:
Postal Code:

Person to contact in case of emergency/Next of kin

(Different address and tel)

Surname: Initials: Title:
Tel No: (W) Tel: (H) Cell:
Relationship to patient:

Main member / Person responsible for account

I, (Full names) give Cure Somerset West Day Clinic the authority
to claim/submit the account(s) on my behalf to (Medical Aid),
Member No:
Date:

Signature

I hereby confirm all details supplied on this form are correct.

PREOPERATIVE SCREENING CHECKLIST

Patient (full names and surname):

Date of birth: Height Weight BMI
(For office use)

Contact telephone number:

Operation: Surgeon:

Date of surgery:

QUESTIONNAIRE

Kindly tick the relevant box or provide us with the necessary information:

Do you have Medical aid/insurance? If not, how will you pay for the procedure?	<input type="checkbox"/> Y <input type="checkbox"/> N	Can you sleep flat at night?	<input type="checkbox"/> Y <input type="checkbox"/> N
If you are on a Medical aid, did you check with your scheme whether a co-payment applies?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have lung problems (asthma, emphysema, bronchitis, chronic coughing)?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you aware you need to call if there is any reason you can't come on the day of the surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you suffer from the following: heavy snoring, choking, gasping or stop breathing while asleep?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have someone to drive you home after your surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have a current infection (cold, skin infection, urinary tract infection, other)?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you aware that you shouldn't eat or drink anything on the day of your surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you get heartburn/reflux?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any allergies to medication/food/latex/plaster/other? Please provide details of your allergies:	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have a stomach or peptic ulcer?	<input type="checkbox"/> Y <input type="checkbox"/> N
Will you be walking into the hospital? If not, how will you enter the building?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you suffer from diabetes or thyroid problems?	<input type="checkbox"/> Y <input type="checkbox"/> N
What previous operations have you had?		Do you suffer from liver problems, jaundice / hepatitis? If past, when?	<input type="checkbox"/> Y <input type="checkbox"/> N
What problems have you experienced with previous anaesthesia?		Do you suffer from kidney or bladder problems?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you experienced/suffered from the following: porphyria, malignant hyperthermia, scoline apnoe?	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had problems with blood clots or embolisms in your lungs or legs?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you able to do fast walking, climb a flight of stairs or do moderate house work?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have prolonged bleeding after an injury?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have any heart problems (chest pain, heart attack, irregular heartbeat, heart failure)?	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you taken aspirin, arthritis medicine, warfarin or other blood thinners in the last week?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have problems with high / low blood pressure?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you suffer from epileptic convulsions or blackouts of any sort?	<input type="checkbox"/> Y <input type="checkbox"/> N
		Do you suffer from muscle weakness or a stroke?	<input type="checkbox"/> Y <input type="checkbox"/> N
		Are you pregnant or currently breast feeding?	<input type="checkbox"/> Y <input type="checkbox"/> N
		Do you have false, loose, or crowned teeth? If so, where?	<input type="checkbox"/> Y <input type="checkbox"/> N
		Are you a smoker? If so, how many per day?	<input type="checkbox"/> Y <input type="checkbox"/> N

CURRENT MEDICATION HISTORY (list all that apply, including herbal supplements and over-the-counter medication)

MEDICATION	DOSE	COMMENTS