Djerriwarrh Health Services

ADULT SURGICAL ADMISSION REQUEST FORM

Dear Patient,

Please complete . . .

Fax all sides to: (03) 5367 9656 or
Send to: PO Box 330, Bacchus Marsh, Vic. 3340
For enquiries please phone: (03) 5367 1568

Affix UR Label Here

1. To be completed by Medical Staff Requesting Admission:
(All information must be completed and forwarded to Pre-admission Clinic before request will be accepted.)

Source of request: ☐ **Melton Health** ☐ **Surgeon's Room**

Surname:..... Given Name:.....

Address:.....

Phone:..... D.O.B:...../...../..... Gender: M / F

Class: Public ☐ Private ☐ Workcover ☐ Veterans Affairs ☐ TAC ☐

Planned operation:

.....

Date of operation:..... MBS ☐☐☐☐☐

☐ Day Procedure ☐ Inpatient Expected length of stay.....

☐ Likelihood of Hospital in the Home

Relevant medical history and Allergies:.....

.....

Relevant investigations done or ordered:.....

.....

Special Instructions:.....

.....

.....

Surgeon details:..... Date of request:...../...../.....

The Adult Questionaire has 4 pages.
Please ensure that all pages of Admission Details are complete.

PRE ADMISSION CLINIC USE ONLY

Date form received:...../...../.....

Date form assessed:...../...../.....

Name/Signature:.....

Waiting list entry: ☐ Date:...../...../.....

Nurse PAC required Y N Date:...../...../.....

Doctor PAC required: Y N Date:...../...../.....

SURGICAL ADMISSION & CONSENT FORM

MR 092

SPEEDEX PRINTING

DEC 2010

Djerriwarrh Health Services

CONSENT TO OPERATIVE TREATMENT AND ADMINISTRATION OF ANAESTHETIC

Unit Record Number _____

Family Name _____

Given Names _____

Date of Birth ____ / ____ / ____

USE PATIENT LABEL

I, ...
(please print full name)

hereby request the following operation .....
(specify operation)

be performed upon .....
(relationship to patient & name of patient)

the nature and effect of which has been explained to me by Doctor .....

I also request that such further operative procedures as may be found necessary be performed during the course of the operation stated above, and consent to required post operative treatment.

I understand that my tissue(s) will be used for diagnostic and treatment purposes. I understand that it will be kept and may be used for ethically approved research, education and laboratory quality procedures.

In conjunction with the above stated operations, I request the administration of such anaesthetic and any related procedures which may be considered by the Anaesthetist to be necessary or advisable.

Signature of Patient: ..... Date: ...../ ...../20 .....

Signature of Witness: ..... Date: ...../ ...../20 .....

Name of Witness: .....

CONFIRMATION by Doctor

I, Dr/Mr/Ms:.....have properly informed this patient and obtained consent as indicated above.

Signature of Doctor:..... Date: ...../ ...../20 .....

FOR STERILIZATION PROCEDURES ONLY

(e.g: Vasectomy, Tubal Ligation, Laproscopic Sterilisation)

1. It has been explained to me that this operation is intended to result in my sterility, but no such result has been guaranteed.
2. I understand that if the operation proves successful the results may be permanent making it thereafter impossible for me to conceive or bear children.

Djerriwarrh Health Services
Bacchus Marsh Campus
P.O. Box 330
Bacchus Marsh, 3340
Pre-Admission Clinic: 5367 1568
Fax: 5367 9656

Unit Record Number _____

Family Name _____

Given Names _____

Date of Birth ____/____/____

Date questionnaire completed ____/____/____

USE PATIENT LABEL

ADULT HEALTH QUESTIONNAIRE

(To be completed by patient)

Please complete this form and forward to Djerriwarrh Health Services within 48 hours to allow us to process your admission. You will be advised of a time and date for the operation after confirmation by your surgeon of the date of surgery. You may be asked to attend the Pre-Admission Clinic at the hospital - our staff will arrange this if necessary.

Please bring your Medicare card and Health Insurance card with you on the day of admission.

Name: _____ **Date of birth:** ____/____/____

Past Health: Have you ever had?

Heart trouble, chestpain, angina	YES/NO	High blood pressure or stroke	YES/NO
Heart attack	YES/NO	Blood clot in leg or lung	YES/NO
Sleep apnoea	YES/NO	Anaemia/blood disorder	YES/NO
Lung problems; asthma, wheezing	YES/NO	Diabetes	YES/NO
Bronchitis, breathlessness	YES/NO	Epilepsy	YES/NO
Fainting, funny turns or blackouts	YES/NO	Migraine headaches	YES/NO
Kidney or urinary problems	YES/NO	Hepatitis, jaundice or liver problems	YES/NO
Indigestion, stomach ulcers, reflux	YES/NO	Psychiatric illness or depression	YES/NO
Rheumatic fever	YES/NO	Cancer or other serious illness	YES/NO
Family history of Creutzfeldt-Jakob Disease (CJD)	YES/NO	Human growth hormone, dural graft, corneal graft	YES/NO
Details if YES to any of the above:		Thyroid conditions	YES/NO

_____

_____

_____

Details of operations you have had: _____

_____

_____

Have you ever had a blood transfusion? YES/NO

Do anaesthetics cause unusual reactions in you or your relatives? YES/NO

Do you have ALLERGIES to any?
Drugs _____
Foods _____
Iodine _____
Adhesive tapes _____
Other _____

Do you drink alcohol regularly? YES/NO

Do you smoke? YES/NO How many per day _____

Do you take recreational drugs? YES/NO Please list _____

Are you, or could you be pregnant? YES/NO

PLEASE COMPLETE QUESTIONS ON NEXT PAGE ***PTO*** ➡

Checked by admission registered nurse Signature Date / /

ADULT HEALTH QUESTIONNAIRE

Height_____ Weight_____ (Please estimate if unsure)

Are you on any routine medications (including alternative therapies)? YES/NO

Please list all medication and dosages

Drug	Dosage

Do you live alone?		YES/NO
Do you have a responsible adult to stay with you overnight when you leave hospital?		YES/NO
Do you have caring responsibilities?		YES/NO
Do you live in residential care?		YES/NO
Do you need assistance when discharged from hospital?		YES/NO
Do you have someone to collect you from hospital?		YES/NO
Can you normally walk without stopping:	- around the house?	YES/NO
	- one flight of stairs?	YES/NO
Do you use a walking aid?		YES/NO
Do you need assistance with:	- showering?	YES/NO
	- dressing?	YES/NO
	- eating?	YES/NO
	- meal preparation?	YES/NO
	- shopping?	YES/NO
	- housework?	YES/NO
	- medication	YES/NO
Do you use community services	- district nurse?	YES/NO
	- home care?	YES/NO
	- meals on wheels?	YES/NO
	- day rehabilitation?	YES/NO
	- other	
Does the carer feel they will be able to manage on discharge?		YES/NO
Do you have a problem with your sight?		YES/NO
Do you require a special diet?		YES/NO

Admission Details

Djerriwarrh Health Services
P.O. Box 330
Bacchus Marsh 3340
Ph: 5367 1568 (Theatre/Admission)
Ph: 5367 2000 (Switchboard)
Fax: 5367 9656 *(fax all sides of form)*

Surgeon: _____

Procedure: _____

_____

Planned Date (If known)

____ / ____ / _____

Estimated Delivery Date (Maternity)

____ / ____ / _____

(1) Please fill in all sections on **both** sides of this form.
(2) Please return this form to the above address as soon as possible.
Thank you for your cooperation

Personal Details

Surname:

Given Names

☐ Male ☐ Female Birthdate:

Previous Surname *(If applicable)*

Address:

Town:

Postcode: State: Mobile Ph:

Telephone (Home): (Work):

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Defacto ☐ Widow

Country of Birth:

If born in Australia - Which State: Preferred Language:

Are you of Aboriginal or Torres Strait Islander origin?
(For persons of both Aboriginal and Torres Strait origin mark both "yes" boxes)

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Religion:

Next of kin: Name:

Address:

Suburb:

Phone No. (Home): (Work):

(Mobile): Relationship to Patient:

Second Person to Contact:Name:

Address:

Suburb:

Phone No. (Home): (Work):

(Mobile): Relationship to Patient:

Admission Details

Unit Record Number _____

Family Name _____

Given Names _____

Date of Birth ____ / ____ / ____

Other Details

USE PATIENT LABEL

GP/Local Doctor/Clinic:

Address:

Phone No.

Have you previously used DjHS services? Yes ☐ No ☐

(Bacchus Marsh Hospital, Melton Health, Melton Community Health Centre)

If Yes, when approximately _____ Under what surname _____

Medicare No: | Reference No. (the number next to your name on your medicare card) | Expiry Date: mm / yyyy

Health Card or Pension No: | Expiry Date: dd / mm / yyyy

Pension Type - Aged ☐ Carer Payment ☐ Disability Support ☐

Other Government ☐ Unemployment Related ☐ Unknown ☐

Please bring your Medicare Card in with you

Are you to be admitted as

☐ Public ☐ Private ☐ Vet Affairs: Card Colour _____ ☐ Workcover ☐ TAC

Private - If ticked complete Private Health Fund Details

Fund:

Membership No:

PUBLIC PATIENTS:

On the day of admission please bring your Medicare Card, Health Care Card with you.

PRIVATE PATIENTS

Bring your Medicare Card, and private insurance details if you are privately insured. You are advised to check with your health fund regarding your current level of hopsital cover. Payment of an "excess" or co-payment may apply.

WHAT TO WEAR

Do not wear make-up, jewellery or nail varnish on the day of admision. Wear loose comfortable clothing and do not bring valuables with you.

WHAT TO BRING

Please bring relevant x-rays, scans and pathology reports.
Overnight patients: please bring toiletries, night wear, dressing gown & slippers, current medications.

WHERE TO PRESENT

When you arrive please report to the Reception Desk in Theatre Services/Day Procedure Unit.
Enter via the Clarinda Street entrance at the back of the hospital.

GETTING HOME

As certain types of anaesthetics may cause drowsiness and impair your mental awareness, please arrange for someone to collect you after your procedure, and remain with you overnight.

SMOKING

You should cut down smoking as much as possible in the 6 weeks prior to surgery.
Please note the hospital has a no smoking policy.

MOBILE PHONES

Mobile phones may interfere with vital elecro-medical equipment. Usage is restricted.

Turn over to complete questionnaire