Admission Form

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Privacy: Pittwater Day Surgery acknowledges its obligations to you under the Privacy Act 1988 as amended. Please forward any concerns / complaints to the Director of Nursing for Pittwater Day Surgery or the Health Care Complaints Commission (Toll Free) 1800 043 159; www.hccc.nsw.gov.au.

Operation Date: ………../……………/………. Surgeon: ……………………………………………………………………

Admitting Diagnosis ……

Planned Procedure ……

………GA / LA / Sedation

Corresponding Item Numbers

Patient Name:
Mr. Mrs. Ms. Miss. Master ……………………………………………………………………………………

D.O.B. ………./…………/……… Age ………… Sex ☐**M** ☐**F**

Address: ……

……………………………………………………………………………………………………Post Code: ……………………

Phone: (H)……………………………………… (W) ……………………………………… (M) ………………………………………

Email: ………

Marital Status: ☐Child ☐Single ☐Married ☐Widow ☐Separated ☐Divorced ☐Defacto

Country of Birth: ……………………………………… Language spoken at Home: ………………………………………

Occupation: ……

Aboriginal: ☐ Yes ☐ No Torres Str. Is. ☐Yes ☐No

Next of Kin: ……………………………………………… Relationship: ……………………………… (Ph)……………………………

Do you have an Advanced Care Directive? ☐Yes ☐No A copy is required if applicable

Health Fund Details- To be completed by Patient and *Office staff*

Medicare No: …………………………………………… DVA No: …………………………………………… White / Gold

Health Fund: …………………………………Membership No: ……………………………Co-payment/ Excess…………………

Financial Yes ◻ No ◻ *Fund Check……………………..(Initial) Uninsured fee on admission…………………………..*

Financial Consent

1) ***Accommodation & Theatre fee*** - Both claimable from Health fund only
2) ***Surgeons fee*** - NB: Dental patients this fee is payable upon admission
3) ***Anaesthetists fee*** - NB: Dental patients this fee is payable upon admission
4) ***Pathology fee*** - This fee may apply if my specialist takes specimen(s) to be tested

Insured patients may be able to claim some of the Surgeon & Anaesthetist fees from the health fund & Medicare

◻ I agree to pay the excess associated with my chosen health fund cover upon admission.

◻ I agree to pay all fees incurred during my admission that are not covered by my chosen level of health fund cover

◻ I acknowledge that Pittwater Day Surgery will provide an estimate only for my surgery & I understand that alternate or additional procedures during the course of my operation may result in additional fees to be incurred which I agree to pay in full.

◻ I understand that should I require admission to hospital for further care I will be responsible for the costs incurred.

◻ If I do not have health fund cover I agree to pay the ***Uninsured fee*** in full on admission.

◻ In line with legislation, I consent to my details being released to the State Health Authority, Health Funds & Private Hospital Data Bureau.

Patient / Guardian ……………………………………………………………………………… Date ………../………..

Pittwater Day Surgery

Medical History Questionnaire
Consent for Surgery & Anaesthesia

Patient name ....
D.O.B .... /............/..
MRN ....
Surgeon ....
Admission Date ..../............../...................................
Please affix **PDS** patient label here

Medical History	Yes	No	N/A		Yes	No	N/A
Problem with Anaesthetics General / Local				Have you had a cold/flu in the past 2 weeks?			
Family history of Anaesthetic Problems				Have you taken steroids / Cortisone in last 6 months?			
Asthma / Lung Disease/ Shortness of Breath				Do you take aspirin, warfarin, viagra/cialis?			
Sleep Apnoea / CPAP				Have you had anaemia or a blood transfusion?			
Reflux or Indigestion							
Cardiac Disease / Chest Pain				Do you have bleeding or clotting tendencies?			
High Blood Pressure							
Rheumatic fever				Do you have a pressure area or broken skin?			
Diabetes							
Stroke				Have you been exposed to any communicable illnesses ?			
Epilepsy							
Any Back or Hip problems?				Have you been investigated for CJD exposure?			
Could you be pregnant?							
Do you currently smoke? If yes, how long have you been smoking?...........yrs				Do you a history of MRSA, VRE?			
				Pacemaker / Cochlea Implant?			
				Are you unsteady & use a walking frame/stick ?			
Do you drink alcohol? /day							
Weight kgs	2.2lbs/kg			Have you recently undergone a cognitive assessment?			
Height cms	2.5cm/inch						

If you answered YES to any of the above, please provide details here or on a separate page
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Allergies & associated reactions ....

Previous Operations/ Hospitalisations ……………………………………………………………..

Current medications ....

....

Consent for Surgery & Anaesthesia

I,..acknowledge that Dr ....has discussed the following procedure for my child ……. ....(name) / me ....

....

....

□ We have discussed available alternatives; the nature & risks of this procedure & the possibility of altered or additional procedures being required. We have also discussed the involvement of anaesthetics & medications & their associated risks.

□ A sample of my blood may be taken for serology in the event of a sharps injury to PDS staff.

□ I confirm that a responsible adult will escort me home & stay with me overnight (GA/ Sed'n).

□ I understand that I should not sign legal documents, operate machinery or drive/ride a motorcycle or vehicle in the first 24 hours following my general anaesthetic or IV sedation.

□ I acknowledge that PDS is not liable for any injury/damages I may cause or sustain if I ignore overlook or not accept the above cautions or warnings.

Patient/ Guardian Signature	**Surgeon Signature**	**Date**
....	....	........./........../.........