GENERAL HOSPITAL
Atlas
EXPERTS IN SURGERY

PRE-ACEPTION FORM

PLEASE COMPLETE PRE-ACEPTION FORM AND DELIEVER IT TO US AT LEAST ONE DAY BEFORE PLANNED ADMISSION TO HOSPITAL ON MAIL: STACIONAR@ATLASKLINIKA.RS OR BRING FILLED FORM IN HOSPITAL WITH OTHER DOCUMENTATION.

Personal information

Name and surname	
Parent name	
Male Female	
Date of birth	
ID number	
Living address	
Phone number	
Cell phone number	
E-mail	

Allergies

Are you allergic to any medication or food? Are you allergic on iodine, iodine based contrast solutions or latex? Please fill in the next form:

I am allergic on following substances:

Health questionnaire

Please take your time and answer the following questions. Your answers will help our team to acquire a comprehensive look of your health status and to plan the course of your treatment:

Body weight:____________________________ Body height: ______________________________________

Did you have previous surgeries: YES NO

If your answer is YES, please tell us what type of surgery you had:_________________________________

Did you have bad experience with general or local anesthesia: YES NO

If your answer is YES, please give us details:____

Did you suffer from postoperative nausea/vomiting? YES NO

Do you suffer from following diseases/conditions:

DISEASE / CONDITION	YES	NO	COMMENT
HEART DISEASE (FOR EXAMPLE CHEST PAIN), RHEUMATIC FEVER, HEART ATTACK, ANGINA PECTORIS?			
HEART MURMURS, PALPITATION?			
CARDIO SURGERY (FOR EXAMPLE PACEMAKER IMPLANTATION, STENT PLACEMENT, INTERNAL DEFIBRILLATOR, HEART VALVES SURGERY)?			
HIGH BLOOD PRESSURE?			
LUNG AND BREATHING DISEASES, SUCH AS ASTHMA, TUBERCULOSIS, BRONCHITIS?			
OBSTRUCTIVE SLEEP APNEA?			
HIATUS HERNIA, INDIGESTION?			
LIVER DISEASES, FOR EXAMPLE HEPATITIS B OR C, LIVER CIRRHOSIS, JAUNDICE?			
KIDNEY DISEASES?			
ABNORMAL BLEEDING OR APPEARANCE OF BRUISES ON YOUR BODY?			
ANEMIA, HEMATOLOGIC DISORDERS?			
BLOOD VESSELS THROMBOSIS?			
DIABETES MELLITUS TYPE I OR II?			
EPILEPSY?			
MIGRAINE OR HEAVY HEADACHES?			
DRUG ADDICTION?			
HIV POSITIVE OR AIDS?			
STROKE?			
DEMENTIA?			
PSYCHIATRIC DISEASES THAT REQUIRE THERAPY?			
SPINAL COLUMN ISSUES?			
THYROID GLAND DISORDERS?			
STOMACH OR DUODENAL ULCER?			
HEARTHBURN?			
MUSCLE WEAKNESS/DISORDERS?			
ARE YOU SMOKING? IF YOU ARE, HOW MANY CIGARETTES DAILY AND FOR HOW LONG?			

DO YOU DRINK ALCOHOL EVERY DAY? IF YOU DO, IN WHAT AMOUNTS?			
HAVE YOU EVER RECEIVED CHEMOTHERAPY AND/OR RADIO-THERAPY? IF YOU HAVE, WHAT WAS THE REASON?			
ARE YOU PREGNANT OR ARE YOU SUSPECTING THAT YOU MIGHT BE PREGNANT?			
HAVE YOU BEEN ADMITTED TO A HOSPITAL IN THE PAST 6 MONTHS? IF YOU HAVE, WHAT WAS THE REASON?			
DO YOU HAVE SPECIAL DIETARY DEMANDS?			

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

Medication list

Please fill in the following form. What medications are you currently using? We remind you that there are certain medications that you shouldn't take before surgery, and that you should discuss this with your doctor. Also, you should bring all of the medications that you are using to the hospital.

You can find general rules when to stop using certain medications prior to the surgical procedure.

MEDICATION	DOSAGE	TIME TO TAKE MEDICATION

Are you using blood thinners (Warfarin, Clopidogrel, Aspirin, Cardiopirin etc)?

IF YOU DO, PLEASE CONTACT OUR HOSPITAL IMMIDIATELY TO RECEIVE PROPER INSTRUCTIONS!

Other information

Do you live alone? Who will take care of you in the first 48h after discharge from the hospital?

Name and surname______________________________ Contact tel:__________________________

Who will be a contact person while you are hospitalized?___________________________________

Contact person: _________________________________Contact tel: __________________________

Do you have special needs and demands (for example, if you have problems with sight or hearing, culture specific demands etc)? If you do, please write them down for us:

____

Do you special religious demands? If you do, please write them down:

____

Can you take care of yourself without help from other person: (for example, washing and yourself, everyday home activities etc)?

____

Do you need us to provide equipment and assistive devices for walking

(canes, walkers, wheelchairs etc.)?

____

Do you need an interpreter present? If you do, for which language:

____

We will contact you before admission to discuss all the details related to your stay at our hospital. If we should be unable to reach you on the phone number that you gave us, do we have your permission to send you a SMS? YES NO

If you haven't been contacted by us 24 hours prior to planned admission, please be so kind to call us at a following number:

011 785 88 88

Your signature _______________________________________Date: ___________________________________

Your name and surname (in printed letters): ____

This informator has been filled by: patient parent legal guardian other person (who?)

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