Kingsgrove Day Hospital
(02) 9554 4065
Lvl 1, 322 Kingsgrove Road
KINGSGROVE NSW 2208

Reception@kingsgrovedayhospital.com.au

SURGICAL PRE-ADMISSION FORM

Instructions to Surgeons:

Please complete consent form on page 3 together with your patient. Give completed form to patient and ask patient to send this to Kingsgrove Day Hospital along with the rest of their completed pre-admission forms.

Instructions to patients:

Please call Kingsgrove Day Hospital on (02) 9554 4065 for hospital fees. The Anaesthetist and Surgeon have separate fees from Kingsgrove so please talk to your specialists about their fees.

Please complete all sections on pages 2 to 8. Send all completed forms including the consent form on page 3 which you have completed together with your surgeon to Kingsgrove Day Hospital at least 1 week prior to your admission. Please bring the original copy of your entire pre-admission form with you on day of your admission.

If you have an Advanced Care Directive, please ensure you forward this to Kingsgrove Day hospital together with your pre-admission forms.

You can send your forms to:

Fax: (02) 9554 8081
Email: admissions@kingsgrovedayhospital.com.au
Post: Level 1, 322 Kingsgrove Road, Kingsgrove NSW 2208

If you are sending you forms via fax or email, please bring the original copy along with you on the day of your admission.

If you need help with completing your pre-admission forms or have any other queries, please feel free to contact our friendly staff for assistance.

Phone: (02) 9554 4065

Thank you.

PRE-ADMISSION FORM

TO BE COMPLETED BY PATIENT

Please complete all sections

Patient's label

PERSONAL DETAILS

Specialist's name _____ Admission date _____

Proposed Item Numbers _____

Procedure _____

Title: Dr / Mr / Mrs / Ms / Miss / Master Age: _____ Sex: M / F

Patient's Surname _____Given Names _____

Address (not PO Box) _____ Post Code _____

Telephone Home _____ Mobile _____ Email_____

Date of Birth: _____ Marital Status: Married / Single /Divorced / Widowed / Separated / De Facto

Medicare Number _____ Position on Card ____ Worker's Compensation: Y / N

Health Fund Name_____ Membership Number _____ Excess _____

Country of Birth_____ Language Spoken at Home _____

Occupation_____

Are you: Aboriginal / Torres Strait Islander / Neither Religion_____

Local GP _____ Phone Number_____

EMERGENCY CONTACT / SUPPORT PERSON (Who will be taking you home)

Surname _____ Given Names _____

Relationship: _____Telephone _____

Address _____

After your surgery, you must have a responsible adult to accompany you home and stay with you overnight as well. If you do not have a support person then we cannot admit you to the hospital. If you can't arrange a support person please contact our admissions staff who can put you in touch with a nursing agency. The agency can arrange for someone to act as your support person. This will incur a charge that is payable by you directly to them.

CONSENT FORM

TO BE COMPLETED BY SURGEON TOGETHER WITH PATIENT.

Patient's label

I, Doctor _____ have discussed with my patient*/patient's guardian, the patient's condition, alternative treatments available and the benefits and risks of the proposed operation/procedure/treatment.

The proposed operation/procedure/treatment is:

_____

I, _____ **CONSENT TO the above operation/procedure/treatment to be performed.**

- **I also consent** to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this operation/procedure/treatment.
- **I understand** that other unexpected operations/procedures/treatment may be necessary and I request that these be carried out if required.
- Although this operation/procedure/treatment is carried out with all due professional care and responsibility, **I understand** that in some circumstances the expected result may not be achieved.
- **I also understand** that complications may occur with any operation/procedure/treatment and **I accept** the possible risks associated with this operation/procedure/treatment.
- I have had the opportunity to ask questions about the above operation/procedure/treatment, and **I am satisfied** with the information I have received.
- **I consent** to blood being taken for testing for HIV and other diseases in the event of accidental staff injury involving contact with my blood. **I understand** that pre-test counselling will be provided if blood taken for this purpose is recommended.

MEDICAL OFFICER'S SIGNATURE _____

Signature of **Patient/Guardian** _____

Interpreter present – signature of **Interpreter** _____

Date: _____

ACKNOWLEDGEMENT BY PATIENT

TO BE COMPLETED BY PATIENT

Patient's label

I acknowledge that any medical treatment received by me at Kingsgrove Day Hospital (the "Hospital") performed by a doctor at the hospital (the "Doctor") will be performed by the Doctor pursuant to a direct engagement between me and the Doctor and not on behalf of the Hospital or the operator of the Hospital, Baydoor Pty Limited ("Baydoor").

I acknowledge that neither Baydoor nor the Hospital is liable to me for the acts or omissions of a Doctor and I release Baydoor and the Hospital for any claim for damages, losses or expenses which I may have at any time against either of them in respect of medical treatment performed by a Doctor.

I have read and understood my Healthcare Rights and the Patient Privacy and Disclosure of Information and give consent for information collection and usage.

I have been informed of hospital fees and I agree to accept full responsibility for accounts rendered by the hospital including any shortfall in reimbursement by my health fund.

I understand the hospital fees given to me prior to my admission is based on the information my surgeon and my health fund (if applicable) has provided the hospital and is therefore an estimate of cost only so it is subject to change according to the actual procedure performed, any prosthesis used, and / or the terms of my private health insurance policy.

I consent to the hospital providing information about myself and my treatment to my private health insurer if I wish to have my insurer pay for the costs of this admission.

I acknowledge that the hospital fees do not include fees charged by other service providers such as, but is not limited to Surgeon, Anaesthetist, Surgical Assistant, Pathology, Radiology or Pharmacy.

I agree to settle all accounts on the day of treatment or within an agreed timeframe.

In case of emergency or if my condition requires unforeseen extended hospital stay, I consent to be transferred to another hospital and agree to bear any additional costs incurred including travelling costs if applicable.

I acknowledge that there may be unexpected delays in admission times and operating schedule due to unforeseen reasons.

I realise that the consequences of eating and drinking before an operation could cause irreversible damage to myself and, if I have done so, I must inform the staff at the hospital beforehand.

Following my surgery, I will have a responsible adult to accompany me home via own transport or taxi and care for me overnight. If I cannot arrange such a person, I will be required to engage a carer/nurse as well as taxi fare to my accommodation at my own expense. I am aware that failure to do so may result in cancellation of my surgery.

I realise that mental impairment may persist for several hours following administration of anaesthesia. I acknowledge that I must not drive a motor vehicle, operate machinery or sign legal documents for 24 hours after the procedure.

I have answered all questions correctly to the best of my knowledge and I have not withheld any information.

I herein acknowledge that I understand all of the above.

Patient's Signature: _____ Date: _____

MEDICAL HISTORY

TO BE COMPLETED BY PATIENT

Please complete all sections

Patient's label

ANAESTHETIC HEALTH INFORMATION			
Please tick Yes or No to all following questions	**Yes**	**No**	**Provide details if you have answered Yes**
Allergies or sensitivities to any medications, ointments, dressing, food, Latex?			Specify allergy and reaction:
Have you had any previous operations? Attach list if not enough room			Specify operation and date:
Have you or any family member had any reactions/side effects to anaesthetic? E.g. nausea/vomiting, malignant hyperthermia			Who: Self / Family? Specify:
What is your: Height: cm Weight: kg			If your weight is greater than 125 kg it is essential that you contact us prior to your procedure to assess your suitability to meet our admission criteria for your surgery.
Have you ever smoked?			For how many years? When did you give up?
Do you currently smoke/ drink alcohol ?			How many per day?
Do you suffer from sleep apnoea? Do you own a CPAP machine? If yes, please bring your CPAP machine.			Specialist details:
Have you ever had a blood clot in your leg or lungs E.g. DVT or PE?			Specify:
HEALTH HISTORY - DIABETES			
Do you have Diabetes?			Current management plan: Specialist details:
HEALTH HISTORY - RESPIRATORY			
Do you have asthma / bronchitis/ emphysema/ shortness of breath on exertion etc? (If yes, please bring your asthmatic medication) Have you ever been hospitalized for this?			Specify: Current management plan:
Any recent cold/respiratory infection/fevers/sore throat in last 4 weeks? (please circle)			Specify:

MEDICAL HISTORY

TO BE COMPLETED BY PATIENT

Please complete all sections

Patient's label

Please tick Yes or No to all of the following questions	Yes	No	Provide details if you have answered Yes
HEALTH HISTORY - CARDIOVASCULAR			
Have you ever suffered from: High blood pressure			Specify and give details:
Heart Disease			
Chest pain/ discomfort/ heart attack			
Palpitations/ Irregular heart beat / heart murmur			
Rheumatic fever / heart disease			
Anaemia/ bleeding problems			
Do you have any artificial implants/ devices / grafts? E.g. pacemaker, stents or implantable defibrillator?			Specify:
Have you taken any blood thinners within the last 2 weeks? E.g. Cartia, Aspirin, Nurofen, Voltaren, Plavix, Warfarin, Pradaxa ***Please follow your specialist's direction regarding continuing or ceasing your blood thinner.***			Specify: Date ceased:
HEALTH HISTORY – NEUROLOGICAL			
Have you ever had strokes/ mini strokes/ TIA?			Details:
Have you ever had faints/ blackouts / funny turns?			Details:
Do you suffer from epilepsy/ fits/ seizures?			Date of last seizure:
Have you seen a Neurologist?			Name: Last Appointment:
HEALTH HISTORY – GENERAL MEDICAL			
Do you have anxiety, depression or mental health conditions?			Specify:
Do you have any significant neck or back injuries?			Details:
Do you suffer from chronic pain?			Details:
Have you previously had hernia repair or Scrotal Surgery?			
Do you suffer from reflux/ stomach ulcer?			
Do you have vision or hearing or mobility impairment?			Aids:
Female patients could you be pregnant?			Details:

MEDICAL HISTORY

TO BE COMPLETED BY PATIENT

Please complete all sections

Patient's label

Please tick Yes or No to all of the following questions	Yes	No	Provide details if you have answered Yes
HEALTH HISTORY – GENERAL MEDICAL			
Do you have any other medical conditions or see other Medical Specialists not listed above? Please attach list if not enough room.			List:
Have you been diagnosed or are you at risk of Creutzfeldt-Jakob disease? (mad cow disease)			Specify:
HEALTH HISTORY – INFECTION CONTROL			
Have you ever had a Multi Resistant Organism, such as? - Multi/ methicillin resistant staphylococcus (MRSA) - Vancomycin resistant enterococci (VRE) - Clostridium difficile (c.diff)			Specify:
Have you ever had Tuberculosis?			Specify:
Do you have / have you ever had a blood borne infection E.g. Hepatitis B and C, HIV?			Specify:
Do you currently have an infection?			If yes, where?
Are you currently suffering from diarrhoea or faecal incontinence?			
Do you currently have any open wounds or ulcers with uncontrolled discharge?			
LEGAL DOCUMENTATION			
Do you have an Advanced Care Directive?			If yes, please attach.

MEDICATION MANAGEMENT PLAN

Please list all regular prescription and over-the-counter medications taken prior to hospital below. Include puffers, eye drops, patches, topical cream, supplements.

Medication	Dose	Frequency	Indication

MEDICAL HISTORY

TO BE COMPLETED BY PATIENT

Please complete all sections

Patient's label

MEDICATION MANAGEMENT PLAN CONTINUED			
Please list all regular prescription and over-the-counter medications taken prior to hospital below. Include puffers, eye drops, patches, topical cream			
Medication	**Dose**	**Frequency**	**Indication**

Discharge Planning			
Answering these questions will assist us in planning your discharge from the hospital.			
Please tick Yes or No to all of the following questions	**Yes**	**No**	**Provide details if you have answered Yes**
Have you arranged a responsible adult to take you home after your surgery?			Relationship: