

WESTERN DAY SURGERY

145 Furlong Road St. Albans Victoria 3021
 Telephone 9366 0666 Facsimile 9366 0777

**FORM MUST BE RETURNED PRIOR TO ADMISSION TO CONFIRM BOOKING.
 IF THERE IS INSUFFICIENT TIME TO POST THE FORM, PLEASE TELEPHONE THE HOSPITAL.**

MEDICAL ADMISSION DETAILS

Patient Name (please print) _____
 Operation Date _____ Admission/Time _____
 Fast From Time _____ am/pm Date _____
 Provisional Diagnosis _____
 Proposed Operation(s)/Procedure(s) _____
 Relevant Medical Details _____

PATIENT'S CONSENT

I, _____ (given name) _____ (surname) hereby request
 the following operation(s)/procedure(s) _____ (specify)

and such further operative procedures found to be necessary to be performed during the course of the operation(s)/procedure(s) and/or medical and nursing care including examinations, tests, blood transfusions and drugs as deemed necessary during this stay in hospital being performed upon,

_____ (given name) _____ (surname)
 I confirm that I understand, to my satisfaction, the nature and effect of the above operation(s)/procedure(s) which have been explained to me by doctor _____
 In conjunction with the above stated operation(s)/procedure(s) I request the administration of such anaesthetic(s) as may be considered by the anaesthetist to be necessary or advisable.

Dated this _____ day of _____ 20_____
 Signed (Patient/Next of Kin) _____ Relationship to patient* _____
 Signed (witness to signature only) _____ *eg mother, son, friend

DOCTORS CONFIRMATION OF CONSENT

I, Doctor _____, have explained to the patient/person responsible for the patient the nature and effect of the above operation(s)/procedure(s) and the anaesthetics(s) involved. In my opinion he/she understood this explanation.

Dated this _____ day of _____ 20_____
 Signature of Doctor _____

INVESTIGATIONS/SPECIAL REQUIREMENTS ON ADMISSION

MEDICATION ORDERS ON ADMISSION

Drug orders on Admission	Date	Dose	Route	Frequency & Duration	Doctor's Signature	Record of Administration				
										time given
										time given
										time given
										time given
										time given
										time given
										time given
										time given

DOCTORS TO COMPLETE

PREADMISSION FORM MRI

- Smoking is not permitted within the hospital.
- Please safeguard your valuables by leaving them at home.

PLEASE READ THROUGH THIS FORM CAREFULLY BEFORE SIGNING THIS SECTION

I elect to be treated as a private patient and I will be responsible for all charges listed below:

- (a) hospital fees
- (b) charges for medical services including diagnostic services performed and/or ordered by the doctor of my choice or by other medical practitioners to whom I may be referred
- (c) prostheses and
- (d) dental services.

I understand that if I have private health insurance, it may not fully cover all costs incurred as a result of treatment as a private patient.

Please contact Western Day Surgery on 9366 0666 if you have any queries relating to your Health Insurance cover or out of pocket expenses.

I agree to be personally responsible for payment of all hospital treatment irrespective of any claim I may have against any health funds or other third party.

Signed _____ Date _____

Relationship to patient* _____ *eg mother, son, friend

Admitting Doctor _____

Admission Date _____ Time _____ am/pm

PRIVACY ACT

This form is subject to the Privacy Act of July 2002.
For further information please contact Western Day Surgery on 9366 0666

FASTING - PREPARATION FOR SURGERY

Prior to your procedure you must fast for at least six hours.

Morning procedures - Nothing to eat or drink after midnight.

Afternoon procedures - No food or drink for at least 6 hours.

Smoking - avoid for at least 12 hours prior to your procedure.

Medication - check with your doctor about taking any current medications prior to admission. With your doctors permission, medications may be taken on the morning of the procedure with a small sip of water.

Diabetic Patient - while fasting do **NOT** take insulin or oral diabetic tablets. Bring your medication with you.

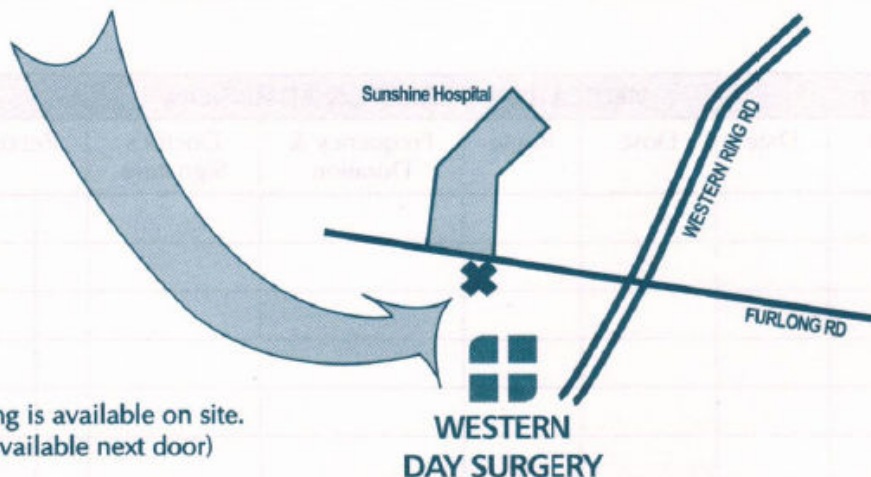
PLEASE NOTE: You are not permitted to drive following your anaesthetic. You should arrange for a responsible adult to accompany you home and remain with you.

Due to the anaesthetic, it is important that for the next 24 hours you do not:

- Drive a vehicle
- Operate machinery
- Drink alcohol
- Take sedatives unless prescribed
- Sign any important legal documents

Instructions - written and verbal instructions for after-care will be given at time of discharge. If required a follow-up appointment will be organised.

HOSPITAL LOCATION AND OFF STREET PARKING



Limited car parking is available on site.
(Public car park available next door)

PATIENT TO COMPLETE

PATIENT DETAILS

Mr Miss Mrs Ms

Surname _____ Given Names _____

Previous Name (if applicable) _____

Address _____ Postcode _____

Date of Birth _____ Age _____ Religion _____

Marital Status: M S W D Defacto Occupation (usual or past) _____

Tel: Home _____ Bus _____ Mob _____

Country of Birth _____ State _____

Language(s) Spoken _____ Interpreter Required? Yes / No

Are you an Australian Aboriginal or Torres Strait Islander? Yes / No

Have you been at Western Day Surgery before? Yes / No Date if known _____

Medicare No _____ Valid to _____

Pension No _____ Veteran Affairs No _____

NEXT OF KIN

Surname _____ Given Names _____

Address _____ Postcode _____

Relationship _____

Tel: Home _____ Bus _____ Mob _____

ACCOUNT DETAILS

ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF ADMISSION

Not insured W/Cover · Hospital Benefits Fund _____

Health Fund TAC · Member No: _____

Dept Veterans Affairs · Level of Cover _____

(please tick appropriate box) · Name of Contributor _____ Date paid to _____

WORKCOVER PATIENTS

Workcover Agent Name _____

Address _____

Claim No _____ Date of Injury _____ Contact Person _____

Employer Name & Address _____

Contact Person _____ Telephone No _____

TRANSPORT ACCIDENT COMMISSION PATIENTS

Date of Accident _____ Location _____

Vehicle(s) Registration No(s) _____ & _____ Claim No _____

ADMISSION

Admitting Doctor _____ Date to be admitted _____ Time _____

Family Doctor/Clinic Name _____

Address _____ Postcode _____

Tel _____ Fax _____ Mobile _____

PATIENT TO COMPLETE

PREADMISSION FORM MR1

PREADMISSION ASSESSMENT

Are you allergic or do you react to: **Yes No**

Medicine / Drugs _____

Tapes (i.e. bandaids) _____

Latex or rubber _____

Food(s) _____

Other _____

If Yes, please specify _____

Have you ever had any of the following complaints: Yes No

High blood pressure _____

Heart attack /Heart operation(s) _____

Chest pain _____

Indigestion or reflux _____

Rheumatic Fever _____

Anaemia _____

Stroke _____

Blood clot on lungs / legs _____

Is there family history of blood clots? _____

Asthma / Bronchitis _____

Shortness of breath _____

Hayfever _____

Tuberculosis _____

Pneumonia _____

Kidney disease / Kidney Stones _____

Epilepsy / Fits or Fainting Spells _____

Diabetes _____

Sleep disorders _____

Back or neck problems _____

Are you in a high risk group for Hepatitis or HIV? _____

Females: Could you be or are you pregnant? _____

Have you recently had a cough, cold or sore throat? _____

Do you smoke? _____

If yes, how many do you smoke daily? _____

Do you drink alcohol? _____

Have you any other medical disease or illness? _____

Are you on a medically prescribed diet? _____

Are any of the above being treated? _____

If yes, give relevant details and name of Doctor monitoring illness _____

Have you ever had an anaesthetic? _____

Have you had a problem with an anaesthetic? _____

If yes, give details _____

If you haven't had an anaesthetic has a relative had problems? _____

If yes, give details _____

PATIENT LABEL

Do you tend to bleed or bruise easily? _____

If yes, to any of the above, please give details _____

Tick appropriate box if you wear denture plate(s)

Upper Lower Partial

Tick appropriate box if you have: Upper Lower

Cap(s)

Crown(s)

Bridgework

Specify any other _____

Yes No

Do you have any artificial implants in your body? _____

If yes, give details _____

Have you had any injection in the last 4 weeks? _____

Are you currently taking any tablets / medicines? _____

If yes, please state drug and dosage and bring them to hospital with you:

Drug	Dose
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Have you had any Cortisone / Steroids **Yes No**

in the past 3 months? _____

If Yes, was it tablets _____

injection _____

cream _____

inhaler _____

Have you had any aspirin in the last week? _____

If Yes, how many and when _____

To your knowledge do you or any of you family **Yes No**

suffer from a degenerative brain disorder? _____

To your knowledge have you ever been treated with growth hormone injections? _____

Have you ever undergone an operation on the brain? _____

If Yes, who was the surgeon / hospital? _____

Have you ever had a corneal graft to the eye? _____

Have you suffered any significant confusion or loss of memory _____

Who will drive you home? _____

Who will care for you on your return home? _____

Checked by RN Signature _____ Date _____

PATIENT TO COMPLETE