SOCIAL QUESTIONNAIRE

Your treatment may be carried out as a day care procedure. To find out if this would be suitable for you, please provide the following information:

		YES	NO
1.	Do you currently receive any help or have any difficult home circumstances that you will require help with?		
2.	Will you be able to be escorted home by a responsible adult (aged 18+) in a car or taxi? (Public transport is not acceptable)		
3.	Will you have access to a telephone at home day/night?		
4.	Will you have easy access to a toilet?		
5.	Will you have a responsible adult (aged 18+) at home to look after you for 24 hours after surgery?		
6.	How long will it take you to travel home? hours mins		

I confirm to the best of my knowledge the above information is correct.

Signature _____ **Date** _____

Please give the completed form to the Pre-Op Assessment staff before leaving the clinic

TO BE FILLED IN BY PRE-OP ASSESSMENT STAFF:

Patient's telephone numbers:

Daytime: Home: Mobile:

Patient available at short notice (ask patient): Yes ☐ No ☐

Patient agrees to pooled consultant admission: Yes ☐ No ☐

		Assessment:		**Action:**	
BP:	mmHg	Full Assessment today	☐	Info. Leaflets: Anaesthetic	☐
Weight:	Kg	Anaesthetic clinic	☐	Surgical	☐
Height:	m	GP referral	☐	Weight Loss	☐
BMI:	kg/m2	Routine Assessment	☐	Smoking	☐
		Telephone Assessment	☐	Social Circumstances	☐
		Assessment by:		Booking form copy to admissions	☐

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Addressograph

Surgical Booking Form & Health Screening Questionnaire

TO BE COMPLETED BY SURGEON:

Consultant surgeon: _____ Case listed by: _____ Date _____

Planned operation: _____

Priority: Urgent ☐ Routine ☐ Time Frame _____

OPCS Code _____

Estimated duration of surgery (excluding anaesthesia): _____

Not suitable for Registrar Yes ☐ No ☐ Pooled consultant list Yes ☐ No ☐

X-ray required in theatre: ☐

Special equipment/personnel needed: _____

Proposed anaesthetic: GA/regional ☐ Sedation ☐ LA ☐ Anaesthetist not required: ☐

Is patient on warfarin? Yes ☐ → Highest acceptable INR for surgery _____

Intended duration of stay: Daycase ☐ 23:59 ☐

Inpatient: Day of Surgery Admission (DOSA) ☐

Day before Surgery Admission (DBSA) ☐ Admit _____ days pre-op

Estimated length of stay _____ days

Critical care bed required? Yes ☐

Theatres: ☐ SSSU UHW ☐ Main theatres UHW

☐ Main theatres Llandough/CAVOC ☐ Day Case Unit Llandough

Specific instructions to be relayed to theatre: _____

Significant medical problems: _____

Other information: _____

HEALTH SCREENING QUESTIONNAIRE

This form must be filled in today before your operation can be booked.

Have you ever suffered from any of the following? (If yes, please give details)

	YES	NO	DETAILS
Angina or chest pain:			
If YES, does this happen when you:			
Exercise or hurry?			
Climb one flight of stairs at normal pace?			
Walk 100-200 yards on level ground at normal pace?			
Does it disappear on resting?			
Does it ever happen when you are at rest?			
Do you get chest pain (angina) more than once per week?			
Do you get chest pain (angina) on most days?			
High blood pressure:			
Heart attack:			When?
Heart murmur:			
Heart failure or fluid in your lungs:			
Breathlessness on lying flat in bed:			
Woken at night with extreme breathlessness:			
Blood clots in the lungs or legs:			
Stroke or TIA (mini-stroke) :			
Palpitations or an irregular heart beat:			
Blackouts/faints:			
Diabetes:			
Asthma:			
Bronchitis/Emphysema:			
Sleep apnoea:			
Severe bleeding or bruising problems:			
Anaemia or other blood disorder:			
Convulsions or fits:			
Kidney or other urinary trouble:			
Jaundice / hepatitis or other liver disease:			
Heartburn or hiatus hernia:			
Thyroid disorder:			
Muscle disease or neurological disorder:			
Arthritis:			
Any other serious illness:			
Do you smoke? Now or previously:			
Do you drink alcohol? *(1 unit = 1 glass wine or 1/2 pint beer)*			Please state units per week:
If female, could you be pregnant?			
Are your parents of Afro Caribbean or Eastern Mediterranean origin? If YES, have you or any of your family had sickle cell disease?			
Do you have particular cultural or religious needs?			

What exercise are you able to do?

	YES	NO
Can you walk indoors around the house		
Walk 100 – 200 yards on level ground slowly		
Do light housework like dusting or washing dishes		
Climb a flight of stairs or walk up a hill		
Walk on level ground at a brisk pace		
Do heavy housework like scrubbing floors or moving furniture		
Moderate exercise like play golf or tennis or go dancing		

If NO to any of the above, are you limited by:

	YES	NO
Arthritis?		
Breathlessness?		
Angina or chest pain?		

Do you have any allergies or intolerances to drugs? Please give details.

What medications or drugs are you currently taking?

Have you had any previous operations or admissions to hospital? Please give details.

Have you or your family had any anaesthetic problems? Please give details.

Do you understand what operation you are coming in for? **YES** ☐ **NO** ☐