Health New Zealand
Te Whatu Ora
Lakes

Affix Patient Label Here

PAEDIATRIC PREOPERATIVE HEALTH QUESTIONNAIRE

(For patients aged 15 years or younger. Age 16 years and above, complete the Adult Preoperative Health Questionnaire)

BOOK ONE

Please complete pages 2 – 6

Date record commenced:	Date Fit for Surgery:	Planned Admission Date:	Ht.	Wt.	BMI

Proposed Operation:

MDRO Admission Screening			
Overseas hospital admission in last 2 years? Isolate and notify IP&C Extn 8746	N	Y	**Screen for MRSA/ESBL/VRE**
Direct transfer from another Hospital or Admission in another Hospital in the last 12 months? *Do not isolate*	N	Y	**Screen for MRSA**
Renal dialysis or oncology patient with other Hospital admission in the last 12 months?	N	Y	**Screen for MRSA/ESBL**
Has your child been a patient at Waikato Hospital since 1 October 2022?	N	Y	**Screen for VRE**

Anaesthetic Registrar Case (If no, document reason) — Y ☐ N ☐

MRSA Swabs: Nasal Perineum Wound

ESBL/VRE Swab: Rectal or Stool Sample

DATE: _____/_____/_____ Result: Positive/Negative

ALLERGIES:	NO
Drug	**Reaction**

RED FLAG Sent on: **Sent by:**

ICU / HDU Form and Email sent on:

Instructions to Booking Administrator:

1 ☑
2 ☐
3 ☐
4 ☐

Southern Cross Hospital Y / N
Taupo Hospital Y / N *(for Dental only)*
Stand down for ☐ weeks Research Patient ☐

Admission Requirements:

Please return pack to clinic to arrange:
☐ Red Flag ☐ HDU/ICU bed ☐ Others
☐ SW referral *(Complete SW referral form)*

Upload info onto Theatre List:

Fast Tracked Y ☐ N ☐	Phone Fast Tracked Y ☐ N ☐	CNS Assessment ☐
Short notice ok Y ☐ N ☐	How much notification required? Days…….. Weeks……	

SECTION ONE -PATIENT HEALTH QUESTIONNAIRE

Please answer these questions carefully. Questions to be answered are in regard to the person undergoing the operation and NOT the person completing the form.

Please answer the questions by ticking the appropriate box √

1. Has your child **been in hospital** for any health problems including previous surgery? Please describe:

……
……
……
……..

2. **Has your child ever had:**	**No**	**Yes**	
Heart murmur			When?
Congenital heart condition			What?
Rheumatic fever			When?
Heart or lung surgery			What?
Blackouts or fainting			When?
Any other heart conditions			What type?
Frequent Chest Infections			When?
Croup			When?
Bronchiolitis			When?
Asthma			How often?
Has your child ever been hospitalised with asthma or breathing difficulties?			When?
Does your child use a puffer (e.g. Ventolin)?			How often?
Other lung, chest or breathing problems?			What type?
COVID			When?
Has your child needed steroids for breathing problems?			When was the last course?
Obstructive Sleep Apnoea - does your child snore loudly and holds his/her breath when sleeping?			How often?
Brain or spinal cord problems			What?
Cerebral Palsy			
Diabetes			Does your child use insulin? Yes ☐ No ☐
Epilepsy, seizures or fits			When was the last one?
Abnormal bleeding, bruising or bleeding disorder			What type?
Kidney or renal condition			What type?
Hepatitis or liver condition			What type?
Muscle disease or progressive weakness			What type?
Any other medical conditions/syndromes/ chromosome abnormalities not covered above? E.g. Down Syndrome, Pierre Robin, Goldenhar, Treacher Collins etc			What?

3. Does your child take any **regular medications.** Please list them below or attach a copy.
(e.g. tablets, pills, injections, puffers, health supplements).

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

	No	Yes	
4. Does your child have any **allergies?** (Especially to medicines, sticking plaster or food).			What did your child react to? What kind of reaction did your child have?
5. Was your child's birth premature?			How many weeks premature?
6. Was there any concerns with your child's health after birth?			If yes, please describe
7. Is your child is up to date with immunization?			
8. Has your child had **a general anaesthetic** before? Has your child ever had a **problem** with an anaesthetic? (e.g. a bad reaction)			If Yes, when? If Yes, what happened?
9. Have any family members related to this child had a **problem** with **a general anaesthetic** or a **spinal anaesthetic**?			What happened? How is your child related to this person?
10. Is there any condition that runs in the **family** (blood relatives)? (e.g. thalassemia, muscular dystrophy, bleeding disorders, malignant hyperthermia)			If yes, what?
11. Does your child have problems keeping up physically with children of a similar age?			
12. Does your child get reflux?			When?
13. Does any one in the household smoke?			
14. Does your child have any special communication needs e.g. hearing, sight, speech?			Please describe
15. How **tall** is your child? …….. metres			
16. How much does your child **weigh**? …….. kgs.			

IMPORTANT

To assist with consenting and maintaining a child's safety, please answer the following questions

16. Are you (the person completing the form) this child's legal guardian?
Usually a child's parents are the guardians. ☐ Yes ☐ No

If you have answered No, who is this child's legal guardian?

Name……

Contact phone number……..

Type of guardian (please tick the appropriate box)

Parent ☐	Court appointed Guardian ☐
Testamentary Guardian ☐	Guardianship of the Court ☐
Whangai ☐	Other ☐……

17. Is there any active custody, consent or protection orders involving this child? If yes, please indicate below:

…..……...

…..……..

18. Does this child have an Advanced Directive, My Advance Care Plan or any other personal documentation that the hospital needs to know about? If yes, please indicate below

……

…..……..

If you have answered no to question 16 or yes to the question 17 and 18, then please provide a copy of this documentation to the hospital prior to your next appointment.

19. Do you have any particular concerns or worries about this child's admission, operation or about their discharge home? Please describe below:

……..

……

20. Do you have any spiritual or cultural beliefs that we need to know about that may impact on this child's care? Please describe below:

……

……

SECTION TWO – PATIENT DEMOGRAPHIC INFORMATION

SURNAME: …… **HOSPITAL NHI NUMBER:** ……

FORENAME(S): ……
(Given or Christian Names)
Previous or other names used: ……

Title: Miss / Mr / Other ..... **Sex:** M ☐ F ☐ **Date of Birth:** ..... / ..... / …….

Family Doctor (GP): ……

What Kindergarten / School does this child attend: ……

Mother's full name at time of birth: ……

PATIENT CONTACT DETAILS

Permanent Residential Address ....
Street No. Street Name Town/City

Postal Address ....
(If different from above) Street No. Street Name Town/City

Phone: Home: (…..) ..... Mobile: ..... Work: (…..) .....

Email: ..... Fax: (…..) .....

Local Address (if on holiday) ....
Street No. Street Name Town/City

Country of Birth:	Place of Birth:

If born outside of New Zealand is this child a:

New Zealand Resident: Yes ☐ No ☐	New Zealand Citizen Yes ☐ No ☐

If Yes, please indicate residency document type:

☐ Passport (returning Res Visa/ Res Permit)	☐ Birth Certificate
☐ Student Permit	☐ Refugee Status

Please note you are required to provide a copy of your residency documentation for our records.

Ethnic Group:

☐ New Zealander	☐ NZ Maori	☐ Pacific Islander	☐ Samoan
☐ Cook Island Maori	☐ Tongan	☐ Niuean	☐ Tokelauan
☐ Fijian	☐ Indian	☐ Chinese	☐ South East Asian
☐ European	☐ Other – Print ethnic group here		

Spoken Language: ..... Interpreter Required: Yes ☐ No ☐

Religion: (optional) ……

NEXT OF KIN CONTACT DETAILS

First Contact Person	**Second Contact Person**
Name:	Name: .....
Relationship:	Relationship: .....
Parental Responsibility: Yes ☐ No ☐	Parental Responsibility: Yes ☐ No ☐
Address:	Address: .....
.....	.....
.....	.....
Ph Home: (….) ……	Ph Home: (….) ……
Work (….) ……	Work (….) ……
Mobile:	Mobile: .....

I give consent for Te Whatu Ora Lakes to access my child's health records from their General Practitioner and other Health Providers (e.g. other district health boards) to assist with planning their care.	N	Y

Declaration:

I declare that to the best of my knowledge I have given complete and accurate answers to the questions in this questionnaire.

Completed by: ☐ Parent ☐ Caregiver ☐ Other please specify ……..

Parent / Caregiver Signature: ……..……. Date: ……
(Please circle as appropriate)

Please Print Full Name: .....

Patient Label.

For completion by Preoperative Assessment Nurse

Patient suitable for fast track? ▪ ASA1 or ▪ ASA II –Asthma optimised ▪ 1 night or less in hospital	**YES** ☐ Please complete boxes below
	NO ☐ Please proceed to full assessment

**BASELINE OBSERVATIONS or Phone Fast Track. Spoke to ……...Relationship…..…….....				
BP	Pulse	Resp	SpO_2	Peak Flow

PRESENT MEDICATION (including herbal preparations)					
Drug	**Dose**	**Frequency**	**Drug**	**Dose**	**Frequency**

Previous GA? No ☐ Yes ☐ Any problems? No ☐ Yes ☐

Any FH of anaesthetic issue No ☐ Yes ☐ FH of MH No ☐ Yes ☐

Any recent chest infection, cough, colds, flu No ☐ Yes ☐

Please document any problems or FH:

Information / Pamphlets Given	**Planning for Discharge**	**Yes**	**No**
Fast Track Pack ☐ Given ☐ Posted ☐ Emailed	Discharge / Post Op Instructions Given		
Child Information ☐ Given ☐ Posted ☐ Emailed	Transport able to be arranged		
Aware parent / legal guardian to be present for consent ☐ Yes ☐ No	Meets conditions for day surgery		
Suitable to see anaesthetist DOS ☐ Yes ☐ No	Meets conditions for discharge		

Completed by:
Signature …… Date: ……

Name : *(Please print)* ……
Clinical Nurse Specialist – Preoperative Assessment Clinic

Patient Label

SEQUENCE OF EVENTS

Date	Action/ Outcome	By Whom