



# Adult Integrated Pre-Procedure Screening Tool

Clinical Pathways Team  
Healthcare Improvement Unit

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# Introduction

This presentation provides an overview of the changes that have been made to the Adult Integrated Pre-Procedure Screening Tool

# Background

The Adult Integrated Pre-Procedure Screening Tool is used to determine a patient's readiness for a planned surgical procedure/s.

## The Screening Tool:

- Provides standardised pre-admission assessment.
- Promotes implementation of best practice prior to planned surgical procedure.

## The expected benefits are to:

- Optimise a patient's health status and knowledge prior to admission for their surgical procedure.
- Provide comprehensive health screening and education prior to a patient's scheduled surgery.
- Reduce the length of stay in hospital, and to plan for the continuum of care from hospital admission through to discharge home.

# Review process

- The 2017 review of the screening tool was undertaken to update clinical content to:
  - Reflect current evidence based guidelines.
  - Comply with Department of Health documentation Style Guidelines and Australian Standards for clinical records.
  - Ensure broad consultation with clinicians representative of perioperative departments.
- In addition, the latest review process has undergone format changes to streamline clinical content into a more succinct and user-friendly document.
- Overall governance for the review was through the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet).
- Feedback on the content was sought through SWAPNet.
- A clinical expert group was established to review the feedback and finalise the content.
- The final version (version 3.00) was endorsed by SWAPNet on 17 March 2017.

# Old vs New Version

This document no longer available

New Version 3.00 – showing page 1

**Queensland Government** (Adult identification label here)

Adult Integrated Pre-Procedure Screening Tool

URN: \_\_\_\_\_  
 Family name: \_\_\_\_\_  
 Given name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Sex:  M  F  I

Facility: \_\_\_\_\_

**Patient to complete this section**  
 Please complete and return this form to avoid any unnecessary delays in booking your surgery

**General information**

Interpreter required?  No  Yes If Yes, preferred language: \_\_\_\_\_  
 Do you have any religious / cultural needs?  No  Yes  
 Are you of Aboriginal or Torres Strait Islander origin?  No  Yes, Aboriginal  Yes, Torres Strait Islander  
 Do you have an Advance Health Directive?  No  Yes  
 Do you have an Enduring Power of Attorney?  No  Yes

Local doctor's (GP) name: \_\_\_\_\_ (town: \_\_\_\_\_)  
 Medical centre name: \_\_\_\_\_

**Do you have any allergies** (e.g. penicillin, latex, food etc.)  
 Nil known  Yes If yes, please detail: \_\_\_\_\_

**Have you seen a specialist doctor** (e.g. cardiologist) or had surgery in the last 5 years?  
 No  Yes if yes, please provide details: \_\_\_\_\_

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

**Current Medications Taken** (Bring medications with you whenever you come to hospital)  
 Please list all medications below, include over the counter medications, inhalers, topical eye drops, pain relievers, herbal medication. If you have a medication list, please attach it to this form.

Medication name	Dose	Reason (e.g. blood pressure)
1		
2		
3		
4		
5		
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8		
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10		

Page 1 of 4

**Queensland Government** (Adult identification label here)

Adult Integrated Pre-Procedure Screening Tool

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 Given name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Sex:  M  F  I

Facility: \_\_\_\_\_

**Patient to complete this section**  
 Please complete and return this form to avoid any unnecessary delays in booking your surgery

**General information**

Interpreter required?  Yes  No If yes, preferred language: \_\_\_\_\_  
 Do you have any religious / cultural needs?  Yes  No If yes, provide details: \_\_\_\_\_  
 Are you a Jehovah Witness?  Yes  No  
 Are you of Aboriginal or Torres Strait Islander origin?  Yes, Aboriginal  Yes, Torres Strait Islander  No  
 Do you have an Advance Health Directive?  Yes  No  
 Do you have an Enduring Power of Attorney?  Yes  No

Local doctor's (GP) name: \_\_\_\_\_ Phone (if known): \_\_\_\_\_  
 Medical centre name: \_\_\_\_\_

**Allergies**  
 Do you have any allergies (medicines, stocking plaster, iodine, latex, food etc.)?  Yes (provide details)  Nil known  
 Details: \_\_\_\_\_

**Illness / Surgical history**  
 Have you seen a specialist doctor (e.g. cardiologist) or had surgery?  Yes (provide details)  No

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

**Current medications taken** (Bring medications with you whenever you come to hospital)  
 Please list all medications below, include blood thinners, steroids, diabetic medications, over the counter medications, inhalers, topical eye drops, pain relievers, herbal medication. If you have a medication list, please attach it to this form.  I am on blood thinners

Medication name	Dose	Reason (e.g. blood pressure)
1		
2		
3		
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Page 1 of 4

# Major Changes – Page 1

## Page 1

- ‘Have you send a specialist doctor’ heading replaced with ‘Illness/Surgical history’ heading.
- Illness and Surgical history separated into two sections.
- Surgery restriction of ‘last 5 years’ removed.
- Prompts for blood thinning medication included in medication list.

# Major Changes – Page 2

## Page 2

- Observations moved from page 4 to page 2.
- New Referral Pathways for staff included.
- Inclusion of the following General Health Questions:
  - Neck or jaw limiting movement
  - Dentures and loose or chipped teeth
  - Heart surgery
  - Arrhythmia or palpitations
  - Liver and kidney disease
  - Anaemia/previous blood transfusions
  - Further details for COPD/Emphysema/Lung Disease, Epilepsy and Arthritis.

# Major Changes Pages 3

## Page 3

- New 'Office Use' section.
- Infection alert moved from page 4 to page 3.
- Nutrition and skin integrity condensed.
- New 'nurse comments' section included.



# Major Changes Pages 4

## Page 4

- Inclusion of checklist with the following:
  - Patient still requires/wants surgery
  - Current health status
  - Allergies
  - MRO status
  - Weight
  - Skin integrity
  - Blood thinning medication
  - Vitamins and supplements
  - Transport
- New 'confirmed /action taken' and 'patient education' sections.
- Review by 'nursing/medical staff' section added.

# Page 1

## General Information

- This section is for the collection of information on the following:
  - Religious and cultural needs
  - Interpreter required
  - Aboriginal or Torres Strait Islander status
  - Advance Health Directive
  - Enduring Power of Attorney
  - GP Details
  - Allergies
  - Major Illnesses
  - Surgical History
  - Medications

Queensland Government

Adult Integrated Pre-Procedure Screening Tool

(Affix identification label here)

URN: \_\_\_\_\_

Family name: \_\_\_\_\_

Given name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Facility: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex:  M  F

**Patient to complete this section**

Please complete and return this form to avoid any unnecessary delays in booking your surgery

**General Information**

Interpreter required?  Yes  No  Just if yes preferred language: \_\_\_\_\_

Do you have any religious / cultural needs?  Yes  No if yes provide details: \_\_\_\_\_

Are you a Jehovah Witness?  Yes  No

Are you of Aboriginal or Torres Strait Islander origin?  Yes Aboriginal  Yes Torres Strait Islander  No

Do you have an Advance Health Directive?  Yes  No

Do you have an Enduring Power of Attorney?  Yes  No

Local doctor's (GP) name: \_\_\_\_\_ Phone (if known): \_\_\_\_\_

Medical centre name: \_\_\_\_\_

**Allergies**

Do you have any allergies (medicines, sticking plaster, iodine, latex, food etc.)?  Yes (provide details)  Not known

Details: \_\_\_\_\_

**Illness / Surgical history**

Have you seen a specialist doctor (e.g. cardiologist) or had surgery?  Yes (provide details)  No

**Major illness**

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

**Surgical history**

Date of last visit	Hospital / Clinic	Name of doctor	Reason for seeing doctor / type of surgery (e.g. heart / lung problems, diabetes)

**Current medications taken** (bring medications with you whenever you come to hospital)

Please list all medication's below. Include: blood thinners, steroids, diabetic medications, over the counter medications, inhalers, topical, eye drops, pain relievers, herbal medication. If you have a medication list please attach it to this form.  I am on blood thinners

Medication name	Dose	Reason (e.g. blood pressure)
1		
2		
3		
4		
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# Page 2

## Health Questionnaire

- This section is for the collection of observations, relevant medical history and referral pathways.

Weight	Height	Temp	Pulse	Blood pressure	Temp	Rescs	O. sat.	BCL
kg	cm	°C	/	/	°C	%	mmol/L	mmol/L
Please complete the following sections to help us to plan your care for your hospital stay								
<b>Health questionnaire</b>								
Do you have, or have you ever had, any of the following? If yes, provide further details:								
1. Have you, or any of your blood relatives ever had a problem with an anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
2. Difficulty swallowing, opening your mouth or moving your neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
3. Difficulty waking up more than two nights of sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What stops you from waking better?						
4. Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Upper only <input type="checkbox"/> Lower only <input type="checkbox"/> Both upper and lower						
5. Loose or chipped teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
6. High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is it controlled on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No						
7. Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	How frequently? Details:						
8. Arrhythmia or palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
9. Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? Details:						
10. Heart surgery / pacemaker / defibrillator implanted	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
11. Other heart problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
12. Heartburn or acid reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Well controlled on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No						
13. Liver disease / hepatitis / jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
14. Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:						
15. Blood clots in the legs or lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
16. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Usual blood sugar level: <input type="checkbox"/> Pre-diabetic <input type="checkbox"/> Diet controlled <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin						
17. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	How frequent are attacks? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Never Ever had asthma requiring hospitalisation or close GP monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No						
18. COPD / Emphysema / Lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent / recent infection / exacerbations? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:						
19. Sleep apnoea	<input type="checkbox"/> Yes <input type="checkbox"/> No	CPAP Machine? <input type="checkbox"/> Yes <input type="checkbox"/> No						
20. Stroke or TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
21. Epilepsy or fits	<input type="checkbox"/> Yes <input type="checkbox"/> No	How frequent are attacks? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Never Details:						
22. Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:						
23. Bleeding / bruising disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
24. Anaemia / Previous blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:						
25. Have you ever smoked tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you smoked in last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of cigarettes per day: <input type="text"/>						
26. Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often? <input type="text"/>						
27. Do you take recreational (party) drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What do you take and how often? <input type="text"/>						
28. Could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many weeks? <input type="text"/>						
29. Do you suffer from anxiety, depression or emotional disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: <input type="text"/>						
30. Other medical conditions or disabilities not already mentioned	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: <input type="text"/>						
Office use: referral pathways: <input type="checkbox"/> Refer to Anaesthetist <input type="checkbox"/> Outline <input type="checkbox"/> IAGOS <input type="checkbox"/> Social Worker <input type="checkbox"/> GP <input type="checkbox"/> My Age Care <input type="checkbox"/> Other: <input type="text"/>								

DO NOT WRITE IN THIS BINDING MARGIN

## Planning for your care

- This section is to document the care required for patients during their hospital stay and upon discharge.
- Includes skin integrity, infection alert, falls history, nutrition and nurse comments section.

(Affix identification label here)

**Queensland Government**

**Adult Integrated Pre-Procedure Screening Tool**

URN: \_\_\_\_\_  
 Family name: \_\_\_\_\_  
 Given name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Sex:  M  F

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**Planning for your care**

Accommodation:  Home /  Hotel  Boarding  Retirement village  Nursing home  Other \_\_\_\_\_  
 Number of stairs - Front / Back: \_\_\_\_\_ Internal: \_\_\_\_\_

**Please answer the following questions**

Question	Response	Office use (if yes, complete the following)
1 Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Discuss with patient <input type="checkbox"/> Refer to: _____
2 Do you have friends or family to help you when you leave hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Discuss with patient <input type="checkbox"/> Refer to: _____
3 Do you have care responsibilities for others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Discuss with patient <input type="checkbox"/> Refer to: _____
4 Do you have difficulty managing day to day activities?	<input type="checkbox"/> Mobility <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Other _____	<input type="checkbox"/> Consider anaesthetist referral <input type="checkbox"/> Communicate with ward
5 Do you have any special dietary requirements (list)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details: _____	<input type="checkbox"/> Discuss with patient
6 Do you have any bowel or urine problems (e.g. bleeding or incontinence)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details: _____	<input type="checkbox"/> Communicate with ward
7 Do you have Community support services?	<input type="checkbox"/> Community nursing <input type="checkbox"/> Other / Name of provider: _____ <input type="checkbox"/> Home help <input type="checkbox"/> Meals on wheels	<input type="checkbox"/> Consider anaesthetist referral <input type="checkbox"/> Refer to: _____
8 Do you have difficulties with any of the following?	<input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Touch <input type="checkbox"/> Vision If yes, details: _____	<input type="checkbox"/> Consider anaesthetist referral <input type="checkbox"/> Communicate with ward
9 Will your occupation affect your recovery / or do you need a Medical Certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Discuss with patient
10 How do you intend to arrive for your admission and discharge?	Admission: _____ Discharge: _____	<input type="checkbox"/> Discuss with patient suitability of mode <input type="checkbox"/> PREAC review
11 Skin integrity: Do you have skin problems such as sores, skin tears, bruises, blisters, rashes, corns, eczema or pressure sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details: _____	<input type="checkbox"/> Discuss with patient / consultant / GP <input type="checkbox"/> OPD review <input type="checkbox"/> Consider anaesthetist referral
12 Infection alert: Have you ever been placed in a private room during your hospital stay due to an infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details: _____	<input type="checkbox"/> Communicate with ward
13 Falls history: Have you had any falls in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Complete full falls / frailty assessment
14 Nutrition: Have you lost more than 5kg over the last 6 months without trying?	<input type="checkbox"/> Yes (2) <input type="checkbox"/> Unsure (2) <input type="checkbox"/> No (0)	Total score: _____ If yes, or unsure, contact dietitian or refer to Malnutrition Action Flowchart
15 Have you been eating poorly because of a decreased appetite?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	

DO NOT WRITE IN THIS BINDING MARGIN

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Nurse comments**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Page 3 of 4

# Page 4

## Staff to complete section

- Staff to document that they confirmed the following with the patient:
  - Wants/requires surgery
  - Changes in condition or health
  - Allergies
  - MRO status
  - Current illnesses
  - Skin intact
  - Medications/vitamin supplements
  - Discharge arrangements
- Patient education
- Review sign off by nursing/medical staff

Queensland Government		(Affix identification label here)	
Adult Integrated Pre-Procedure Screening Tool		URN:	
Facility:		Family name:	
		Given name(s):	
		Address:	
		Date of birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I
Staff to complete this section			
<b>Surgery details</b>		Consistent:	
Date of assessment:			
Procedure:			
Confirmed with the patient		Confirmed / Action taken	
1. Patient still requires / wants surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason: _____	<input type="checkbox"/> Discussed with the team <input type="checkbox"/> Removed from ESWL	
2. Patient has not had any changes in condition or health since completion of last health assessment for this procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what has changed? _____	<input type="checkbox"/> Discussed with the team <input type="checkbox"/> Surgery delayed <input type="checkbox"/> Consider anaesthetist referral	
3. Allergies recorded on AIST checked with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consider anaesthetist referral <input type="checkbox"/> MCBIS updated	
4. MRO status checked with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Weight recorded on AIST checked with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Patient is currently well (cough, cold or other illness)?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason: _____	<input type="checkbox"/> Discussed with the team <input type="checkbox"/> Surgery delayed <input type="checkbox"/> Consider anaesthetist referral	
7. Patient's skin is intact – free from cuts, scratches and signs of infection (redness, oozing, pusulent)?	<input type="checkbox"/> Yes <input type="checkbox"/> No, describe: _____	<input type="checkbox"/> Discussed with the team <input type="checkbox"/> Surgery delayed <input type="checkbox"/> Consider anaesthetist referral	
8. Patient's medication on AIST has been confirmed / patient has not recently started taking any new medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No List new medications: _____	<input type="checkbox"/> Discussed with the team <input type="checkbox"/> Consider anaesthetist referral	
9. Patient is on blood thinning medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of medication: _____ Patient advised to cease medication from: / / Other: _____		
10. Vitamins or natural supplements have been discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Patient advised to cease medication from: / / Other: _____		
11. Transport for admission and discharge has been arranged by the patient?	Admission: <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Refer to Social Worker <input type="checkbox"/> Refer to other: _____	
12. Somebody is available to assist with ADL's as necessary after discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Surgery delayed	
<b>Patient education</b>			
Admission information	<input type="checkbox"/> Admission time (subject to change - confirmed when patients phone 3 days prior for health check)	<input type="checkbox"/> Admission location	<input type="checkbox"/> Morning medication instructions
Pre-operative education	<input type="checkbox"/> Patient journey explained (DSU -> Holding bay -> Theatre -> Recovery -> Day surgery or ward) <input type="checkbox"/> Expected length of stay is between _____ and _____ days <input type="checkbox"/> Showering – the night before and morning of your surgery <input type="checkbox"/> Males – use an electric shaver or take safety care when using a blade to prevent cutting skin, trim beards	<input type="checkbox"/> Skin care (e.g. gardening as cuts can result in the cancellation of your surgery) <input type="checkbox"/> Nails – all nail polish and Acrylic / Gel nails must be removed <input type="checkbox"/> Valuables – jewellery to be removed and left at home, minimal money to be brought into hospital	
Discharge restrictions / requirements discussed	<input type="checkbox"/> Driving <input type="checkbox"/> Lifting <input type="checkbox"/> Responsible adult for 24hours for day case (over 18) <input type="checkbox"/> N/A	<input type="checkbox"/> Post-operative visit <input type="checkbox"/> Home hold check <input type="checkbox"/> Pre-prepared beds	
Information / Education given by:	Name: _____ Designation: _____	Signature: _____	Date: _____
Review by nursing / medical staff	Suitable for anaesthetic review on day of procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No Requires referral to anaesthetic clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No Requires specialist anaesthetic assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____ Designation: _____	Signature: _____ Date: _____

DO NOT WRITE IN THIS BOUNDARY

# How to Order

OM Code	Form ID	Version	Form Title	Description in OfficeMax Catalogue
4317564	SW269	v3.00-04/2017	Adult Integrated Pre-Procedure Screening Tool	Adult Integrated Pre-Procedure Screening Tool v3.00 - SW269 (Pack of 25)

- Clinical Pathways website:  
<http://qheps.health.qld.gov.au/car/clinical-pathways/default.htm>
- For further information and enquiries regarding Clinical Pathways, contact:  
[Clinical\\_Pathways\\_Program@health.qld.gov.au](mailto:Clinical_Pathways_Program@health.qld.gov.au)