



www.qldeye.com

Name: _____

Surgeon: _____

Date of Surgery: ____/____/____

IMPORTANT:

Please **COMPLETE & RETURN** to:
P.O. Box 293, Spring Hill, QLD, 4004
FAX: (07) 3236 9855

Please return at least 1 week prior to the procedure

Paediatric Pre-Operative Health Assessment

Booking and admission details

Names and contact details of parents _____

Operation Booked _____

Health History

Is your child currently well? No ☐ Yes ☐

Details:

Has your child been in contact with any infectious diseases in the past 2 weeks.
e.g. Chicken pox or Gastroenteritis. No ☐ Yes ☐

Details:

Has anyone close to the child or you returned from over seas in the past 2 weeks No ☐ Yes ☐

Details:

Has your child had heart problems at any time? No ☐ Yes ☐

Details:

Has your child ever had Asthma / Bronchitis / Croup or a recent Respiratory infection?
Does the child snore? No ☐ Yes ☐

Details:

Was your child's birth Premature or a low birth weight No ☐ Yes ☐

Details:

Has your child or any blood relative had a life threatening reaction to an anaesthetic? No ☐ Yes ☐

Details:

Has your child been admitted to intensive care at any time No ☐ Yes ☐

Details:

What is your child's weight & height? Kg: Cm:

Does your child have any special dietary requirement? No ☐ Yes ☐

Details:

Social Assessment

Are there any custody or guardianship orders that Queensland Eye Hospital should be aware of? No ☐ Yes ☐

Details:

Please attach a copy of current documents

Does your child have any limitations with Hearing, Vision, Mobility or Learning? No ☐ Yes ☐

Details:

Does your child use any mobility aids? No ☐ Yes ☐

Details:

Who is going home with the child? Details:
Parents / Grandparents, Need two persons for the trip home as child may need reassurance during the journey.



Patient Name:

Surgeon:

Op Date:

Past Surgical History

	Surgery	Year	Surgery	Year	Surgery	Year
<input type="checkbox"/> None						

Medical History

<input type="checkbox"/> No	
<input type="checkbox"/> Other	

Medications: All REGULAR medications including over the counter / complimentary medications

	Drug	Drug	Drug
<input type="checkbox"/> None			

Allergies & Adverse Reactions: Please document any known allergies or sensitivities e.g. Medication, tape's, food etc. **AND** the **resulting reaction**

	Drug, Food or other	Description of reaction
<input type="checkbox"/> Nil known		

Post-Operative Food: What would your child prefer on a sandwich following surgery?:

I certify that the information given above, on the previous page and on any attachments is correct to the best of my knowledge:

Name: (Print) _____ Signature: _____

Relationship to Patient: _____ Date: ____/____/____

Pre-operative Instructions

- Before admission
 - Bath or shower as usual, but do not use talcum powders, face creams or nail polish
 - Dress the child in loose comfortable clothing with no jewellery
- You will need to bring to hospital
 - Medicare, Health fund and Pension Cards
 - Spare set of clothing – children do not change for surgery
 - Any Inhalers / puffers / Insulin / special food requirements
 - Any special comfort toy or blanket (please wash prior to admission)

