# THERAPY SERVICES
# PRE-OPERATIVE QUESTIONNAIRE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

| Name: | Hospital Number: **R** | Surgery Date (if known): |
|---|---|---|
| Date of Birth: | Consultant Name: | Surgery Procedure: |
| Patient Phone Number: | | |

**Please answer the following questions to enable your Occupational Therapist to plan your discharge home following your operation**

## Accommodation

**What type of property do you live in?**

☐ House ☐ Flat ☐ Bungalow ☐ Other _____

**Are there any steps to get into your property?**

☐ Yes ☐ No

If Yes, please state how many and if there are any rails to hold: _____

**Are there any steps between rooms inside?**

☐ Yes ☐ No

If Yes, please give details: _____

**Is there a bannister on the stairs?**

☐ One ☐ Two ☐ None ☐ Stair Lift ☐ Other

**Where is your bed?**

☐ Upstairs ☐ Downstairs

**Where is your toilet?**

☐ Upstairs ☐ Downstairs ☐ Both

**Can you get off the toliet unaided?**

☐ Yes ☐ No

If No, please give details: _____

## Social situation

**Do you live with anyone?**

☐ Yes ☐ No

If No, do you have family/friends who are able to support you on discharge? _____

**Are you a carer for someone else?**

☐ Yes ☐ No

If Yes, have you made arrangements for their care supprt during your recovery? _____

**Do you have any help? eg. homecare / assistance with household tasks, please note how often?**

☐ Yes ☐ No

If Yes, please give details: _____

## Mobility

**How do you mobilise indoors?**

☐ Independently ☐ Wheelchair ☐ with aids (e.g. sticks/walking frame)

☐ Other: _____

**How do you mobilise Outdoors?**

☐ Independently ☐ Wheelchair ☐ with aids (e.g. sticks/walking frame)

☐ Other: _____

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**Personal / Kitchen Tasks**

**Can you get in and out of bed independently?**

☐ Independently ☐ With assistance ☐ Other: _____

**Can you get on and off your chair/sofa independently?**

☐ Independently ☐ With assistance ☐ Other: _____

**Are you able to stand to strip wash?**

☐ Yes ☐ No

If No, consider arranging to have a suitable chair/stool to use at the sink.

**What kind of washing facilities do you have?**

☐ Bath ☐ Over bath shower ☐ Cubicle shower ☐ Wet room ☐ Other: _____

**Are you able to cook your own meals?**

☐ Yes ☐ No

If no, consider arranging support to help you with this on dischrage

**How will you manage your shopping when are discharged home?**

_____

**Memory**

**Do you have any problems with your memory?**

☐ Yes ☐ No

If Yes, please give details: _____

**Other**

**Do you have medical problems that affect you completing your everyday tasks?**

☐ Yes ☐ No

If Yes, please give details:

_____

**Do you have any equipment/adaptations at home? eg. toliet raises, stair lift, long handled shoe horn, helping hand**

☐ Yes ☐ No

If Yes, please give details:

_____

**Who do you pay council tax to?** _____

**Please provide a contact who willl have key access during your hospital stay in the event you require equipment to be delivered to the property.**

**Relationship:**

**Name:**

**Number:**

_____

_____

**If you have any questions regarding this form, please call Therapy services on 0121 728 9442**