

**Prof. Eoin O'Malley National Centre for Cardiothoracic Surgery
Mater Misericordiae University Hospital
Preadmission Checklist**



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Name: _____

G.P.: _____

Address: _____

Address: _____

Referring Hospital MRN _____

Referring Physician: _____

D.O.B: _____ Age: _____

Referring Hospital: _____

Weight _____

Occupation: _____

Scheduled Surgery Details: _____ Surgeon: _____

Diagnosis: _____

Proposed Surgery Date: _____ Inpatient Home (Please tick)

Chest Xray Date: _____ Where done: _____ Xray No: _____

CT Scan Date: _____ Where done: _____ Scan No: _____

PET Scan Date: _____ Where done: _____ Scan No: _____

Bronchoscopy: NO YES; Details: _____

Histology: NO YES; Details: _____

Previous Cardiac/Thoracic Surgery: NO YES Details: _____

Comorbid Medical Problems

Respiratory Problems: COAD NO YES

FEV1 ____L ____% FVC ____L ____%

Diabetes: NO NIDDM IDDM

Renal Impairment (Creatinine > 115) NO YES

Previous History of Stroke/TIA: NO YES

Angina Pectoris/Previous MI NO YES

Mobility: No Problems Has Problems; Please clarify: _____

Social : (Please tick appropriate category)

Patient lives alone NO YES

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