Hospital use only
Hospital number:..

Spire Healthcare

Assessing you for admission

The purpose of this assessment is to help us better understand you as an individual. Your wellbeing is our main concern and the information you give here will allow our nursing and paramedic teams to plan a programme of care that suits your needs. Please give us as much detail as possible.

Please tick all the relevant boxes.

Please fill in the form, sign the box at the end and return it to the hospital as soon as possible. If you can, please do this within three days of receiving the form. Thank you.

About you

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ **Surname:** ____________

Your first name: ____________ **Date of birth:** / /

By what name do you prefer to be known? ____________

While you are in hospital, would you prefer: to receive visitors at any time? ☐ **your visiting to be restricted?** ☐

Following your surgery would you like us to contact a partner, relative or friend? Yes ☐ No ☐

If Yes, please give their name and phone number. ____________

To monitor quality we may review your medical records - are you happy for this to take place? Yes ☐ No ☐

Your medical history

Have you ever had, or are you currently being treated for, any of the following?

Illness	Yes	Year	Tick (✓) if you are currently being treated for this illness
Heart attack	☐		
Chest pains (or angina)	☐		
Rheumatic fever	☐		
Heart murmurs	☐		
Pacemaker fitted	☐		
High blood pressure	☐		
Shortness of breath when you are resting	☐		
Pneumonia or bronchitis	☐		
Asthma	☐		
Tuberculosis (TB)	☐		
Pleurisy	☐		
Coughing up blood	☐		
Lung embolus (PE)	☐		
Nervous problems	☐		
Depression	☐		
Epilepsy	☐		
Migraine	☐		
Stroke (CVA) or mini strokes (TIA)	☐		
Sleep apnoea	☐		

Illness	Yes	Year	Tick (✓) if you are currently being treated for this illness
Frequent indigestion	☐		
Hiatus hernia	☐		
Stomach ulcer	☐		
Jaundice	☐		
Hepatitis (A, B or C)	☐		
HIV OR AIDS	☐		
Blood disorders such as sickle cell, leukaemia and so on	☐		
Serious bleeding or bruising	☐		
Leg thrombosis (DVT)	☐		
Kidney or urinary problems	☐		
Thyroid problems	☐		
Diabetes	☐		
Cancer	☐		
Back problems	☐		
Neck or jaw problems	☐		
Arthritis	☐		
MRSA (Meticillin-resistant staphylococcus aureus)	☐		
Eye or Ear conditions	☐		

Do you have or have you been treated for any other conditions/illnesses we have not listed above? Yes ☐ No ☐

If 'Yes', what?

Are you regularly taking any medications? Yes ☐ No ☐

If 'Yes', please list them in the box below. (include any herbal, homeopathic or shop-brought medication.)

Medicine	Dose (for example, 10mg)	Frequency (for example, once daily)	Date you first started taking it

Are you allergic to anything (medicines, foods, animals, plasters, latex and so on)? Yes ☐ No ☐

If 'Yes', what?

Have you ever been treated with steroids? Yes ☐ No ☐

If 'Yes', when did you stop taking them?

Have you ever been treated with anti-coagulants (drugs to thin the blood)? Yes ☐ No ☐

If 'Yes', when did you stop taking them?

Have you ever been notified that you are at risk of CJD for public health purposes? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ If 'Yes', how many each day?

Do you drink alcohol? Yes ☐ No ☐ If 'Yes', what, how much and how often?

Do you take recreational drugs? Yes ☐ No ☐ If 'Yes', what, how much and how often?

What is your current weight? What is your height?

Female patients only. Is there any possibility that you may be pregnant? Yes ☐ No ☐

The nurse will fill this in on the day of admission. Date of your last period: / /

Have you ever had any operations or hospital admissions in the past (at any age)? Yes ☐ No ☐

If 'Yes', please list them in the box below.

Operation or admission	Year	Name of hospital where it took place

Have you previously had a general or local anaesthetic? Yes ☐ No ☐

Have you, or any of your family, ever experienced problems following an anaesthetic? Yes ☐ No ☐

If 'Yes' what complications were there?

Have you had any x-rays or scans in the last six months? **Yes** ☐ **No** ☐

If 'Yes', please give details:

Your home situation

Please describe the accommodation in which you live (for example a house or flat, lift access, flights of stairs and so on).

You will need to leave your room in the morning on the day of your discharge. What arrangements have you made to be collected? (If you are booked as a day case, please also explain your arrangements for being collected).

When you go home, will there be an adult with you who can properly support you? **Yes** ☐ **No** ☐

If 'Yes', who will this be? If 'No', how will you make sure you are safe at home?

Do you have any social services support at home? **Yes** ☐ **No** ☐

If 'Yes', please give details:

Daily living assessment

It is important that we understand how you function on a day-to-day basis. Please fill in the white boxes, writing down any problems you have with each daily function. If you have no associated problems, please write 'None or 'No'. We have given some questions to help, but please write whatever is important to you.

A safe environment Do you have any adaptions to your home to support special needs? Are there any special precautions that you have to follow to make sure you are safe at home or when going out? Do you have a panic alarm at home?	*Patient* *Nurse*
Communication Do you have any problems with hearing, seeing or speaking? Do you use a hearing aid or read Braille? Do you have any difficulties associated with understanding others or with others understanding you?	*Patient* *Nurse*
Breathing Do you have any problems with your breathing? Do you get breathless while resting or doing very mild exercise? Do you use a cylinder or compressor oxygen at home or an inhaler regularly?	*Patient* *Nurse*
Eating and drinking Do you have any special dietary needs or need help to eat and drink properly? Do you have to prepare your food in a special way?	*Patient* *Nurse*

Using the toilet Do you have any problems going to the toilet? Please include problems of incontinence.	*Patient* *Nurse*
Cleaning and dressing Do you need any help in washing and dressing? Do you need any medical products associated with skin care?	*Patient* *Nurse*
Controlling body temperature Do you 'feel the cold' badly or have problems with the circulation in your hands or feet? Do you suffer with night sweats or experience uncomfortable 'flushes'?	*Patient* *Nurse*
Moving around Do you use any walking aids (such as a stick or frame)? Do you use a wheelchair, or are you unable to get in and out of bed on your own? Is the distance you can walk restricted in any way, maybe due to pain?	*Patient* *Nurse*
Working and playing What job do you do? How do you like to relax? If retired, how do you spend your time? Do you take part in any hobby, pastime or job that is physically demanding and may delay your recovery? Have you arranged an appropriate amount of time off work after your treatment?	*Patient* *Nurse*
Relationships Do you have a partner? Which other people are very important to you? Do you have any children? Do you have anyone who depends on you?	*Patient* *Nurse*
Sleeping Do you need any special routine to help you settle at night? Do you use a sleeping aid? Do you usually get up during the night or perhaps wake up very early? Do you have problems with snoring?	*Patient* *Nurse*
Fears and anxieties Do you have any specific worries, concerns, phobias or fears about coming into hospital? Do you have any significant phobias that it may be helpful for us to know about, such as crowded spaces?	*Patient* *Nurse*

Thank you for takin g the time to fill in this form. The contents will be very useful to the nursing team who will be caring for you. Please sign the 'Patient signature' section below.

Patient signature	**Nurse's signature:** ....
To be filled in by the assessment nurse **Clinical effectiveness:**	**Print name:** ....
Date:	**Date:** ....