fraserhealth

LATEX ALLERGY QUESTIONNAIRE

Site:_____ Name: _____ Date:_____

(PATIENT TO COMPLETE QUESTIONS 1- 8)

PART A:	**YES**	**NO**
1. Do you have Spina Bifida?		
2. Have you ever had an UNEXPLAINED allergic reaction during a medical or dental procedure such as a drop in blood pressure, breathing difficulty, wheezing, fainting, shortness of breath, seizures? Please describe your reaction: _____ _____ _____		
3. Have you experienced a rash, itching, nose or eye irritation or shortness of breath after contact with rubber gloves, balloons, condoms, or other rubber/latex products?		
PART B:	**YES**	**NO**
4. Do you have a history of urinary/bladder problems or defects requiring frequent catheterizations?		
5. Does your work involve repeated contact with rubber or latex products? (e.g. - health care workers, workers who manufacture rubber or latex products)		
6. Do you have a history of more than 5 surgical procedures?		
7. Do you have a history of Hay fever, Asthma and/or Eczema?		
8. Are you allergic to any of the following foods? (please circle) Chestnut Banana Avocado Tomato Kiwi Potato Papaya Please describe your reaction: _____ _____ _____		

If Part A is **YES**, treat as Latex sensitive until proven otherwise and complete checklist below.
If any of Part B is **YES**, document & observe for any allergic reactions.

CHECKLIST FOR ADMITTED PATIENT IDENTIFIED AS HAVING KNOWN OR SUSPECTED LATEX ALLERGY

R.N. RESPONSIBILITY	✓	**SIG.**
Notify physician of known or suspected latex allergy		
Obtain a Latex Kit from SPD		
Identify CCI - Latex Sensitivity through Order Entry Select category - Health Records; Procedure - CCI **Note: Following identification of CCI through Order Entry, an order will automatically be sent to Housekeeping, Supervisor, Lab, Pharmacy, Nurtrition.**		
For pre-op patient, phone: O.R./P.A.C.U. Patient Care Manager, Receiving Unit (if patient being transferred)		

Stores # 307847

(PATIENT TO COMPLETE QUESTIONS 1 - 5)

CAGE QUESTIONNAIRE

1. Have you ever felt the need to CUT DOWN on drinking? Yes ☐ No ☐
2. Have you ever felt ANNOYED by criticism of your drinking? Yes ☐ No ☐
3. Have you ever felt GUILTY about your drinking? Yes ☐ No ☐
4. Have you ever had a drink (or drug) to get you started in your day or to steady your nerves? Yes ☐ No ☐
5. When did you have your last drink? DATE: _____

(PATIENT TO COMPLETE QUESTIONS 1 - 6)

DETAILED FAGERSTRÖM ASSESSMENT

1. How soon after waking do you have your first cigarette?	☐ Within 5 minutes (3 points) ☐ 6 - 30 mins (2 points) ☐ 31 - 60 mins (1 point) ☐ More than 1 hours (0 points)
2. Do you find it difficult to refrain from smoking in places where it is forbidden?	☐ Yes (1 point) ☐ No (0 points)
3. Which cigarette would you be most unwilling to give up?	☐ First in morning (1 point) ☐ Any others (0 points)
4. How many cigarettes, on average do you smoke per day?	☐ 31 or more (3 points) ☐ 21-30 (2 points) ☐ 11 - 20 (1 point) ☐ 10 or less (0 points)
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	☐ Yes (1 point) ☐ No (0 points)
6. Do you smoke even if you are so ill that you are in bed most of the day?	☐ Yes (1 point) ☐ No (0 points)

PATIENT SIGNATURE: _____

NURSING SIGNTURE: _____

DATE: _____