Artarmon Day Surgery

448 Pacific Hwy, Artarmon NSW 2064
Phone: 1300 559 848
www.artarmondaysurgery.com.au

Complete and send this form at least 7 days before Admission

patient label

PLANNED ADMISSION DATE

PATIENT DETAILS

TITLE	GIVEN NAMES	FAMILY NAME
ADDRESS		
POSTAL ADDRESS (IF DIFFERENT TO ABOVE)		POSTCODE
TEL HOME	TEL WORK	MOBILE
EMAIL ADDRRESS *please print clearly*		
DATE OF BIRTH / /	SEX FEMALE ☐ MALE ☐	PERMANENT RESIDENT YES ☐ NO ☐
MARITAL STATUS MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED ☐ DE FACTO ☐		
INDIGENEOUS ABORIGINAL ☐ TORRES STRAIT LANDER ☐ BOTH ☐ NEITHER ☐		
LANGUAGE SPOKEN AT HOME	COUNTRY OF BIRTH	OCCUPATION
MEDICARE NO. ☐☐☐☐☐☐☐☐☐☐ REFERENCE NO. ☐ (LOCATED BESIDE YOUR NAME ON CARD)		EXPIRY DATE

EMERGENCY CONTACTS

NEXT OF KIN		RELATIONSHIP	MOBILE
NAME OF ESCORT		RELATIONSHIP	MOBILE

YOUR HEALTH FUND

NAME OF FUND	MEMBERSHIP NO.
I HAVE NO HEALTH FUND COVER ☐	
I HAVE OVERSEAS INSURANCE ☐	WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSION OR FULL PAYMENT WILL BE REQUIRED ON ADMISSION.
HAVE YOU BEEN ADMITTED TO HOSPITAL IN THE LAST 28 DAYS? YES ☐ NO ☐	

PENSION & HEALTH CARE CARD DETAILS (IF APPLICABLE)

PENSION NO. ☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE ☐☐☐☐	
DEPT VETERANS AFFAIRS NO. ☐☐☐☐☐☐☐☐☐	DVA CARD COLOR
REFERRING LOCAL DOCTOR	SUBURB OF LOCA DOCTOR

IF CLAIMING WORKERS COMPENSATION/THIRD PARTY ACCIDENT INSURANCE

WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSION OR FULL PAYMENT WILL BE REQUIRED ON ADMISSION.

EMPLOYER		
ADDRESS		POSTCODE
TEL	CONTACT	DATE OF ACCIDENT
INSURANCE COMPANY	CONTACT	CLAIM NO..
ADDRESS	POSTCODE	TEL

APPROVAL GIVEN YES ☐ NO ☐ (IF YES, PLEASE ATTACH CONFIRMATION LETTER)

VERSION 1
10APR17

PAYMENT AGREEMENT

To the best of my knowledge, the above information is true and correct. I agree to pay any shortfall in reimbursement by the Health Fund.

PATIENT SIGNATURE

PLACE BARCODE LABEL HERE

RISK ASSESSMENT

MEDICAL HISTORY

List previous operations, hospital admissions or any major/serious illness

Have you experienced an adverse reaction during anaesthesia general or local ? YES ☐ NO ☐

Has any of your Family experienced an adverse event during anaesthesia?
YES ☐ NO ☐ if yes, please specify

MEDICATIONS / ALLERGIES

Please list current medications including any non-prescribed medications such as vitamins, herbs, natural or traditional therapies

MEDICATION/DRUG OR VITAMIN NAME	STRENGTH	NO. TAKEN	HOW OFTEN

Have you used steroid/cortisone medication in the past 6 months?
YES ☐ NO ☐

BLOOD THINNERS — Have you taken any blood thinning medication this week? Aspirin, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix, Brufen, Nurofen, Indocid) or Natural Thinners (eg Vitamin E, Chinese herbs, Ginko, Fish Oil)? YES ☐ NO ☐

DIABETES
- Do you use insulin ? YES ☐ NO ☐
- Are you tablet controlled ? YES ☐ NO ☐
- Are you diet controlled? YES ☐ NO ☐

Please bring ALL diabetic tablet medications AS WELL as your INSULIN on day of admission.

ALLERGIES — Do you have any known allergies to any medications, dressings, latex or food? If yes, please list

HEIGHT in cms _____ WEIGHT in kgs _____

DO YOU HAVE, NOW OR IN THE PAST, ANY OF THE FOLLOWING?	YES	NO
CIRCULATION		
SEVERE HEART PROBLEMS Heart attack, heart failure, acute myocardial infarction. Any recent hospitalisation for heart disease		
A PACEMAKER OR DEFIBRILLATOR Please bring your Pacemake / Defibrillator card with you		
BLOOD CLOTS (DVT/PE)		
STROKE (TIA)		
Malignancy or recent fracture		
Blood pressure NORMAL ☐ HIGH ☐ LOW ☐		
Anaemia		
RESPIRATORY		
SEVERE LUNG DISEASE		
Asthma		
Recent respiratory infection (cold or flu) or signs or symptomscwith a temperature over 38 degrees? If YES, please contact the Clinical Services Manager at your nominated hospital.		
SYSTEM		
Sleep apnoea		
Vision impairment		
Hearing impairment		
Cochlear implant		
Bladder / kidney problems		
Anxiety / depression /panic attack		
Epilepsy / seizures / fits / dizzy spells		
INFECTION		
Tick if any apply to you Hepatitis A ☐ B ☐ C ☐ D ☐ E ☐		
Tick if any apply to you TB ☐ MRSA ☐ VRE ☐ CRE ☐		
In the last 2 weeks, have you had, or been in contact with, anyone with Chicken Pox or German Measles?		
Do you or any of your family suffer from or had exposure to **Creutzfeldt jakob disease (CJD)**?		
Received human pituitary hormone or had a dura mater graft between 1972 and 1989?		
DENTAL		
Crowns, bridges, dentures, caps		
Dental problems (eg gum disease, loose teeth, cracks)		
MOBILITY		
Fallen in the past 12 months		
Medication in the past 24 hours that impairs your co–ordination/ mental function		
Cognitive impairment (eg disorientation, dizziness, confusion, memory loss, inabilitiy to follow instructions)		
Back pain or injury / mobility problems Bed or wheel chair bound		
SKIN		
Skin rash, eczema, skin tear		
History of pressure areas		
LIFESTYLE		
Alcohol: How much each day ? _____ Standard drinks		
Tobacco: How many each day? _____		
OTHER		
Have you ever used IV or recreational drugs? If female, are you pregnant?		
Needle phobia: If YES, please inform reception staff upon arrival		
Any medical conitions/physicall disability that may affect your procedure with us? If YES, please list		
Do you have any advanced directive or limiting order? If YES, please supply a copy prior to your surgery to our medical team.		

PATIENT/GAURDIAN SIGNATURE

ADMISSION NURSE: If YES to any of the above, record in COMMENT section of Theatre Checklist

NURSE SIGNATURE

patient label

PRIVACY INFORMATION STATEMENT

In order to provide your medical treatment, the Day Hospital will need to collect and use personal information about you. The information we may need to collect and how it will be used, including possible disclosure to third parties and rights you have in relation to that information is explained in this statement. We appreciate the sensitivity of personal health information and undertake to keep your information confidential and use it only as outlined below.

1. Collection

The Day Hospital and its medical practitioners and staff will collect the information that 's necessary for us to provide advice and treatment to you. This information nay include:

- your medical history;
- your family rredical history:
- your symptoms, diagnosis and recommended treatment;
- ethnicity;
- contact details;
- Medicare/private health fund details; and
- billing/account details.

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, including other medical practitioners or health providers and with your consent, from family members.

2. Use & Disclosure

Artarmon Day Surgery and its medical practitioners and staff will use and disclose your personal information fora range of purposes related to your treatment. These purposes may irclude:

- Disclosure of your information within the treating team for the purposes of your treatment
- Communica ion with referring medical practitioners;
- Sending of specimens for analysis;
- Account keeping and billing, including Medicare and private health insurance claims;
- The management of our practice, including quality assurance and practice accreditation;
- Complaints handling and notification to our insurers;
- Disclosure to third parties, including the Director General of the NSW Ministry of Health, where legally required to do so, such as producing documents in answer to a court subpoena or mandatory reporting of certain notifiable diseases.

In addition, we may use non–identifying information taken from your medical tile for data analysis and research.

3. Access

Except in a very limited range of circumstances recognised under relevant privacy legislation, you are entitled to access your own health records at any time convenient to both yourself and the practice. Your request should be forwarded in writing. A fee will be charged for staff time in retrieving files and photocopying to process the request.

If you dispute the accuracy of the information we have recorded, you should notify us in writing. It is our policy that all steps will be taken to record your corrections, and place them with your file. The original record however will not be erased.

4. Consent

If after receiving this privacy information statement, you request treatment from the Artarmon Day Surgery, we will assume you have consented to the collection, use and disclosure of your personal information as described above. If you have any questions or concerns, please do not hesitate to discuss them with one of our staff or your treating medical practitioner.

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

You are entitled to expect:

- An environment that provides quality health care which meets recognised standards and practices while conscious of your needs as an individual.
- Confidentiality of your personal information except when information needs to be provided to another health care worker to assist in your care, when authorised by or under law, or when specifically consented to by yourself.
- Adequate information to prepare for your procedure.
- Consultation in the planning of your care for your stay and in preparation for your discharge.
- An explanation of your potential treatment, the possible risks, expected outcomes and significant side effects as part of the informed consent by your doctor.
- Advice on the likely out-of-pocket expenses which you are required to pay
- The right to request access to your personal information through the Clinical Services Manager.

It is your responsibility to:

- Inform us of any medical condition, ongoing treatment or circumstance which may impact on your care while a patient at the Day Hospital.
- Read and follow the guidelines which are given to assist you in preparing for your surgery and care following your discharge.
- Be considerate of staff and other patients.
- Arrange for an adult to escort you home and stay with you for 24 hours following surgery under general anaesthetic.

initial

☐ I have read and agree with the Artarmon Day Surgery privacy information statement

PLEASE COMPLETE THIS SECTION DURING ADMISSION

	YES	NO
DENTAL RISK : I accept the risks associated with the use of an airways device as explained by my docotor. I acknowledge that I have been informed by hospital staff of the following requirements relating to my discharge from the hospital:		
• I must be escorted home by a responsible person and have arranged for a responsible person to stay with me overnight and preferably for the first 24 hours past procedure.		
• Take all medications prescribed by the doctor.		
• NOT drink any alcohol on the day or night of admission.		
• It is essential NOT to drive a motor vehicle or motor bike until the day AFTER my admission. This means no driving on the remainder of the day of my admission after discharge, but I can drive the next day after a good night's sleep.		
• Avoid tasks that involve concentration or responsible decision making		
• I understand that the premises are under constant video surveiillance for security reasons and I agree for the recording to handed to law enforcement agencies/security if requested.		

PATIENT SIGNATURE DATE

PRE ADMISSION SUMMARY TO BE COMPLETED BY SPECIALIST

patient label

PROVISIONAL DIAGNOSIS

OPERATION DATE

PROVISIONAL ITEM NUMBERS

RELEVANT HISTORY (Comorbidities)

PHYSICAL EXAMINATION

SPECIFIC PRE-OPERATIVE INSTRUCTIONS (including bowel preparation)

ANAESTHETIC REVIEW REQUIRED YES ☐ NO ☐

DOCTOR STATEMENT

I, Dr _____ have discussed with my patient _____

/their parent/guardian, the procedure being performed (stated below), their present condition, alternative treatments available and explained the benefits and material risks of the proposed operation/procedure/treatment.

DOCTOR SIGNATURE

REQUEST FOR SURGICAL OPERATION/PROCEDURE &/OR MEDICAL TREATMENT

I, _____ (PATIENT/GUARDIAN) have discussed the

Estimated length of procedure

operation/procedure/treatment of _____

with the Doctor named above and request the above operation/procedure/treatment to be performed.

The doctor has told me that:

- The procedure/treatment carries some risks and that complications may occur;
- An anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I consent ☐ / I DO NOT consent ☐ to blood transfusions/blood products if required during the operation/procedure/treatment.

PATIENT / GAURDIAN SIGNATURE | DATE

CONSENT FOR STUDENT/S TO BE PRESENT AT PROCEDURE

Artarmon Day Surgery are committed to supporting nursing and medical students in developing high standards of professionalism through education and training. At times, these students may be present in the operating theatre to observe procedures.

I consent ☐ / I DO NOT consent ☐ to the presence of medical and/or nursing students in the operating theatre during my procedure.

PATIENT / GAURDIAN SIGNATURE | DATE

PLEASE COMPLETE ON ADMISSION IF ANOTHER SPECIALIST IS ATTENDING YOUR PROCEDURE TODAY

I understand that Dr. _____ will be attending me as the patient and I agree to him/her performing the operation / procedure / treatment.

PATIENT / GAURDIAN SIGNATURE | DATE

INTERPRETER

I, _____ am an accredited interpreter have accurately interpreted the advice given by the Doctor named above (name of patient) _____

INTERPRETER SIGNATURE | DATE