

EAR, NOSE, THROAT AND MAXILLOFACIAL SURGERY

Admission and Assessment (Adult)

Source Hospital (tick) Monklands Hairmyres Law Strathclyde Stonehouse

NAME: ADDRESS: UNIT NUMBER: PHONE NUMBER: AGE:	Consultant: Admission Date: Time: Theatre Date: Time: Transport Required: Ordered: Named Nurse: Team: Reason Admitted:
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1.NEXT OF KIN: Relationship: Address: Phone Number:	2.NEXT OF KIN: Relationship: Address: Phone Number:	G.P. ADDRESS:
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ADMISSION DETAILS

DISCHARGE PLAN

Date of Discharge:

Discharged to:

SERVICES	ON ADMISSION	ON DISCHARGE	INITIAL & DATE
Transport			
District Nurse			
Social Worker			
McMillan Nurse			
Hospice			
Home Help			

OTHER DISCHARGE ARRANGEMENTS

	YES	NO	N/A	DETAILS	INITIAL & DATE
Discharge Prescription	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
District Nurse Letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Written Advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Discharge Letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

ANAESTHETIC MEDICAL HISTORY					
Diabetes	Yes*	No	Asthma	Yes*	No
Epilepsy	Yes*	No	Hypertension	Yes*	No
Bleeding Problems	Yes*	No	Angina	Yes*	No
Mallampti Class:					
Thyromental distance:					
Other:					
*Can you walk up two flights of stairs with no ill effects? Yes No					
Do you get out under your own steam at least twice a week? Yes No					
Previous Operations:					
Details of any previous anaesthetic complications:					

MEDICATION	
Present Medication:	
Allergies:	

LIFESTYLE			
Smoker	Yes	No	Details:
Alcohol	Yes	Nounits per week
Special Diet	Yes	No	please specify.....

SOCIAL HISTORY			
Married	<input type="checkbox"/>	Single	<input type="checkbox"/>
		Widow(er)	<input type="checkbox"/>
		Divorced	<input type="checkbox"/>
Religion	S.O.S	Yes No Date:
Employment (give details):			

FAMILY HISTORY					
Diabetes	Yes	No	Hypertension	Yes	No
T.B.	Yes	No	Asthma	Yes	No
Ischaemic Heart Disease Yes No					
Anaesthetic Complication Yes No					
Further Information:					

DISABILITIES / MOBILITY					
Arthritis	Yes	No	Muscle Disease / Weakness	Yes	No
Limited Mobility	Yes	No	Mobility Aid	Yes	No
Visual Impairment	Yes	No	Glasses / Contact Lenses	Yes	No
Hearing Impaired	Yes	No	Hearing Aid	Yes	No
Dentures	Yes	No	Caps / Crowns		
Restricted neck movements	Yes *	No	Loose Teeth		
Further Information:					

CARDIO -VASCULAR & RESPIRATORY					
Angina	Yes	No	Palpitations	Yes	No
Wheeze	Yes	No	Sputum	Yes	No
Anaemia	Yes	No	Claudication	Yes	No
Dyspnoea Yes No					
Cough Yes No					
Excessive Bleeding / Bruising Yes No					
Further Information:					

GASTRO - INTESTINAL					
Weight Loss	Yes	No	Weight Gain	Yes	No
Frequent Indigestion	Yes	No	Problems with Bowels	Yes	No
Hiatus Hernia	Yes*	No	Abdominal Pain Yes No		
Blood PR Yes No					
Further Information:					

RENAL & GENITO - URINARY

Pregnant Yes No LMP (date)
Haematuria Yes No Previous kidney surgery Yes No

Further Information:

CENTRAL NERVOUS SYSTEM

Visual Disturbances Yes No Headaches Yes No Vertigo Yes No
Seizures Yes* No TIA Yes No Glaucoma Yes* No

Further Information:

Pulse: Blood Pressure: Weight: kg
Temp.: Respirations:
Height: Waterlow Score: BMI
Skin Condition:
Urinalysis:

Signature: Designation: Date: Time:
Name: (printed)

This Section To Be Completed By Medical Staff Only

HISTORY OF PRESENTING COMPLAINT :

Empty box for History of Presenting Complaint.

This Section To Be Completed By Medical Staff Only

ON EXAMINATION :

Lined area for On Examination notes.

This Section To Be Completed By Medical Staff Only

CONTINUATION SHEET

Continuation sheet with multiple horizontal lines for text entry.

INITIAL MANAGEMENT PLAN

IMPRESSION

Differential Diagnosis:

Management Plan:

Signature: Designation: Date: Time: (Doctor)

Name: (print)

This Section To Be Completed By Any Team Member

INITIAL INVESTIGATIONS

- List of medical investigations with checkboxes: FBC, Full Screen, Group & Save, X-match, Mono Spot, Coagulation Screen, Bleeding Times, U&E, LFT, Blood Glucose, BM (Ward), Audiogram, Tymp, CXR, OPG, OM Views, Sinus View, Mastoid, Soft Tissue Neck, ECG.

Other Investigations:

REFERRAL

- List of referral types with checkboxes: Anaesthetist, Occupational Therapist, Speech Therapist, Physiotherapist, Dietitian, Specialist Nurse (specify).

Other Referrals:

OTHER COMMENTS

Signature: Designation: Date: Time:

Name: (printed)

OPERATIONS

CONSENT BY PATIENT

MONKLANDS HOSPITAL

I of

hereby consent to undergo the operation of

the nature and purpose of which have been explained to me by Dr/Mr

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a general, local or other anaesthetic for any of these purposes.

*No assurance has been given to me that the operation will be performed by any particular surgeon.

Date (Signed)
(Patient)

I confirm that I have explained to the patient the nature and purpose of this operation.

Date (Signed)
(Medical Practitioner)

MONKLANDS HOSPITAL TRUST / THEATRE PRE-OP CHECK

Ward Check Yes-No	Recovery Check Yes-No	Theatre Check Yes-No
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ID Band Correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent Form Correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last time ate/drank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-med noted on Anaes, sheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Site marked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(specify):

Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Capped, crowns, slack teeth etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(specify):

Time last passed urine/catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Underwear present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jewellery present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make up/Nailpolish present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kirby grips/clasps present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anything artificial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(specify):

Items used to Theatre with Patient

Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foam troughs/A frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV infusion pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charts and X-rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug prescription & Admission Kardexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel prep.	<input type="checkbox"/>	<input type="checkbox"/>	

DVY prophylaxis

(specify):

Additional Info:

Ward	Room No.	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Name
Address

Age
Hospital

Proposed Operation

Pre-operative

Blood Pressure
Pulse
Weight (Kg)
Temperature
Bm

Ward Check by:

Name and Grade

Recovery Check by:

Name and Grade

Theatre Check

Name and Grade

Correct patient handed over to theatre

Recovery Nurse

Name and Grade

Theatre Nurse

Name and Grade

