Patient Name: _____

Surgeon: _____

Date of Surgery: _____/ _____/_____

Paediatric Health Assessment
(12 yrs and Under)
Queensland Eye Hospital

Parent / Guardian Contact Details

Parent / Guardian 1: _____ **Telephone number:** _____

Parent / Guardian 2: _____ **Telephone number:** _____

Health Assessment

Does your child currently have, or have they ever had any of the following?	Please Document Details		
Heart problems	☐ No	☐ Yes	
Asthma / Bronchitis / Croup or a recent Respiratory infection	☐ No	☐ Yes	
Gastric Reflux	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Anxiety / Behavioral Conditions / Mental Health Disorder?	☐ No	☐ Yes	
Was your child's birth Premature or a low birth weight?	☐ No	☐ Yes	
Has your child been admitted to intensive care at any time?	☐ No	☐ Yes	
Has your child been admitted to intensive care at any time?	☐ No	☐ Yes	
Does your child have any special dietary requirement?	☐ No	☐ Yes	
What is your child's weight & height?	___Kg	___Cm	

Infection Prevention and Control

Is your child currently un-well?	☐ No	☐ Yes	
Does your child currently have any infected cuts / abrasions?	☐ No	☐ Yes	
In the past two weeks, has your child developed or been in close contact with anyone who has had an infectious illness? e.g. Measles / Chicken pox / Gastroenteritis / School Sores	☐ No	☐ Yes	
Has your child returned from overseas in the last two weeks?	☐ No	☐ Yes	
Has your child had an overnight stay in an overseas hospital in the last 12 months?	☐ No	☐ Yes	
Has your child ever been infected with a multi-resistant colonized infection (MRSA / VRE)?	☐ No	☐ Yes	
Does your child have any blood borne infections? e.g. Hepatitis B or C, HIV	☐ No	☐ Yes	

Social Assessment

Are there any custody or guardianship orders that Queensland Eye Hospital should be aware of?	☐ No	☐ Yes	*Please attach a copy of current documents*
Does your child have any limitations with Hearing, Vision, Mobility or Learning?	☐ No	☐ Yes	
Does your child use any mobility aids?	☐ No	☐ Yes	

Patient 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

Surgical History

	Surgery	Year	Surgery	Year
☐ None				

Other Health Issues (Not already mentioned)

☐ None	

Medications List all REGULAR Medications including over the counter / complimentary medicines

☐ None	

Allergies / Adverse Reactions (Please list all known Allergies / Adverse Reactions e.g. Medications, Tapes, Food etc.)

	Drug, Food or Other	Description of Reaction
☐ None		

Admission Requirements

To meet the QEH admission criteria for your child you must:

- Not use public transport to travel home as this is against the strict policy of the Queensland Eye Hospital. Failure to do so will result in your child's procedure being postponed or cancelled.
- It may be beneficial for you to arrange two responsible adults to drive your child home as your child may need reassurance during the journey e.g. Parent / Grandparent

The adults taking your child home:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Following surgery what would your child prefer on a sandwich? _____

Please return your child's Patient Details Form and Consent Form as soon as possible to minimise delays with your admission.
Fax: 3236 9855 Email: info@qldeye.com

Nurse use only: This form was completed by a registered nurse at QEH
Nurse Signature:
(Print / Sign / Designation) _____ **Date:** ____ /____ / ____