



(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐ M ☐ F ☐ Other

Please read this form carefully and complete for any conditions you **have currently** or **have had in the past**. Use the space provided for any further information.

Patient History to be reviewed at each admission, if no changes record the date and admission number in this section. If changes identified complete a new MR60

Date:							
Changes identified?	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Admission No.:							
Initials / Role:							
Date:							
Changes identified?	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Admission No.:							
Initials / Role:							

MEDICATION

Medicines taken Prior to Presentation to Hospital (Prescribed, Over the Counter, Complementary)

Administration Aid (Specify): _____ **Own medicines brought in?** ☐ Yes ☐ No

GP: Community Pharmacy:.....

Medicines usually administered by:

[illegible]

Documented by:

Sign:

Date:



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SURGICAL HISTORY

Operations (please list any major operations you have had in the past)

Year

STAFF ONLY

Anaesthetic

Yes

No

STAFF ONLY

Have you had anaesthetic?

☐ General ☐ Sedation ☐ Local ☐ Epidural/Spinal

Problems following surgery?

Problem: _____

Advise Anaesthetist

Cancer

Specialist/s: _____

Yes

No

STAFF ONLY

Cancer

Body Site: _____

Cancer treatment

☐ Chemotherapy ☐ XRT ☐ Methotrexate

Last treatment:

Family history of cancer

Family Member: _____

Body Site: _____

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Respiratory	Specialist/s: Dr	Yes	No	STAFF ONLY
Bronchitis		<input type="checkbox"/>	<input type="checkbox"/>	Record on Medication Chart
Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>	
Asthma		<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema		<input type="checkbox"/>	<input type="checkbox"/>	
COPD		<input type="checkbox"/>	<input type="checkbox"/>	
Acute respiratory infection		<input type="checkbox"/>	<input type="checkbox"/>	
Treatment: <input type="checkbox"/> Home Oxygen <input type="checkbox"/> Nebuliser <input type="checkbox"/> Puffer		<input type="checkbox"/>	<input type="checkbox"/>	
Neurology	Specialist/s: Dr	Yes	No	STAFF ONLY
Stroke/TIA	Date: ____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>	Falls Assessment Pressure Injury assessment Consider Discharge Planner
Multiple Sclerosis	Date: ____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>	
Residual Deficits:		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Speech <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Incontinence				
<input type="checkbox"/> Other (Specify): _____				
Residual weakness/Body Site: _____				
Epilepsy		<input type="checkbox"/>	<input type="checkbox"/>	
Last Episode: _____				
Parkinson's Disease		<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any paralysis		<input type="checkbox"/>	<input type="checkbox"/>	
Body site affected: _____				
Difficulty walking/unsteady on feet		<input type="checkbox"/>	<input type="checkbox"/>	Falls Assessment Pressure Injury assessment Consider Discharge Planner
Specify: _____				
Fall or falls within last 6 months		<input type="checkbox"/>	<input type="checkbox"/>	
Where: _____				
When: _____				Falls Assessment Pressure Injury assessment Consider Discharge Planner
Injury: _____				
Are you afraid of falling?		<input type="checkbox"/>	<input type="checkbox"/>	Falls Assessment Pressure Injury assessment Consider Discharge Planner
How often: _____				
Fits/faints/"funny turns"		<input type="checkbox"/>	<input type="checkbox"/>	Falls Assessment Pressure Injury assessment Consider Discharge Planner
How often: _____				
Speech/ swallowing problems		<input type="checkbox"/>	<input type="checkbox"/>	Refer to Dietician
Specify: _____				
Cough/ choking when eating/drinking		<input type="checkbox"/>	<input type="checkbox"/>	Refer to Dietician
Specify: _____				
Confusion	Long term <input type="checkbox"/> Acute <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complete 4AT Cognitive screening / assessment tool
Short term memory loss		<input type="checkbox"/>	<input type="checkbox"/>	
Dementia		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				

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Endocrine	Specialist/s: Dr	Yes	No	STAFF ONLY
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2		<input type="checkbox"/>	<input type="checkbox"/>	Blood Glucose Monitoring
Treatment: <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet		<input type="checkbox"/>	<input type="checkbox"/>	
Low blood sugar		<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	Specialist/s: Dr	Yes	No	STAFF ONLY
High blood pressure		<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain, angina		<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				
Heart attack		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Heart failure/congestive cardiac failure		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Cardiac devices		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Other - Specify: _____				
Gastro-intestinal	Specialist/s: Dr	Yes	No	STAFF ONLY
Bowel disorders		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Hepatitis or jaundice		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Gastric ulcer/reflux/hiatus hernia		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Diarrhoea and vomiting		<input type="checkbox"/>	<input type="checkbox"/>	Isolation Precautions
Specify: _____				
Haematology	Specialist/s: Dr	Yes	No	STAFF ONLY
Blood/bleeding disorders/bruise easily		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Previous blood clots/circulation disorders		<input type="checkbox"/>	<input type="checkbox"/>	
Specify: _____				
Anaemia		<input type="checkbox"/>	<input type="checkbox"/>	If pre-op and not ceased, notify VMO/Anaesthetist
Specify: _____				
Take blood thinning/arthritis/aspirin based medication?		<input type="checkbox"/>	<input type="checkbox"/>	
Medication: _____				
Have you ceased medication? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date last taken: / /				
Genitourinary	Specialist/s: Dr	Yes	No	STAFF ONLY
Renal/kidney impairment		<input type="checkbox"/>	<input type="checkbox"/>	
Bladder disorders		<input type="checkbox"/>	<input type="checkbox"/>	
Type: <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain <input type="checkbox"/> Incontinence <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Other: _____		<input type="checkbox"/>	<input type="checkbox"/>	Falls Assessment Pressure Injury assessment

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Musculoskeletal Specialist/s: Dr	Yes	No	STAFF ONLY
Osteoporosis Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Neck and spinal problems Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Management Specialist/s: Dr	Yes	No	STAFF ONLY
Do you have any pain? <input type="checkbox"/> New Pain <input type="checkbox"/> Old Pain Body Site: _____ Cause of pain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Observation Chart
General Health & Wellbeing Specialist/s: Dr	Yes	No	STAFF ONLY
Are you 65 years or above?	<input type="checkbox"/>	<input type="checkbox"/>	If patient meets one or more of this criteria, Complete 4AT Cognitive screening / assessment tool
Are you 45 or over and identify as Aboriginal or Torres Strait Islander?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a known cognitive impairment/dementia?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a hip fracture?	<input type="checkbox"/>	<input type="checkbox"/>	
Have family, friends or carers raised concerns about your cognition?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a severe/ terminal illness?	<input type="checkbox"/>	<input type="checkbox"/>	
Mental health condition Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnosed with anxiety and/or depression Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Skin integrity issues <input type="checkbox"/> Wound <input type="checkbox"/> Broken Skin <input type="checkbox"/> Other Skin Conditions <input type="checkbox"/> Pressure Injury Body Site: _____ Treatment: _____	<input type="checkbox"/>	<input type="checkbox"/>	Wound Assessment Chart Pressure Injury Assessment
Disturbed sleep patterns/sleep apnoea <input type="checkbox"/> Sedation <input type="checkbox"/> CPAP	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? How many per day: If no, have you in the past Date ceased: / /	<input type="checkbox"/>	<input type="checkbox"/>	
Drink Alcohol Standard drinks/day:	<input type="checkbox"/>	<input type="checkbox"/>	
Would you like a support person to visit you? <input type="checkbox"/> Chaplain <input type="checkbox"/> Other - Specify:	<input type="checkbox"/>	<input type="checkbox"/>	Notify appropriate person
Do you have any other conditions you think we should know about? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	

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Nutrition	Specialist/s: Dr	Yes	No	STAFF ONLY
Have you lost weight recently without trying? How much?		<input type="checkbox"/>	<input type="checkbox"/>	Nutrition Screen (MR 63) if BMI <25 Pressure Injury Assessment
Have you been eating poorly?		<input type="checkbox"/>	<input type="checkbox"/>	
Take a special or modified diet Specify: _____		<input type="checkbox"/>	<input type="checkbox"/>	
Weight and height Weight: _____ kg BMI: _____ Height: _____ cm		>120kg ► Refer to Physiotherapist BMI <17 or >40 Anaesthetist PAC		
Infection Control	Specialist/s: Dr	Yes	No	STAFF ONLY
Do you work of have you been a patient in another hospital or nursing home in the past 6 weeks Specify: _____		<input type="checkbox"/>	<input type="checkbox"/>	If yes, MRSA Screen. <input type="checkbox"/> Nasal Swab taken
Have you ever had an infection relating to a multi-resistant bacteria <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> ESBL <input type="checkbox"/> c Difficile <input type="checkbox"/> Other When: _____ Specify: _____		<input type="checkbox"/>	<input type="checkbox"/>	Isolation Precautions MRSA <input type="checkbox"/> Nasal Swab ESBL/VRE <input type="checkbox"/> Rectal Swab
Classic Creutzfeldt-Jacob Disease (CJD) <input type="checkbox"/> Dura mater graft prior to 1990 <input type="checkbox"/> Family with CJD or reviewed for CJD <input type="checkbox"/> Medical risk letter for CJD <input type="checkbox"/> Human pituitary / growth or fertility hormone prior to 1986 <input type="checkbox"/> Progressive neurological illness of less than 12 months duration which has not been diagnosed		<input type="checkbox"/>	<input type="checkbox"/>	Notify Infection Control Coordinator or Hospital Coordinator
ALLERGIES				
Document any known allergies or sensitivities e.g. medications, anaesthetics, latex, sticking plaster, iodine, x-ray dyes, food allergies.				
MEDICATION/ANAESTHETIC	REACTION	STAFF ONLY		
		Record on ALL00 Patient Alerts & Adverse Reactions		
FOOD		Record on Trendcare		
OTHER		If latex allergy, enter in webPAS & notify JSU NUM		

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SPECIAL NEEDS

STAFF ONLY

Primary Language:

Interpreter Required Yes / No

Arrange Interpreter

Special Needs:

- ☐ Visual aids: ☐ Glasses ☐ Contact Lenses ☐ Eye Prosthesis
- ☐ Walking aids:
- ☐ Hearing aids: ☐ Left ☐ Right
- ☐ Dentures: ☐ Upper ☐ Partial ☐ Full
- ☐ Lower ☐ Partial ☐ Full
- ☐ Other:

Falls Assessment

ENDURING POWER OF ATTORNEY / ADVANCE HEALTH DIRECTIVE

STAFF ONLY

☐ Enduring Power of Attorney

Name:

☐ Advance Health Directive

Phone:

Please bring a copy to the hospital on admission

☐ Filed behind
Medicolegal Divider

DISCHARGE PLANNING

STAFF ONLY

Do you live in a: ☐ House ☐ Unit/Flat ☐ Retirement Village ☐ Nursing Home/Hostel

☐ Live alone

Who will care for you on discharge:

☐ Caring for someone else

Specify:

☐ Have problems caring for yourself

Notify Discharge
Planner

☐ Currently use any community services (specify below)

☐ Nursing

Service Provider:

☐ Home Help

Service Provider:

☐ Meals

Service Provider:

☐ Other

Service Provider:

Notify Services of
Admission

DISCHARGE TIME IS 10AM

STAFF ONLY

☐ Can someone collect
you by this time?

Name:

Telephone:

Record on Discharge
Checklist

☐ If not, how do you plan
to get home?

Specify:

Discuss date & time
with patient/carer

PATIENT OR CARER SIGNATURE

I certify that the information given is correct to the best of my knowledge.

Signature of Patient/Carer

Date

Name of Patient/Carer

Relationship of Patient

PRE ADMISSION ASSESSMENT (COMPLETED)

Signature of Clinician

Date

Name of Clinician

Designation

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ADMISSION TO HOSPITAL

History reviewed with patient/family/carer ☐

Condition at Time of Review:

Post-Operative ☐ Yes ☐ No

(If Yes, no further action. If No, complete assessment below)

Physical Appearance: ☐ NAD ☐ Pale/Sweating ☐ Dyspnoeic ☐ Cyanotic

Mental Status: ☐ Orientated ☐ Vague ☐ Confused Other: _____

Emotional Status: ☐ Calm ☐ Somewhat Distressed ☐ Very Distressed Other: _____

Signature of Clinician

Date

Name of Clinician

Designation

Unit

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