HAWKE'S BAY
District Health Board
Whakawāteatia

Fill in only if patient label is unavailable

Name:..... DoB: .....

NHI: ..... Phone: .....

Address: .....

PRE-OPERATIVE ASSESSMENT FOR ELECTIVE SURGERY (TRIAL)

PRE-OPERATIVE ASSESSMENT FOR ELECTIVE SURGERY (TRIAL)

Consultant:	**Procedure:**
Indication:	
History of Presenting Complaint/Background:	
X-Ray/USS/CT/Other:_____ *(circle relevant imaging)* **Date:**	
Other Surgical History:	
Medical History:	
Social Circumstances:	**Allergies:** ☐ NKDA
	Regular Medications:
Smoking, Alcohol, Drugs:	

PRE-OPERATIVE ASSESSMENT FOR ELECTIVE SURGERY (TRIAL)

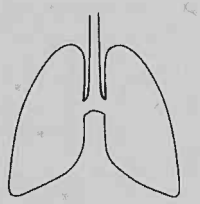
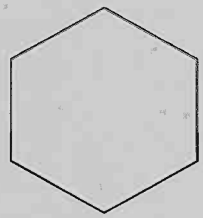
PRE-OPERATIVE ASSESSMENT FOR ELECTIVE SURGERY (TRIAL)

Fill in only if patient label is unavailable

Name:..... DoB: .....

NHI: ..... Phone:.....

Address: .....

SYSTEMS ENQUIRY & EXAMINATION	TEST RESULTS & DATES
General/Physical Appearance: _____kg	**Hb:** **WC:**
	Plt: **Neut:**
	Na: **Ur:**
CVS:	**K:** **Cr:**
BP: _____ mmHg	**eGFR:**
HR: _____ / min	
Sats: _____% (_____)	**LFTs:**
Respiratory: 	
	Coag:
	HbA1c:
Abdomen: 	**ECG:**
	Echo:
Neuro, Gynae etc if relevant:	
	G & H
	☐ Not required

Plan/Questions for Anaesthetists/Surgical team:

1.
2.
3.
4.
5.

Assessed By:

Name: ..... Signature:..... Date:..... Time:..... RN/HS/Reg

Name: ..... Signature:..... Date:..... Time:..... RN/HS/Reg

Name: ..... Signature:..... Date:..... Time:..... RN/HS/Reg