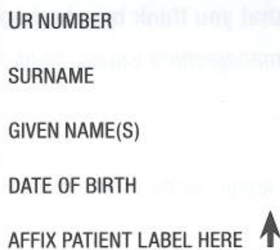
FRC027700

The **Royal Children's Hospital** Melbourne

Health Questionnaire MR645/A



UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

PLEASE COMPLETE THIS FORM AND RETURN TO RCH PRIOR TO YOUR CHILD'S ADMISSION DATE.

Thankyou for assisting us to provide the best possible care for your child.

Please answer ALL questions as accurately as possible and tick ✔ where necessary

Date of admission ____ / ____ / ____

1. Do you need an interpreter? ☐ Yes ☐ No Please specify which language ____________

2. Reason for surgery or admission to hospital ____________

____

____

____

3. Has your child been in hospital before? ☐ Yes ☐ No

If yes, please give details of the most **recent** or **important** admissions ____________

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4. Does your child have a chronic illness, special needs or disability? ☐ Yes ☐ No

☐ Breathing problems	☐ Fits or Epilepsy	☐ Diabetes
☐ Blood disorder (ie. bleeding/clotting disorders)	☐ Intellectual disability/learning difficulties	☐ Eczema
		☐ Pressure areas
☐ Behavioral issues	☐ Premature ______ weeks	☐ Acne
☐ Physical disability (or limitations)	☐ Heart Problems	

If yes, please provide details ____________

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5. If your child has a cardiac condition and if they are over 18 months of age, have they been to the dentist in the past six months? ☐ Yes ☐ No

If the procedure is cardiac surgery or cardiac catheter, has the dentist completed the Dental Health Checklist and any necessary dental work? ☐ Yes ☐ No

6. Is there a history of bleeding or clotting disorders in:

your child ☐ Yes ☐ No

your family ☐ Yes ☐ No

If yes, please provide details ____________

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7. Does your child have any allergies or reactions to medications, latex, foods, colourings, chlohexidine, tapes etc?

☐ Yes ☐ No

If yes, please give details ______

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8. Do you know of any problems with anaesthetics in the past for

(e.g. airway problem, fever, malignant hyperthermia, succinylcholine apnoea)

your child ☐ Yes ☐ No

other family members ☐ Yes ☐ No

If yes, please give details ______

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9. Does your child have a

Permanent pacemaker ☐ Yes ☐ No

ICD (implantable defibrillator) ☐ Yes ☐ No

Vagal nerve stimulator ☐ Yes ☐ No

Cochlear implant ☐ Yes ☐ No

Baclofen pump ☐ Yes ☐ No

other implants ☐ Yes ☐ No

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10. Please provide details of your child's current medications

Please include all herbal/vitamin and complimentary health medicines: If you require more space, please attach an additional page.

Medication	Dose	How often

11. Is your child taking Clopidogrel, Aspirin, Warfarin (Coumadin) or any other blood-thinning medication? ☐ Yes ☐ No

Have you been given instructions about stopping them before the surgery or procedure? ☐ Yes ☐ No

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12. Is your child using:

Special formula / added calories ☐ Yes ☐ No **If yes**, please give details ______

Special diet ☐ Yes ☐ No **If yes**, please give details ______

Feeding equipment eg milk pump ☐ Yes ☐ No **If yes**, please give details ______

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13. Does your child cope well with procedures and tests (e.g. echo-ultrasound of the heart, blood test)? ☐ Yes ☐ No

If they weren't cooperative did they require sedation? ☐ Yes ☐ No

If yes, please give details ______

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14. Has your child used any of the following resources before? Please name therapist if known.

☐ Play therapy

☐ Occupation therapy

☐ Physiotherapy ______

☐ Social work ______

☐ Other ______

15. Is there any other information that you think may be important for us to know about your child before their admission?

(e.g. past hospital experiences, pain management issues, needle phobic, etc.) ☐ Yes ☐ No

If yes, please provide details

* Please note: your child may bring a small comfort item to help them cope with the day

Caring for your child during and after their admission (mobility status)

16. Are you currently receiving any services to help care for your child? ☐ Yes ☐ No

(eg. respite, personal care, case manager, TAC services, school or home physiotherapy and/or occupational therapy etc.)

If yes, please give details

17. Do you have any concerns with transporting your child to and from hospital? ☐ Yes ☐ No

If yes, please give details

18. Who will be at home to help care for your child after leaving hospital?

19. Do you have any concerns about caring for your child after they leave hospital (particularly if their mobility changes)?

☐ Yes ☐ No

Consider getting into your home, bathroom, car and activities such as bathing, toileting, lifting etc.

If yes, please explain likely problems that you may have.

If you would like information on accommodation please call Ronald McDonald House on (03) 9345 6300 or the hospital social work department on (03) 9345 6111.

20. Do you wish to have a pre-admission visit to the hospital? ☐ Yes ☐ No

This is an opportunity for you and your child to be shown around the hospital, where they will go, whom they will meet and the stay in hospital discussed using age appropriate education. (This may be of benefit if you and/or your child are particularly anxious or worried about coming into hospital).

Completed by

Relationship to child

Date / /

Telephone Work

Home

Mobile

Thank you for completing this questionnaire

This information will be used by your child's nurse, anaesthetist, doctor and allied health staff and will become a part of their confidential hospital file. If you have any queries about this form, please call the Pre Admission Coordinator on (03) 9345 4115.

Visit the following RCH websites for further information

- RCH Parent Factsheets

  Click on the letter you are interested in, for factsheets in relation to your child's admission, e.g., preparing your child for hospital and RCH operating and recovery room.

  www.rch.org.au/kidsinfo/factsheets.cfm

- RCH Departments you may be interested in

  www.rch.org.au/cardiology
  www.rch.org.au/plastic
  www.rch.org.au/preadmission
  www.rch.org.au/daycentre
  www.rch.org.au/anaes

- Educational Play Therapy

  This program helps children cope with their hospital experience by providing play, preparation for medical and surgical procedures and support during procedures.

  www.rch.org.au/ept

- Comfort kids program

  This program offers advice about reducing children's discomfort, anxiety and pain during test and procedures.

  www.rch.org.au/comfortkids

- Privacy Brochure

  This brochure explains how RCH protects patient privacy by keeping personal information secure from unauthorised access use or loss.

  http://www.rch.org.au/emplibrary/rchhis/RCH_privacy_brochure.pdf.

For hospital use only

Pre-admission staff comments ______________________________

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Referral to pre-admission clinic required or requested by parent/carer ☐ Yes ☐ No

Referral to health care professionals required ☐ Yes ☐ No

☐ Anaesthetist	Date sent / /	☐ HACC	Date sent / /
☐ Physiotherapy	Date sent / /	☐ Education Institute	Date sent / /
☐ Social Work	Date sent / /	☐ Pain Management	Date sent / /
☐ Occupational Therapy	Date sent / /	☐ Other	Date sent / /
☐ Play Therapy	Date sent / /	☐ Other	Date sent / /

Staff name ______________________ Signed ______________________

Date Completed / /