wakefield
ANAESTHETIC GROUP

ANAESTHETIC PATIENT HEALTH QUESTIONNAIRE

This form is for *Wakefield Anaesthetic Group* patients only.

This is a **Fillable Form** (PDF). Please follow the steps below:

1. Please save this form to your PC or other device.
2. Complete all blank spaces on the form.
3. Save the document.
4. Email the document back to phq@wagsa.com.au

Please note: If you are on a mobile/tablet you may need to download a PDF app.

If you cannot complete the form digitally, please print, fill-in and email or post it back to us:

- phq@wagsa.com.au

- Wakefield Anaesthetic Group
  243 Wakefield Street
  Adelaide SA 5000

wakefield ANAESTHETIC GROUP

FANZCA Fellow of the Australian and New Zealand College of Anaesthetists

243 WAKEFIELD STREET | ADELAIDE SA 5000
T: (08) 8232 5755 | F : (08) 8232 5715
E: phq@wagsa.com.au | W:www.wagsa.com.au
Facebook: Wakefield Anaesthetic Group
ABN: 60 584 504 675

ANAESTHETIC PATIENT HEALTH QUESTIONNAIRE

PATIENT DETAILS			
Name:			
Name on Medicare Card:		Date of Birth:	
Address:		Suburb:	Postcode:
Home Ph:	Mobile:	Work Ph:	
Email:		Height:	Weight (kg):
Next of Kin/Guardian Name:		Next of Kin/Guardian Ph:	
☐ I consent to being emailed information regarding my procedure involving medically-related & accounts-related matters.			

PROCEDURE DETAILS	
Anaesthetist:	Date of Surgery:
Surgeon:	Hospital:
Procedure:	

HEALTH INSURANCE DETAILS	WORKCOVER OR THIRD PARTY DETAILS
Do you have hospital cover? ☐ Yes ☐ No ☐ Full ☐ Extras	Employer Name:
Health Fund:	Address:
Membership No:	Postcode:
Medicare No:	Telephone:
Centrelink Concession Card No:	Claim Number:
☐ Full Pension ☐ Part Pension ☐ Senior's Card	WorkCover Insurer:
Dept of Vet Affairs Card No:	Claims Rep Name:
☐ DVA Gold ☐ DVA White ☐ DVA Other	Claims Rep Phone No:

ALTERNATIVE CONTACT	
Do you authorise us to liaise with another person on your behalf? ☐ Yes ☐ No	
If yes, please advise the following	Name:
	Relationship:
	Phone No:

ALLERGIES/SENSITIVITIES | List all drugs, food, etc & describe your reactions to same

MEDICATIONS | Please include name, dose & frequency		
NAME	**DOSE**	**FREQUENCY**
Have you taken Aspirin, Warfarin, Clopidogrel or other blood thinners in the last 7 days? ☐ Yes ☐ No		

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COVID-19	
Have you had COVID-19 in the last 4 weeks? ☐ Yes ☐ No	If so, what date did you test positive?

***** Please call us ASAP on 8232 5755 if you contract Covid-19 within 4 weeks prior to your surgery date. *****

PATIENTS PLEASE NOTE: ANZCA (the Australian and New Zealand College of Anaesthetists) guidelines state that, unless it is an emergency, anaesthetics should not be administered to anyone who has been Covid positive / had Covid symptoms within 4 weeks of their operation date. This is because the incidence of intraoperative and postoperative complications increases, including respiratory problems, cognitive problems and blood clots.

TREATING GP	SPECIALIST (inc Cardiologist, Respiratory, etc)
Name:	Name:
Practice Name:	Specialty:
Phone No:	Phone No:
Do you consent to us contacting your health care provider(s) in relation to your procedure? ☐ Yes ☐ No	

PREVIOUS OPERATIONS

List any previous operations including dates and locations:

Date	Procedure	Hospital	Doctor

Have any of your relatives had problems with Anaesthesia? ☐ Yes ☐ No ☐ Don't know

DETAILS OF CONCERNS WITH PREVIOUS ANAESTHETIC	
Date of Previous Procedure:	Hospital:
Surgeon:	Anaesthetist:
Reaction/Concern:	

DO YOU (OR HAVE YOU EVER) SUFFERED FROM:					
Heart Problems (eg, palpitations, fainting, etc)	Y ☐	N ☐	Blood clots or pulmonary embolism	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐	Unusual, excessive bleeding or bruising	Y ☐	N ☐
Breathing/respiratory difficulties	Y ☐	N ☐	Heartburn, gastric reflux, hiatus hernia	Y ☐	N ☐
Obstructive Sleep Apnoea	Y ☐	N ☐	Do you have any caps or crowns	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Do you have loose or broken teeth	Y ☐	N ☐
Kidney Disease	Y ☐	N ☐	Neck or jaw stiffness	Y ☐	N ☐
A gastric band or bypass surgery	Y ☐	N ☐	Do you smoke/vape?	Y ☐	N ☐
Epilepsy, seizures or convulsions	Y ☐	N ☐	If yes, how many per day:		
Mental health/Psychiatric illness	Y ☐	N ☐	Do you drink alcohol?	Y ☐	N ☐
Contact with infectious disease (eg, Hepatitis, HIV or AIDS)	Y ☐	N ☐	If yes, how much:		
			Females – Are you pregnant? Maybe ☐	Y ☐	N ☐

If you have answered yes to any of the above questions, please provide further details:
Could you climb 2 flights of stairs without stopping? ☐ Yes ☐ No
Any additional information/medical conditions or health issues your doctor should be aware of? :

CONSENT

I have read and accepted Wakefield Anaesthetic Group's Privacy Policy. I consent to receiving anaesthesia for this procedure. I understand I am financially responsible for payment of any fees not covered by my health fund and Medicare, or other third party, including for any pre-operative consultations prior to the day of surgery.

Name:	Signed:	Date: