Canterbury
District Health Board
Te Poari Hauora ō Waitaha
Medical Surgical Division

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Highlighted sections are for staff reference

Patient Admission Questionnaire

PATIENT ASSESSMENT QUESTIONNAIRE

C2400 9B

INTERPRETER

Yes ☐ No Do you require an interpreter? What is your preferred language?

CONFIDENTIALITY

Yes ☐ No Is there any immediate family/whānau/ support group you **do not want to share your personal information** with for this admission?

Names: _____

☐ Yes **No** Do you agree for your name to be placed on identification boards?

PERSONAL PROPERTY

You are advised to leave money, jewellery or other items of value at home as the District Health Board can not be responsible for or accept liability for items brought into the hospital.

Yes ☐ No Do you need any valuables kept in storage before they are collected/taken home?

IDENTITY

☐ Yes **No** Is the information on the above label correct?.....

☐ Yes **No** Is the information on your name bracelet correct?.....

What name would you like to be called by? .....

The following information is helpful for us to plan your care appropriately. Please fill in this questionnaire yourself or you are welcome to get assistance from your family/whānau/support person. You are not obligated to complete all or any of the sections but any information you provide us with will be of assistance.

Yes ☐ No If you have recently completed this form on a previous visit, has anything changed? If there are changes please complete this form

ALLERGIES/REACTIONS

Yes ☐ No Do you have any allergies or reactions to any food, medication or anything else?

_____

COMMUNICATION

Yes ☐ No Do you have any of the following:

☐ difficulty forming words ☐ difficulty understanding written/spoken language

☐ difficulty remembering things ☐ difficulty finding words

When did these problems start? _____

Yes ☐ No Are there any other ways we can help with communication?

_____

Yes ☐ No Do you have any ☐ loss of sight ☐ hearing loss

Yes ☐ No Do you use ☐ glasses/contact lenses ☐ hearing aids ☐ dentures/dental plate

☐ Yes **No** Do you have these with you?

PAIN AND COMFORT

Yes ☐ No Do you currently have a wound/broken skin/rash? _____

Yes ☐ No Do you currently have any pain? Where is the pain? _____

Severity of the pain ☐ mild ☐ moderate ☐ severe

Type of Pain ☐ new ☐ long term

How long have you had the pain? ☐ hours ☐ days ☐ weeks ☐ months ☐ years

MEDISTOCK 153396

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Patient Admission Questionnaire

SMOKING/ALCOHOL/DRUGS

☐ **Yes** ☐ No If you currently smoke, would you like to quit?

☐ **Yes** ☐ No Do you drink alcohol?

☐ **Yes** ☐ No Do you use/take recreational drugs?

NUTRITION/SWALLOWING

☐ **Yes** ☐ No Are you on a special diet, thickened fluids/food or have any special dietary requirements?
If yes, please specify

☐ **Yes** ☐ No Do you use prescribed nutrition supplement drinks or are tube fed?

☐ **Yes** ☐ No Have you lost weight in the last 3 months without trying?
If yes, how much? _____

☐ **Yes** ☐ No Have you been eating poorly because of a poor appetite?

☐ **Yes** ☐ No Have you had any difficulties or recent changes with (please tick):
☐ chewing food ☐ swallowing food ☐ swallowing liquids
If yes, when did the swallowing problems start? _____

☐ **Yes** ☐ No Do you experience frequent coughing or choking episodes when you eat or drink?

☐ **Yes** ☐ No Do you have a history of unexplained chest infections?

☐ **Yes** ☐ No Have you had any dental work completed within the last month?
If yes, please comment: _____

☐ **Yes** ☐ No Do you have any problems with your mouth or teeth?
If yes, please comment: _____

☐ **Yes** ☐ No Do you require assistance with eating? (please tell us what would help)
_____

LIVING ARRANGEMENTS

Do you live in: ☐ your own home ☐ rental home ☐ council unit ☐ hospital
☐ housing NZ unit ☐ with parents/guardian ☐ motor home ☐ rest home/unit
☐ other: _____

☐ **Yes** ☐ No Have you any problems that will come from being in hospital e.g. financial, domestic?
Please specify _____

☐ **Yes** ☐ No Do you have any family, pets, etc. who rely on you being at home?

☐ Yes ☐ **No** Have arrangements been made for their care while you are in hospital?

☐ Yes ☐ **No** Does anyone know that you are in hospital?

☐ **Yes** ☐ No Would you like us to tell anyone you are in hospital? (please provide name and contact details) _____

☐ **Yes** ☐ No Other than your own GP, are you currently seeing any other health professional or using any support services to assist you at home?
☐ personal care ☐ meals on wheels ☐ palliative care ☐ home help
☐ district nursing ☐ other: _____

☐ Yes ☐ **No** Are they aware you are in hospital?

☐ **Yes** ☐ No Are you happy for us to contact them to give us health information that will help us care for you and to let them know of your admission?

Patient Admission Questionnaire

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

☐ Yes ☐ No Do you have any hospital appointments scheduled in the next 2 weeks?

What appointments and where:_____

Where do you intend to go on discharge:

☐ own home ☐ alone ☐ with family/whānau ☐ other

SUPPORT/CULTURAL/LIFESTYLE

Which family/support person/whānau members would you like to help you during your stay?

Name: _____ Contact number: _____

Name: _____ Contact number: _____

☐ Yes ☐ No Do you have any specific cultural, wairua/spiritual lifestyle practices you would like to continue while in hospital? (Please specify)

_____

☐ Yes ☐ No Would you like a Healthcare Chaplain to visit you while in hospital?

Would you like to see a ☐ Māori Chaplain ☐ Kaumatua ☐ Māori Health Worker?

☐ Yes ☐ No Do you have a disability? What is this? _____

☐ Yes ☐ No Do you use a Health Passport?

What ways can we help with this during the time you are in hospital?

_____

ACTIVITIES OF DAILY LIVING

☐ Yes ☐ No Have you had a recent fall/slip/trip/stumble in the past 6 months?

At home, do you usually need help/use equipment with?

☐ moving in bed ☐ dressing ☐ feeding ☐ toileting ☐ showering ☐ walking

What help do you need including what equipment you currently use e.g stick/frame:

_____

☐ Yes ☐ No Has this changed with this admission?

MEDICATION/THERAPIES

☐ Yes ☐ No Do you take any of the following medications: (If no, go to the next section)

☐ over the counter ☐ natural therapies ☐ supplements ☐ prescribed

☐ Yes ☐ No Did you bring your medications into hospital?

☐ seven day tray ☐ blister pack ☐ controlled/recorded medication e.g. codeine

☐ Yes ☐ No Have you experienced any problems with your medications? Please specify

_____

☐ Yes ☐ No If you have a yellow card, did you bring it into hospital?

☐ Yes ☐ No Has there been any change to your medications since your yellow card was written?

URINARY/BOWEL

☐ Yes ☐ No Are you having any problems with? (please tick) ☐ urinary incontinence

☐ bowel incontinence ☐ urgency ☐ needing to go to the toilet at night

☐ Yes ☐ No Do you wear pads?

☐ Yes ☐ No Do you have an ostomy / stoma?

☐ Yes ☐ No Do you suffer from constipation? If no, go to next section

Is this ☐ a short term problem or ☐ a long standing problem

When did you last have a bowel motion? _____

How do you manage your constipation?

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Patient Admission Questionnaire

SLEEP/WELLBEING

☐ **Yes** ☐ No Do you have trouble sleeping? (describe any difficulties and how you manage it)

_____

☐ **Yes** ☐ No Do you have any concerns about your mental wellbeing? (describe below)

_____

In the past 4 weeks about how often did you feel…. (please circle the number under the heading that applies)	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Tired out for no good reason?	1	2	3	4	5
Nervous?	1	2	3	4	5
So nervous that nothing could calm you down?	1	2	3	4	5
Hopeless?	1	2	3	4	5
Restless or fidgety?	1	2	3	4	5
So restless you could not sit still?	1	2	3	4	5
Depressed?	1	2	3	4	5
That everything was an effort?	1	2	3	4	5
So sad that nothing would cheer you up?	1	2	3	4	5
Worthless?	1	2	3	4	5
(Add up all circled numbers) **Total Kessler score:**					

ADVANCE DIRECTIVES/RESUSCITATION STATUS/LIVING WILL

☐ **Yes** ☐ No Do you have an Enduring Power of Attorney (EPOA)?

Name of EPOA: _____

☐ Yes ☐ **No** Do you have a copy of this document with you?

☐ **Yes** ☐ No Do you have any current Advance Directives/Resuscitation status/Living Will?

☐ Yes ☐ **No** If yes, is your Family/Enduring Power of Attorney (EPOA) aware of this?

☐ **Yes** ☐ No Do you wish to discuss your advance directive/resuscitation status/living will with your family/EPOA?

Thank you for giving us this information

If there is anything else you wish to tell us or feel is important, please use the space below

_____

Form completed by

☐ Patient (please sign if able) _____

☐ Nurse/Hospital Aide/Hospital Volunteer – Name: _____ Designation: _____

☐ Support person/Whānau/Family member – Name: _____

Relationship to patient: _____ Contact No.: _____

☐ Patient declined or was unable to complete form/authorise/delegate completion

FOR STAFF USE ONLY

Please review the patient questionnaire and complete the risk assessment/action plan for further assessment/actions required to be taken for the highlighted sections within the questionnaire.

Staff member reviewing questionnaire

Name: _____ Signature: _____

Designation: _____ Date: _____