DOUBLE BAY DAY HOSPITAL

PRE ADMISSION FORM

**To be completed and returned with medical history and consent at least 48hours prior to admission.*

PERSONAL DETAILS

Planned Admission Date: .....

Title: (MR/MRS/MISS/MS etc) ..... Surname: ..... Given Names: .....

Address: ..... Suburb: ..... Post Code: .....

Email: ..... Gender: ☐ Male ☐ Female

Date of Birth: ..... Country of Birth: .....

Language spoken at home: ..... Do you require an interpreter? .....

Are you:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ De Facto Relationship

Telephone: Home: ..... Work: ..... Mobile: .....

Medicare No: ..... Exp. Date: ..... ID No: ..... Pension/HCC No: .....

Veteran Affairs: DVA No: ..... Card Colour: .....

Legal Guardian: ..... Relationship: ..... Telephone: .....

Next of Kin: ..... Relationship: ..... Telephone: .....

Name of Escort: ..... Relationship: ..... Telephone: .....

HEALTH INSURANCE DETAILS

Name of Fund: ..... Membership No: ..... ID No: .....

Table: ..... Amount of Excess for this hospitalisation: ..... (if known)

Length of Membership of current hospital table: ☐ Less than 3 months ☐ Less than 1 year ☐ Over 1 year

HAVE YOU PREVIOUSLY BEEN ADMITTED TO DOUBLE BAY DAY HOSPITAL? ☐ **YES** ☐ **NO** If so when: .....

HAVE YOU BEEN ADMITTED TO HOSPITAL IN THE PAST 28 DAYS? ☐ **YES** ☐ **NO** If so where: .....

Procedure to be Performed: .....

Attending Doctor: ..... Referring Doctor: .....

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

Patient / Guardian Signature: ..... Date: .....

If this is a Workers Compensation Claim or this hospitalisation is the result of an accident, please ensure that you inform us prior to your admission.

Please contact Double Bay Day Hospital after 12:00pm on the day prior to your admission to confirm your planned admission time.
Unforeseen circumstances sometimes cause alterations to admission times, but all attempts will be made to advise you if this occurs.

DOUBLE BAY DAY HOSPITAL

CLINICAL DETAILS

PATIENT DETAILS

Patient Name: ..... DOB: .....

CONSENT FOR TREATMENT / PROCEDURE

I, ... , request and consent that the following procedure/s

..... be carried out at Double Bay Day Hospital.

- I confirm that Dr ..... has explained the procedure to me, the alternative treatments, possible complications and risks associated with the above procedure.
- I have discussed this matter with my doctor and have had the answers to all my questions explained. I am aware that the doctor that has explained the procedure to me may not be the doctor that performs the procedure).
- I acknowledge that I have been advised that there are occasions when the desired results and expected outcomes of the procedure are not always achieved and would still like to proceed with the operation.
- I agree to the administration of anaesthetics, medications and other forms of treatment associated with the reason for admission.
- I also agree to my blood being taken for serology in the event of a sharps or needle stick injury of a staff member or medical officers being injured during my procedure. All results will be confidential and I will be informed subsequently, incurring no costs for pathology.
- I also acknowledge that the Double Bay Day Hospital disclaims any and all liability for an injury and/or other damages I may cause or sustain in the event that I should ignore, overlook or not accept the advice, cautions or warnings that have been given to me in these matters.

After care Requirements

- I agree not to drive any vehicle or operate any equipment or machinery for up to 24 hours after discharge from Double Bay Day Hospital. I will avoid making any important decisions or signing cheques or legal documents.
- I agree that my surgery/procedure will not go ahead if I do not have a carer. If I am unable to organise a carer, I will be given a phone number to call by the staff at Double Bay Day Hospital to organise for myself and I understand that I am responsible for the cost of a carer.
- I acknowledge that for my protection and safety, I have arranged to be escorted home from Double Bay Day Hospital by:

Name: ..... Phone Number: .....

Who will be responsible for me for the 24 hour period following my discharge from Double Bay Day Hospital.

Patient/Guardian's Signature: ..... Date: .....

Signature of Witness: ..... Date: .....

Provisional Diagnosis: .....

Proposed Procedure: .....

Significant Medical History, Medications and Findings: .....

Special Instructions to Staff: Medication / Equipment / Biohazard Risks .....

Requires Preoperative: ☐ Anaesthetic Consult ☐ CXR ☐ Pathology .....

To be completed by the Admitting Doctor: ***DR SIGNATURE:*** .....

DOUBLE BAY DAY HOSPITAL

MEDICAL HISTORY

PATIENT DETAILS

(to be completed by the Patient / Guardian)

Patient Name: ..... DOB: .....

MEDICAL HISTORY

List previous operations: .....

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

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

Medication / Drug Name	Strength	No. Taken	How Often?

Do you suffer from or have you ever had any of the following? (only tick the box if applies)

☐ Cough
☐ Hayfever
☐ Rheumatic Fever
☐ Stroke
☐ Blood Clots
☐ Glaucoma
☐ Diabetes – Type I ☐ Type II ☐ Insulin Dep. ☐
☐ Reflux/Indigestion/Hiatus Hernia
☐ HIV / AIDS
☐ TB
☐ Asthma or ☐ Lung Disease
☐ Chest Pain
☐ Do you have a Pacemaker?
☐ Fits / Epilepsy - *date of last fit* ...../...../.....
☐ Persistent Bleeding
☐ Kidney Disease
☐ Arthritis
☐ Hepatitis A
☐ Have you ever used IV or recreational drugs?
☐ Have you ever had a blood transfusion? - *Year of Transfusion* .....
☐ Breathlessness
☐ Heart Problems
☐ High Blood Pressure
☐ Anaemia
☐ Porphyria
☐ Liver Disease
☐ Back or Hip Problems
☐ Hepatitis – B ☐ or C ☐

Do you have any other medical conditions/physical disability that may affect your procedure/stay with us?

☐ YES ☐ NO If yes, please list: .....

Are you Allergic to any other medications or dressings?

☐ YES ☐ NO If yes, please list: .....

What is your height in cm? ..... What is your weight in kg? .....

Do you drink Alcohol? ☐ NO ☐ YES How many standard drinks per week .....

Do you Smoke/ever smoked? ☐ NO ☐ YES How much each day? ..... Cigarettes/Cigar/Pipe .....

When did you stop smoking? .....

Are you Pregnant? ☐ NO ☐ YES

Have you used Steroid/Cortisone medication in the past 6mths? ☐ YES ☐ NO

Have you taken any blood thinning medication this week? ☐ YES ☐ NO

Have you had a head cold or the 'flu' in the past two weeks? ☐ YES ☐ NO

Patient / Guardian Signature: ..... Date: .....

OFFICE USE ONLY

Medical History Checked: ☐ **YES** ☐ **NO** **Date:** ...../...../..... **Signature:** .....

Chief Nurse or Delegate

DOUBLE BAY DAY HOSPITAL

PREOPERATIVE ASSESSMENT

CREUTZFELD JAKOB DISEASE (CJD) PREOPERATIVE ASSESSMENT

ALL PATIENTS MUST COMPLETE

- Have you had a dura mater graft between 1972 & 1989? ☐ YES ☐ NO
- Do you have a family history of two or more relatives with CJD or any other unspecified progressive neurological disorders? ☐ YES ☐ NO
- Have you suffered from recent progressive dementia (physical or mental), the cause of which has not been diagnosed? ☐ YES ☐ NO
- Have you received human pituitary hormone (growth hormones, gonadatrophins, fertility drugs) prior to 1985? ☐ YES ☐ NO

Signature of Patient / Guardian: ..... Date: .....

Checked by: ..... Title: ..... Date: .....

If any of these questions are affirmative then the Director of Nursing, Surgeon and Anaesthetist must be informed.

DISCHARGE PLANNING QUESTIONNAIRE

This information is necessary in order to plan a safe return home.

ALL PATIENTS MUST COMPLETE. You must have a responsible person care for you overnight after your procedure. If you believe you will require some form of assistance post-operatively please do not hesitate to contact us and we will assist you to arrange appropriate care.

- Are you over 75 years of age? ☐ YES ☐ NO
- Do you live alone? ☐ YES ☐ NO
- Are you solely responsible for the care of another person at home? ☐ YES ☐ NO
- Do you currently receive community support services? ☐ YES ☐ NO
- Do you require assistance with any aspect of day to day living? ☐ YES ☐ NO
- Have you fallen in the last year or do you have a fear of falling? ☐ YES ☐ NO

AUSTRALIAN PRIVACY PRINCIPLES

*Double Bay Day Hospital collects and holds personal information about you for specific purposes. The Australian Privacy Principles prohibits the use of this information for other purposes without your consent. Double Bay Day Hospital uses the information collected **only** for the purpose for which it is collected.*

Double Bay Day Hospital would like you to indicate, on this form, whether or not you consent to the use of the personal information it holds about for the purposes described below. You should note that in the event that you do provide consent, the information will be used in an identified format. That is, your identity will be clear in any material generated for the purposes of which you provide consent. You are under no obligation to provide consent to the use of your personal information for any of the purposes described below. In the event that you do not consent, we will respect your wishes and will not use the information for that purpose in any identified format.

Please provide your consent to the use of your personal information for the purposes described below, by ticking and initialing the relevant boxes and signing and dating the form where indicated. All forms must be signed. Any boxes left blank will denote that consent is withheld.

I hereby consent to the use of my personal information for the purposes indicated below:

☐ *To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted the medical practitioner or institution about. This may include a requirement to forward relevant prior information, for example anaesthesia records.*

☐ *To inform Next of Kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.*

☐ *To assist in the development of service delivery and planning in facilities owned and operated by Double Bay Day Hospital.*

☐ *To assist Double Bay Day Hospital in providing practical training and education to medical, nursing and other allied health students.*

☐ *To assist Double Bay Day Hospital in undertaking quality improvement activities.*

☐ *To enable Double Bay Day Hospital to provide only necessary information in relation to this admission, to the Health Fund of which I am a member, if requested by the Health Fund to do so.*

Patient / Guardian Signature: ..... Date: .....