

Waiting List Form

Consultant _____

Addressograph OR	Patient`s Telephone Nos:
Name	H
DoB	W
Unit no.	Mob

1. Provisional Diagnosis _____

2. Proposed Procedure _____

3. Referral source OPD Ward GP Other _____

4. Other Information eg Clopidogrel, Metformin _____

Does this information indicate need for a medical referral Yes No

5. Urgency Urgent Soon Routine
 Patient suitable for a combined list? Yes No
 If yes; discussed and agreed with patient. Yes No

6. Hospital Please indicate suitability for following hospitals:
 RIE St John`s WGH Roodlands
 Would the patient take an appointment at short notice? Yes No

7. Facility
 Outpatient Dept: Minor op list
 Day Surgery Unit: 12 hr 23 hr
 Inpatient Ward
 Admit day before: **reason** _____ admit fasting at _____
 Requires: Level 1 bed Level 2 bed (HDU) Level 3 bed (ITU)
 To attend pre-admission clinic: Yes No
 Hotel bed preop (RIE only): Yes No Bowel prep: N/A Yes No

8. Anaesthetic Anaesthetist required Yes , No

9. Estimated Theatre Time _____ hrs **Estimated stay** _____ days

10. Transport required: Yes No If yes, state type: Car 1 man amb 2 man amb

11. Date on Waiting List / / Clinician`s signature.....

Complete if applicable: **Waiting List Booking Details**
 Date of Admission / / Fasting instructions, if any: _____
 Date of Operation ... / /

INTENTIONALLY LEFT BLANK

**SURGICAL ADMISSION - PRE-OPERATIVE
INITIAL HEALTH SCREEN
at OUTPATIENT APPOINTMENT (p1)**

addressograph label, *or*,
Name _____
DoB _____
Unit no. _____

Date _____ patient age _____
RIE Roodlands St. Johns WGH

**SPECIALTY
CONSULTANT**

Height: (m)	Weight: (kg)	BMI	If BMI >35 - issue dietary advice
BP	<i>comment</i>		If Diastolic >95, or Systolic >180, refer to GP using referral letter
Pulse			

Previous hospital admission in last 5 yrs? No / Yes		
Date(s)	Reason	comment

Heart Problems: No / Yes *describe*
Cardiology on last 5 yrs: No / Yes *request Cardiology notes* No / Yes

Smoker: No / Yes - no. per day Information booklet given? Yes / No

Alcohol: No / Yes - no. Units per week Information booklet given? Yes / No

Urinalysis: No / Yes Prot. Blood Gluc. NAD Other
If 'Other', please specify Action taken Yes / No

Diabetic: No / Yes Type : _____ *comment*

Written patient information given: 'Going to hospital' booklet
'You & your anaesthetic' Procedure-specific information *specify*
If OTHER, please specify

Any further comments
Nurse / Support worker: Signature & Print: _____
Designation: _____ date: _____

MEDICATION HISTORY (PRESCRIPTION and COUNTER BOUGHT, E.G. HOMEOPATHIC)					
Drug	Route	Form	Dose	Frequency	Comments
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Medication History can be continued overleaf as required

**SURGICAL ADMISSION - PRE-OPERATIVE
INITIAL HEALTH SCREEN
at OUTPATIENT APPOINTMENT (p2)**

addressograph label, *or*,
Name
DoB
Unit no.

MEDICATION HISTORY CONTINUED (PRESCRIPTION and COUNTER BOUGHT, E.G. HOMEOPATHIC)

Drug	Route	Form	Dose	Frequency	Comments
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

IF SELF-MEDICATION FORMS ARE USED LOCALLY, INSERT AT THIS POINT

ADVISED OF DIVISION'S USE OF SUPPLEMENTARY PRESCRIBERS: YES N/A

PRE-ASSESSMENT CLINIC notes for comparative analysis or, N/A in your service

Date _____ Blood Pressure _____ *comment* _____
Urinalysis: No / Yes Prot. Blood Gluc. NAD Other
 If 'Other', please specify _____ Action Taken Yes / No
Height: (m) _____ **Weight:** (kg) _____ **BMI** _____ **Assessment** _____
 _____ **Nurse initials** _____

<p>PRE-OPERATIVE ASSESSMENT</p> <p>ASSESSING HOSPITAL SITE :</p> <p>Check registration details : correct <input type="checkbox"/>, changed <input type="checkbox"/></p> <p>date</p>	<p>addressograph label, or,</p> <p>Name</p> <p>DoB</p> <p>Unit no.</p>
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PATIENT DETAILS	
TITLE: Mr / Mrs / Miss / Ms / Other _____	Marital Status: _____
Age: _____	Occupation _____
Tel. Nos. Home _____	GP _____
Work _____	GP Address _____
Mob _____	GP tel no. _____
Ethnic Origin: _____	First Language: English <input type="checkbox"/> Other <input type="checkbox"/>
Interpreter Required Yes <input type="checkbox"/> No <input type="checkbox"/> (0131 226 5036)	
Religion: _____ (If Jehovah's Witness attach appropriate form)	
Request for visit from hospital chaplain: Yes <input type="checkbox"/> No <input type="checkbox"/>	

NEXT OF KIN	SECOND CONTACT (if required)
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
_____	_____
_____	_____
Contact nos: Home: _____	Contact Nos: Home: _____
Work: _____	Work: _____
Aware of surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Aware of surgery Yes <input type="checkbox"/> No <input type="checkbox"/>

WHO TO CONTACT IN EMERGENCY

The following boxed section is not applicable to all clinical settings – if Not Applicable, please indicate

<p>Patient Would (Still) Consider Short Notice Admission Yes <input type="checkbox"/>, No <input type="checkbox"/>.</p> <p>Unsuitable Dates (Holidays booked, etc) _____</p> <p>Post-Op Support discussed <input type="checkbox"/>, Someone to collect you after the op <input type="checkbox"/>,</p> <p style="padding-left: 100px;">Will have responsible adult at home for the first 24hrs <input type="checkbox"/></p> <p>Current Length of Waiting List Discussed Yes <input type="checkbox"/>, No <input type="checkbox"/>.</p> <p>Information Given :</p>
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<p>Suitable for telephone assessment: Yes <input type="checkbox"/> No <input type="checkbox"/> Signature.....</p>
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<p>PRE-OPERATIVE ASSESSMENT</p> <p>ASSESSING HOSPITAL SITE :</p> <p>Check registration details : correct <input type="checkbox"/> changed <input type="checkbox"/></p> <p>Date</p>	<p>addressograph label, <i>or</i>,</p> <p>Name</p> <p>DoB</p> <p>Unit no.</p>
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Planned procedure
Consultant Surgeon

Proposed Admission date / time

Admission: / / time : ward

Proposed date of Surgery / / **or as above**

Proposed date of Discharge / /

Key to Initials of ALL STAFF completing this ICP				
Print name	Designation	Initials	Signature	Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Common Abbreviations Used

BMI	Body mass index	kg	Kilograms	PMHx	Past medical history
BP	Blood pressure	LMP	Last menstrual period	R	Respirations
CM	Centimetres	NA	Not applicable	RA	Rheumatoid arthritis
DOS	Day of surgery	NOK	Next of kin	R/O	Removal of
DVT	Deep venous thrombosis	MI	Myocardial infarction	RF	Renal failure
ECG	Electrocardiograph	OA	Osteo-arthritis	T	Temperature
FBC	Full blood count	OPD	Out patient department	U&E	Urea and electrolytes
HRT	Hormone replacement therapy	P	Pulse	VTE	Venous Thrombo-embolism
I.V.	Intravenous	PE	Pulmonary embolus		

PRE-OPERATIVE ASSESSMENT	addressograph label, or,
SOCIAL ENQUIRY	Name
	DoB
	Unit no.

LIVES ALONE , LIVES WITH PARTNER , OTHER *specify*
 ARE YOU A CARER FOR ANYONE : N Y *specify*

12 / 23 hr PATIENTS:	
Journey home < 90mins	Yes / No
Patient agrees to be accompanied home by responsible adult in private transport	Yes / No
Responsible adult will be at home with patient, at least overnight	Yes / No
Patient advised not to drive or operate machinery within 24 hours of operation	Yes / No
Patient advised not to drink alcohol within 24 hours of operation	Yes / No

PRE-ADMISSION INFORMATION INDICATE IF NOT REQUIRED ON THIS OCCASION

HOUSING
 Flat Level..... House Bungalow Care Alarm
 Sheltered Housing Residential/Part IV Nursing Home Hostel No Fixed Abode .

STAIRS - None
 Inside + Handrail , Outside + Handrail , Lift
 Bedroom upstairs / downstairs , Bathroom upstairs / downstairs .

EQUIPMENT - None
 Toilet Aids , Shower cubicle , shower over bath Bath aids Commode
 High Chair Bed Rail Trolley , Dressing Aids Bath Aids ,
 If Yes to any: *specify*

MOBILITY - No issues , Hand Dominance : L R
 Walking Aid(s) *specify*
 Other – *specify*

MOVING & HANDLING:
 Is the patient: Independent , requires Moderate assistance , or Maximum assistance
Specify the method of assistance / supervision required

HYGIENE - No issues
 Requires Assistance: *specify*

FEEDING ASSESSMENT
 Patient able to feed themselves efficiently / effectively , Requires assistance
Requires Assistance: specify

Home support (no. of hours)	none <input type="checkbox"/>	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Date cancelled
District Nurse	N/A <input type="checkbox"/>								
Health Visitor	N/A <input type="checkbox"/>								
Home Help	N/A <input type="checkbox"/>								
Frozen Meals Service	N/A <input type="checkbox"/>								
Home Support	N/A <input type="checkbox"/>								
Community Psychiatric Nurse	N/A <input type="checkbox"/>								
Day Centre	N/A <input type="checkbox"/>								
Day Hospital	N/A <input type="checkbox"/>								
Other (please specify)									

Ambulance required Yes/No If required, please detail booking in management plan

ICP Discussed with Patient <input type="checkbox"/>	Agreeable to storing this document at Foot of Bed: Yes <input type="checkbox"/> , No <input type="checkbox"/>
Consent form completed Yes <input type="checkbox"/> , No <input type="checkbox"/>	If no, state reason

PRE-OPERATIVE ASSESSMENT	addressograph label, <i>or</i> , Name _____ DoB _____ Unit no. _____
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COMMUNICATION & PERCEPTION	
Sight _____	Hearing _____
Communication _____	Cognition _____

OBSERVATIONS	Record any significant changes from Initial Health Screen on p3
Pulse _____ B/P _____ Height _____ (cms) Weight _____ (kg) BMI _____	
Sats O2 (<i>if indicated</i>) _____	ASU Result _____

FOR FEMALE PATIENTS
Date of LMP Details of last period Details of cycle days <i>(Normal, light, ,heavy)</i>
Date of last cervical smear Method of contraception or N/A <input type="checkbox"/> . Parity
Pregnancy test conducted* <input type="checkbox"/> - positive <input type="checkbox"/> , negative <input type="checkbox"/> , declined <input type="checkbox"/> <i>*If <50yrs or within 2 years of any bleeding.</i>

HEALTH PROMOTION
Cigarette smoking Non smoker <input type="checkbox"/> , Recent ex-smoker <input type="checkbox"/> stopped _____ (Date) Smoker <input type="checkbox"/> Number of cigarettes smoked per day _____ Ever tried to stop? _____ Advised of the value of stopping and the risks to health of continuing to smoke cigarettes _____ Interested at all in stopping now? N <input type="checkbox"/> , Y <input type="checkbox"/> _____ If would like to stop, detail information given to assist _____
Alcohol intake: or None <input type="checkbox"/> Daily intake _____ units OR Weekly intake _____ units <i>(1 unit of alcohol = small glass of wine, or 1 25 ml pub measure of spirit, or half a pint of ordinary strength lager/beer/cider Current daily guidelines for sensible drinking: males 3 – 4 Units per day or less. females 2 – 3 Units per day or less.</i> Any patient concerns about his/her alcohol intake? _____ If yes, detail information given to assist _____
Other Mood Altering Substances: None <input type="checkbox"/> or, Other (please note) _____ Any patient concerns about substances currently used? _____ If yes, detail information given to assist _____
Weight issues: None <input type="checkbox"/> Any patient concerns about his/her weight? _____ If yes, detail information given to assist _____
Please summarise any issues in 'Referral' section

<p>REVIEW OF SYSTEMS (1)</p> <p>it may not be necessary to complete 'R. of S.' in detail if:</p> <ul style="list-style-type: none"> • done very recently as part of diagnosis <input type="checkbox"/> or, • clinically not indicated <input type="checkbox"/> [<i>eg fit, short-stay patient for an uncomplicated procedure</i>] - specify reason(s) <p>.....</p> <p>.....</p>	<p>addressograph label, or,</p> <p>Name</p> <p>DoB</p> <p>Unit no.</p>
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* SUMMARISE ACTIONS IN "SUMMARY OF ASSESSMENT"

If **YES to any main question**, expand on severity / frequency / duration / recent changes – what, when, how, etc

VASCULAR SYSTEM
<p>Do you have a history of Hypertension <input type="checkbox"/>, Angina <input type="checkbox"/>, MI <input type="checkbox"/>, Stroke <input type="checkbox"/>, DVT / PE <input type="checkbox"/>, heart murmur <input type="checkbox"/></p> <hr/> <p>Do you get</p> <ol style="list-style-type: none"> 1. Chest pain? 2. breathlessness 3. ankle swelling <p style="text-align: right;">Requires Medical Referral? Yes <input type="checkbox"/>, No <input type="checkbox"/></p>

RESPIRATORY SYSTEM
<p>Do you have a history of Asthma <input type="checkbox"/>, TB <input type="checkbox"/>, COPD <input type="checkbox"/></p> <hr/> <p>Do you / have you</p> <ol style="list-style-type: none"> 1. a cough? 2. sputum or phlegm 3. coughed up blood 4. get wheezy <p style="text-align: right;">Requires Medical Referral? Yes <input type="checkbox"/>, No <input type="checkbox"/></p>

DIGESTIVE SYSTEM
<p>Do you have a history of Jaundice <input type="checkbox"/></p> <hr/> <p>Do you / have you</p> <ol style="list-style-type: none"> 1. any recent appetite changes 2. a recent unexpected weight loss? 3. are you being sick / brought up any blood 4. have heartburn / indigestion / stomach pain 5. changes in bowel movements: blood or black stools <p style="text-align: right;">Requires Medical Referral? Yes <input type="checkbox"/>, No <input type="checkbox"/></p>

ENDOCRINE system
<p>Do you have a history of Diabetes Mellitus <input type="checkbox"/>, Thyroid condition <input type="checkbox"/></p> <hr/> <p>Describe: e.g. type of Diabetes</p> <p style="text-align: right;">Requires Medical Referral? Yes <input type="checkbox"/>, No <input type="checkbox"/></p>

<p>REVIEW OF SYSTEMS (2)</p> <p>Summarise actions In "Summary of Assessment"</p> <p>If YES to any main question, expand on severity / frequency / duration / recent changes – what, when, how, etc</p>	<p>addressograph label, or,</p> <p>Name</p> <p>DoB</p> <p>Unit no.</p>
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<p>GENITO-URINARY system</p> <p>Do you have a history of Renal conditions / intervention <input type="checkbox"/></p> <p>When passing urine, do you</p> <ol style="list-style-type: none"> 1. pass blood or have pain 2. find yourself needing to pass urine frequently 3. experience difficulty – slow to start, dribble etc 	<p>URINE SAMPLE TAKEN Y <input type="checkbox"/> (record result on p9) , or, N/A <input type="checkbox"/></p> <p>Requires Medical Referral? Yes <input type="checkbox"/> , No <input type="checkbox"/></p>
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<p>NERVOUS system</p> <p>Do you have a history of Epilepsy <input type="checkbox"/></p> <p>Do you get</p> <ol style="list-style-type: none"> 1. severe headaches 2. eye problems 3. faints, muscle weakness or tingling sensations 	<p>Requires Medical Referral? Yes <input type="checkbox"/> , No <input type="checkbox"/></p>
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<p>BLOOD DISORDERS</p> <p>Do you have a history of Anaemia <input type="checkbox"/> , other Blood Disorders <input type="checkbox"/></p> <p>Describe</p>	<p>Requires Medical Referral? Yes <input type="checkbox"/> , No <input type="checkbox"/></p>
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<p>SKIN conditions</p> <p>Do you have a history of Skin Disorders <input type="checkbox"/> , leg ulcers / pressure sores <input type="checkbox"/> , circulation problems <input type="checkbox"/></p> <p>Describe</p>	<p>Requires Medical Referral? Yes <input type="checkbox"/> , No <input type="checkbox"/></p>
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<p>SLEEPING describe your normal sleeping pattern</p> <p>If you have Sleep Apnoea,</p> <p>specify sleeping medication / treatment:</p>	<p>not required for this episode <input type="checkbox"/></p>
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<p>OTHER ILLNESSES: HISTORY of RHEUM.FEVER <input type="checkbox"/> , CANCER <input type="checkbox"/> , ARTHRITIS:OA <input type="checkbox"/> , RA <input type="checkbox"/></p>	<p>Requires Medical Referral? Yes <input type="checkbox"/> , No <input type="checkbox"/></p>
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FURTHER ASSESSMENTS REQUIRED ['OTHER' e.g. Tissue Viability etc] <u>OR</u> , not required for this episode <input type="checkbox"/>			
Physiotherapy	N	Y	IF YES, PT contacted at : reason
Occup'al. Therapy	N	Y	IF YES, OT contacted at : reason
Dietitian	N	Y	IF YES, Dtn contacted at : reason
Other	N	Y	If Yes, contacted at : reason
Other	N	Y	If Yes, contacted at : reason

<p>To be completed by PRE-ASSESSMENT STAFF</p> <p>Initial sections completed</p>	<p>addressograph label, <i>or</i>, Name DoB Unit no.</p>
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DOES THE PATIENT APPEAR TO HAVE COMPLICATED DENTITION: No , Yes

Dentition – patient reports																Mark			
R																	L	D : Denture	L : loose teeth/filling
	8 7 6 5 4 3 2 1								1 2 3 4 5 6 7 8									B : Bridge	
	8 7 6 5 4 3 2 1								1 2 3 4 5 6 7 8									C : Crown	
Dental abscess / issues: No <input type="checkbox"/> , Yes <input type="checkbox"/>																			

AIRWAY ASSESSMENT

1. Patient able to flex and extend neck normally Yes , No
2. Patient able to open mouth >3cms (3 finger breadths) Yes , No
3. Previous history of difficult intubation Yes , No
4. Mallampati classification:

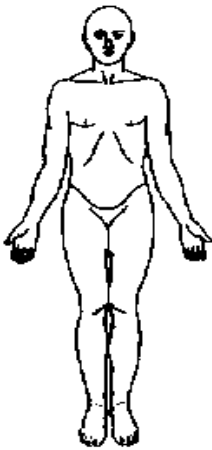
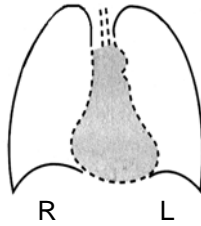
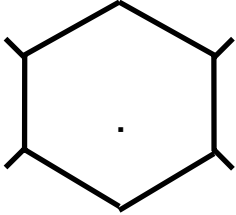
Seated patient protrudes tongue as far as possible. From patient eye level, assess pharyngeal structures

Class I	Class II	Class III	Class IV
 <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <input type="checkbox"/> <div style="text-align: left; padding-left: 20px;"> soft palate, uvula, fauces and pillars visible </div> </div>	 <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <input type="checkbox"/> <div style="text-align: left; padding-left: 20px;"> soft palate, uvula, & fauces visible, pillars obscured. </div> </div>	 <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <input type="checkbox"/> <div style="text-align: left; padding-left: 20px;"> soft palate only visible </div> </div>	 <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <input type="checkbox"/> <div style="text-align: left; padding-left: 20px;"> soft palate not visible </div> </div>
If you cannot see the faucial pillars (palatoglossal & palatopharyngeal arches) & uvula (because they are obscured behind the base of the tongue: grades III & IV), visualisation of the glottis is likely to be more difficult			

5. Thyromental distance >6.5cm Yes , No
6. If necessary and if practical, ask an anaesthetist to assess airway at this time N/A

Where appropriate, please summarise in Medical Referral section.

<p>PRE-OPERATIVE ASSESSMENT</p> <p>DETAILED ASSESSMENT BY MEDICAL STAFF</p> <p>(IF APPLICABLE)</p>	<p>addressograph label, <i>or</i>, Name</p> <p>DoB</p> <p>Unit no.</p>
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PHYSICAL EXAMINATION		
<p>Pale Cyanosed Clubbed Jaundiced</p> <p>Lymphoedenopathy</p> <p>Hydration</p> <p>Skin</p> <p>Thyroid</p> <p>Breasts</p>		<p>PHYSIOLOGY SCORE</p> <p>Please tick</p> <p>Cardiac*</p> <ul style="list-style-type: none"> No failure CVS drugs Peripheral oedema Warfarin therapy Raised JVP <p>ECG*</p> <ul style="list-style-type: none"> Normal Atrial Fibrillation Abnormal rhythm Recent Q, ST/T changes
<p>CVS</p> <p>Pulse</p> <p>BP (Erect/Supine)</p> <p>JVP (Jugular Venous Pressure)</p> <p>Apex Beat</p> <p>Heart Sounds</p> <p>Oedema</p>		<p>Respiratory*</p> <ul style="list-style-type: none"> Nil SOBOE Limiting dyspnoea Dyspnoea at rest <p>CxR*</p> <ul style="list-style-type: none"> Normal Borderline CM Cardiomegaly Mild COAD Moderate COAD Fibrosis Consolidation
<p>RS</p> <p>Respiratory Rate</p> <p>Trachea</p> <p>Expansion</p> <p>PN (Percussion Notes)</p> <p>BS (Breath Sounds)</p>		<p>Abdomen:</p> <p>Vaginal Examination: (if indicated)</p> <p>Rectal Examination (if indicated)</p>
<p>Abdomen:</p> <p>Vaginal Examination: (if indicated)</p> <p>Rectal Examination (if indicated)</p>		<p>Masses</p> <p>Liver</p> <p>Spleen / Kidneys</p> <p>Bowel sounds</p> <p>Herniae</p> <p>Genitalia</p> <p>PR</p> <p>FOB</p>
<p>CNS/Locomotor</p>		

<p>Assessing Doctor: Signature</p> <p style="text-align: center;">Date:</p>	<p>Print Name:</p> <p style="text-align: center;">Time: Designation</p>
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<p>PRE-OPERATIVE ASSESSMENT</p> <p>INITIAL INVESTIGATIONS</p> <p style="text-align: center;">sign & date once taken</p>	<p style="text-align: right;">addressograph label, <i>or</i>,</p> <p>Name</p> <p>DoB</p> <p>Unit no.</p>
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<p>Full Blood Count <input type="checkbox"/></p> <p>Group & Save <input type="checkbox"/></p> <p>Cross Match <input type="checkbox"/> no of Units</p> <p>U & Es <input type="checkbox"/></p> <p>LFTs <input type="checkbox"/></p> <p>TFT <input type="checkbox"/></p> <p>ESR <input type="checkbox"/></p> <p>Glucose <input type="checkbox"/></p> <p>INR / Clotting <input type="checkbox"/></p> <p>Tumour Markers <input type="checkbox"/></p> <p>CA 125 <input type="checkbox"/></p> <p>CEA <input type="checkbox"/></p> <p>CRP <input type="checkbox"/></p> <p>Audiogram <input type="checkbox"/></p> <p>Cardiac Echo <input type="checkbox"/> Why?</p> <p>.....</p>	<p>Urinary Pregnancy Test <input type="checkbox"/></p> <p>HCG <input type="checkbox"/></p> <p>ECG <input type="checkbox"/></p> <p>Urinalysis (<i>noted on p7</i>) <input type="checkbox"/> If +, sent to lab <input type="checkbox"/></p> <p>CXR <input type="checkbox"/></p> <p>Pulmonary Function <input type="checkbox"/></p> <p>Hb A1C <input type="checkbox"/></p> <p>MRSA screening * <input type="checkbox"/> <i>If Y, tick swab sites</i></p> <p>Nose <input type="checkbox"/>, Throat <input type="checkbox"/>, Groin <input type="checkbox"/>,</p> <p><u>if applicable</u> - Wound <input type="checkbox"/> <i>list site(s)</i></p> <p>Urine if catheterised <input type="checkbox"/>, sputum if expectorating <input type="checkbox"/></p> <p>Other(s) <input type="checkbox"/> <i>specify</i></p> <p>Other <input type="checkbox"/></p> <p><i>specify</i> <input type="checkbox"/></p> <p><i>specify</i> <input type="checkbox"/></p> <p><i>specify</i> <input type="checkbox"/></p>
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* MRSA screening – as per MRSA policy (03/03)

WATERLOW PRESSURE SORE PREVENTION / TREATMENT POLICY
 Add up Total : several Scores per category can be used

BUILD / WEIGHT for HEIGHT	Condition of PRESSURE Areas, visual risk areas	SEX / AGE	SPECIAL RISKS
Average 0	Healthy 0	MALE 1	Tissue malnutrition e.g. terminal cachexia 8
Above Average 1	Tissue paper 1	FEMALE 2	Type II Resp. failure 8
Obese 2	Dry 1	14-49 1	Cardiac Failure 5
Below average 3	Oedematous 1	50-64 2	Periph. Vascular disease 5
NEUROLOGICAL deficit (active) e.g. Diabetes Motor/sensory Paraplegia, NS, CVA - 4 - 6	Clammy (temp up) 1	65-74 3	Anaemia 2
	Discoloured 2	75-80 4	Smoking 1
	Broken spot 3	81+ 5	
CONTINENCE	MOBILITY	APPETITE	MAJOR SURGERY / TRAUMA
Complete / Catheterised 0	Fully 0	Average 0	Orthopaedic #NOF 5
Occasion. Incont. (max 1 per day) 2	Restless / fidgety 1	Poor 1	Below waist, Spinal 5
ACTH / incont. : of Faeces 2	Apathetic / depressed 2	NG tube (for aspirate) 2	On table >2hours 5
Doubly Incont. 3	Restricted 3	Fluids only 2	Medications / Steroids / Cytotoxics, High-dose Anti-Inflammatory 4
	Traction / bed rest 4	NBM / Anorexic 3	
	Chair bound 5		

SCORING SYSTEM : 10+ = At Risk 15+ = High Risk 20+ = Very High Risk

SCORE	date	SCORE	date
SCORE	date	SCORE	date

PRE-OPERATIVE ASSESSMENT	addressograph label, <i>or</i> ,
PROPHYLAXIS OF VENOUS THROMBOEMBOLISM [VTE] IN SURGICAL PROCEDURES ^[1]	Name
	DoB
	Unit no.

If patient has an inherited hypercoagulable state, advice should be sought from a Haematologist

Table A – Risk Factors for VTE	
• Age > 70 years	
• Obesity BMI >30 kg/m ²	
• Previous DVT / PE	
• Current Medical conditions:	Heart Failure, COPD, Serious infection e.g. pneumonia, Diabetic coma, Nephrotic syndrome, Inflammatory bowel disease.
• Malignancy – active or within 6 months	
• Thrombophilia	
• Pregnancy, puerperium	
• Major trauma	
• Hormone Therapy -	Combined oral contraceptive pill, HRT, Raloxifene, tamoxifen, high dose progestogens
• Immobility – bedrest >3days, paralysis of lower limbs	

Table B – Contraindications and cautions	
Heparin, Enoxaparin, Warfarin, Alteplase	Graduated elastic compression stockings
• Haemorrhagic disorder	• Massive leg oedema
• Coagulopathy	• Peripheral neuropathy
• Thrombocytopenia <70x 10 ⁹ /l	• Severe peripheral arterial disease
• Active peptic ulcer	• Major leg deformity
• Actual or potential bleeding site	• Dermatitis (active / severe)
• Acute bacterial endocarditis	• Pulmonary oedema
• Acute stroke – seek advise	
• CNS surgery within 3 months	
• Severe arterial hypertension (uncontrolled)	
• Severe liver disease	
• Renal failure (refer to table C of “Pocket Guide”)	
• Previous history of heparin induced thrombocytopenia (HIT)	

- LOW RISK** Minor surgery including Gynae. (<30min), no other risk factors (Table A)
- MODERATE RISK** Minor surgery with any risk factor (Table A)
Major surgery no risk factors (Table A)
- HIGH RISK** Major Pelvic or abdominal surgery with any risk factor (Table A)

¹. “The Anti-Thrombotic Pocket Guide”, (Jan.'05), produced by the NHS Lothian – University Hospitals Divisions

Once Risk group identified, prescribe VTE prophylaxis as per Unit protocol.

Continue with current anti-coagulant therapy as noted on waiting list form? , N/A

If required, liaise with Surgeon and Anaesthetist to initiate / identify plan . N/A

Please record outcome in ‘Summary of Assessment’.

VTE guideline for Gynaecology:	Refer to Policy Manual
VTE guideline for Orthopaedics:	Elective - http://intranet/library//content/dir279/DVT.pdf
VTE guideline for General Surgery:	Refer to Policy Manual

