macquarie st daysurgery

PATIENT ADMISSION DETAILS

Surname
Given Names
Date of birth

Print in BLOCK LETTERS
TICK where applicable ☑

1. PATIENT DETAILS

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other			Gender: ☐ Male ☐ Female
Surname	First name	Middle name	
Address			Date of birth __/__/____
Suburb		State	Postcode
Home	Work	Mobile	
Country of birth	Languages spoken at home	Occupation	
Medicare number _ _ _ _ _ _ _ _ _ _	Number next to name _	Valid to __/____	Email
Veteran Affairs number Colour: ☐ Gold ☐ White			Religion
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Defacto ☐ Separated ☐ Widowed			
Are you an Australian resident ? ☐ Yes ☐ No			
Are you of Aboriginal / Torres Strait Islander (TSI) descent? ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both			

2. PERSON FOR NOTIFICATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other		
Surname	First name	Relationship to patient
Address		Suburb
Home	Work	Mobile

3. OTHER DOCTORS DETAILS

LOCAL DOCTOR – Name	Suburb	Phone
CARDIOLOGIST – Name	Suburb	Phone
OTHER SPECIALIST – Name	Suburb	Phone

4. PREVIOUS TREATMENT

Have you been treated at this day surgery before?	☐ Yes ☐ No	Hospital name
Have you been hospitalised within the last 28 days prior to this admission?	☐ Yes ☐ No	

5. DISCHARGE PLANNING

Do you have someone to look after you when you go home?	☐ Yes ☐ No
Do you have someone to stay with you for the night after surgery?	☐ Yes ☐ No
Do you expect to require assistance following your discharge?	☐ Yes ☐ No

You will require a responsible adult to take you home following your surgery.

Who will take you home when you are discharged?

Name	Relationship	Mobile

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6. HOW WILL YOU PAY FOR THIS ADMISSION ?

6.1 ☐ **UNINSURED** – If you tick this box, **please go to 8.**
Requires upfront fee payment and account settled on discharge. An estimate of costs will be provided.

6.2 ☐ **PRIVATE HEALTH INSURANCE**
May require excess and co-payment prior to admission and account settled on discharge.

Fund name	Membership number	☐ Single ☐ Family
Contributor's name		Relationship to patient

Please go to 7.

6.3 ☐ **WORKCOVER** ☐ **THIRD PARTY** - Insurance approval letter must accompany this form

Name of insurance company / solicitor		Claim No.	
Address		State	Postcode
Case Manager	Email	Tel	

7. PERSON RESPONSIBLE FOR THIS ACCOUNT ?

Is this the patient? ☐ Yes – please sign consent below at 8. ☐ No, please complete details below and go to 8.

Name		Relationship to patient	
Address		State	Postcode
Home	Work	Mobile	

8. PAYMENT OF ACCOUNT

The portion of the estimated day surgery fees not covered by a health fund must be paid prior to admission. Any additional fees incurred during your stay are payable on discharge.

I have received information from my health fund regarding my estimated expenses and I understand and agree to pay all fees in relation to my day surgery stay, including where my health fund or insurance claim is denied for any reason.

Signature of person completing this form	Print name	Date
X		/ /

9. PATIENT DECLARATION

- I have given complete and accurate answers to this questionnaire (including the Patient Health Questionaire on the following page) to the best of my knowledge.
- I hereby consent to the use of personal information to inform my local doctor and other healthcare professionals involved in providing me with care following my discharge of the outcome of treatment provided to me by Macquarie St Day Surgery
- I have been informed of my rights and responsibilities as outlined in the brochure provided.
- I have read and agree with the Macquarie St Day Surgery Privacy Statement as outlined in the brochure provided.
- I have been advised not to bring valuables on my admission and understand that Macquarie St Day Surgery will not be responsible for any loss or damage.

If you do not understand any part of this declaration please contact Macquarie St Day Surgery for clarification.

Signature of person completing this form	Print name	Date
X		/ /

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PATIENT HEALTH QUESTIONNAIRE

Surname
Given Names
Date of birth

Print in BLOCK LETTERS
TICK where applicable ☑

Please answer ALL questions

LIST ALL ALLERGIES	
LIST PAST OPERATIONS AND ILLNESSES	LIST CURRENT MEDICATIONS (tablets, injections, puffers, herbs, vitamins, etc)

Do you require an interpreter? ☐ Yes ☐ No

Height cm	Weight kg	Blood group (if known)

Are you suffering or have you suffered from :

	NO	YES	SPECIFY DETAILS
Problems with anaesthetic in the past (incl family history)			Year :
Diabetes			☐ Type 1 ☐ Type II
Asthma or lung disease			
Cold or flu symptoms in the last 7 days			
Infection MRSA (Staph) VRE, Hepatitis A, B ,C , HIV			Other infections :
Heart attack			Date:
Chest pain/angina/palpitations			
Blood pressure problems			Medications:
Stroke / T.I.A.			
Blood clots : DVT / PE			
Blood transfusion/anaemia/ blood disorder			
Physical disability			
Rheumatic fever			
Liver disease or jaundice			
Arthritis			☐ Osteo ☐ Rheumatoid
Back, hip or neck problems			
Kidney or urinary problems			
Thyroid problems			
Epilepsy, fitting, convulsions			Date of last episode:
Depression, dementia, other mental illness			
Glaucoma or eye problems			
Female patients: could you be pregnant			
Creutzfeldt-Jakob disease (CJD)			
Have you received human pituitary growth hormones prior to 1985?			
Have you had neurosurgery prior to 1985?			
Do you require a special diet ?			
Do you take blood thinning medications (e.g Aspirin) ?			Have you been instructed to cease ?
Do you have a pacemaker or prosthetic heart valve ?			
Do you have an artificial joint or limb ?			
Do you have any pins / plates / screws ?			Where ?
Have you ever smoked ?			Daily amount : or date ceased :
Do you drink alcohol ?			Daily amount :
Do you use recreational drugs ?			Type : How often :
Have you taken any steroid medication in 6 months ?			
Have you fallen in the last 3 months ?			
Have you had fainting or dizziness episodes ?			