

LDS

Liverpool Day Surgery

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Certification Partner Global
NSQHS

Lic No: HTH/2/R61/1176

Member of



Day Hospitals
AUSTRALIA

Our mission is to ensure continuous improvement in the safety & quality of care to patients attending same day surgical services.

ADMISSION FORM

Episode No.

U.R.N.

Surname

Given Names

Date of Birth

Doctor

Procedure

Date of Admission

It is essential that we receive this completed admission form **no later than one week prior** to your admission date in order for us to best prepare for your procedure. You or your representative can bring this form to our admissions desk between 7am & 4.30pm Mon-Fri (not public holidays) or fax it to 9821 4627 or email it to admin@liverpooldaysurgery.com.au. If emailing or faxing please bring original on day of procedure.

DAY SURGERY ADMISSION AGREEMENT: - Please read very carefully & sign.

I understand that I am not allowed to drive myself home following my procedure and that for the 24 hours following my procedure I am not to drive a vehicle, operate heavy machinery and that it is also advisable not to sign legal documents.

I accept that I must be accompanied home by a responsible adult, (i.e. I must not travel in a taxi or by public transport on my own). A taxi driver, public passenger vehicle driver, Veterans Affairs driver are not considered responsible adults **for your care.**

I have been advised to have a responsible adult be with me, to escort me home and to remain with me after discharge for a 24 hour period.

Name of responsible adult providing your transport home _____

Relationship _____ Phone _____

Patient Signature

Date

Staff Signature

ADMISSION FORM

MR01

PERSONAL INFORMATION:

We acknowledge our obligations to you under the Privacy Act 1988 (as amended). Personal information we collect from you will be used primarily to ensure that you receive optimal care but may be used for other purposes. Personal information is released under legislation to the State Health Authority, health funds and the Private Hospital Data Bureau. Our Personal Information Policy is available on request and should you wish to discuss it further our Privacy Officer can be contacted on 02 9601 4488.

PERSONAL DETAILS CONSENT:

I hereby consent to the collection and use of my personal information for the purpose of my care and well-being and in accordance with reporting requirements under legislation.

Signature: _____ **Date:** _____

OR Patient Representative Signature: _____ Relationship to Patient: _____

Irrespective of any request received, I direct you NOT to provide my personal information to (please specify name & details). _____

REQUEST FOR ADMISSION:

ADMITTING DOCTOR MUST COMPLETE

Admission Date: _____

Indications for procedure: _____

Proposed Procedure: _____

Significant medical history, medication & findings: _____

Any known MRO (multi resistant organism) _____

Pre-operative Instructions: _____

Allergies: _____

Diabetic Protocol: _____

Anticoagulant Protocol: _____

Requirements for theatre: (i.e. loan equipment/prosthetics) _____

VTE Prophylaxis – Chemical
– Mechanical

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time of dose	Prescriber / Nurse Initiator (NI)		Give by	Time given
					Signature	Print Name		

PERSONAL DETAILS

PLEASE PRINT CLEARLY IN BLOCK LETTERS

Title:	Surname:
Given Names:	
Previous Name:	
Address:	
Postcode:	
Phone: Hm:	Wk:
Mobile:	Sex: M / F / Indeterminate / Other
Email Address:	
Marital Status:	D.O.B:
Country of Birth:	
Language Spoken at Home	
Interpreter required Yes / No	
Do you have an Advanced Care Directive or Treatment Limiting Order: Yes / No	
Have you previously been a patient here: Yes / No	
Aboriginal: Yes / No	Torres Strait Islander: Yes / No
Referring G.P.	

Height:	cms	Weight:	kgs
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If your weight is greater than **125kgs** it is essential that you contact our admissions department prior to your procedure to assess your suitability to meet our admission criteria. Failure to do so could result in your procedure being cancelled.

THIS SECTION MUST BE COMPLETED

PATIENT TO COMPLETE

Medicare No:	
Card Expiry Date:	Position on Card:
DVA Gold Card No.	
DVA White Card No. and Approval	

HOSPITAL INSURANCE

Name of Fund:
Membership No:

PERSON FOR NOTIFICATION / NEXT OF KIN

Name:
Relationship:
Address:
Postcode:
Telephone:

INFORMED FINANCIAL CONSENT

PAYMENT OF ACCOUNT

All Self Insured Patients are required to pay Account on or before the day of Admission.

The following methods of payment are accepted: American Express, Cash, Visa or Mastercard.

The following are **not** accepted: personal / company cheques.

If your account is subject to Workers' Compensation or Third Party claim, please make sure the details are completed.

I agree to allow the Hospital to contact my Health Fund on my behalf.

I understand the Patient Estimate of Cost is based on the information given regarding my procedure at pre-admission and is subject to change according to the actual procedure performed and prosthesis/disposable items used.

I understand that I am responsible for payment of the Account, in the event my Health Fund/Workers Comp or Insurer does not meet the costs incurred.

The patient or nominee named herein undertake to pay the patient payment as indicated, together with any unforeseen costs which may arise as a consequence of the procedure(s). If a credit management service is required to collect monies owed by the nominee named herein, all fees incurred in the debt recovery will be added to the account (usually 30%).

Signature: _____ Date: _____
(Person responsible for Account)

WORKER'S COMPENSATION / WORK COVER

Worker's Compensation Claim No. must be supplied or full payment is required prior to admission.

Date of Accident:
Employer:
Insurance Company:
Address:
Postcode
Phone:
Claim Nos

PATIENT QUESTIONNAIRE. (Patient to complete prior to admission)

Do you have OR have you ever had:	Yes	No	Do you have OR have you ever had:	Yes	No
An allergic reaction to drugs / food / any substances	☐	☐	Have you travelled Overseas in the last 3 weeks	☐	☐
Physical disability	☐	☐	Do you suffer from mental illness	☐	☐
Heart condition	☐	☐	Are you hearing impaired	☐	☐
Chest pain	☐	☐	Do you have a Pace Maker/Defibrillator	☐	☐
Shortness of breath	☐	☐	If yes attach copy of card or bring on admission	☐	☐
Blood clots ie DVT / PE	☐	☐	Do you drink alcohol (indicate amount per week) per day	☐	☐
High blood pressure	☐	☐	Do You Smoke (indicate number per day) per day	☐	☐
Asthma	☐	☐	Used any recreational substances	☐	☐
Lung disease eg emphysema	☐	☐	Could you be pregnant	☐	☐
Fainting or Blackouts	☐	☐	Have you had a mastectomy L ☐ R ☐	☐	☐
Muscle disease	☐	☐	Do you have chronic pain or arthritis	☐	☐
Fitting or Convulsions / Epilepsy	☐	☐	Lymphodema	☐	☐
Liver disease or jaundice (including hepatitis)	☐	☐	Sleep apnea	☐	☐
Kidney disease	☐	☐	Do you take herbal supplements	☐	☐
Glaucoma / Eye problems	☐	☐	Have you received advice from your Dr regarding taking/ceasing medication prior to admission? If no, contact doctor	☐	☐
Anaemia or other blood disorders	☐	☐	Do you have a fear of falling, are unsteady on feet or have fallen in the last 3 months	☐	☐
Bleeding disorders	☐	☐	Have you taken Steroids	☐	☐
Do you take blood thinning medication or anti-coagulants e.g. Warfarin, Plavix, aspirin	☐	☐	Questions relating to Creutzfeld Jakob disease (Mad Cow disease)	☐	☐
Diabetes	☐	☐		Have you had a dura mater graft between 1971-1989	☐
Please tick what methods are used to manage diabetes ☐ Diet Controlled ☐ Tablets ☐ Insulin Injections			Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder	☐	☐
Thyroid problems	☐	☐	Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985	☐	☐
Tuberculosis	☐	☐	Have you suffered from any recent progressive dementia (physical or mental), the cause of which has not been diagnosed	☐	☐
Stroke / mini stroke	☐	☐		☐	☐
Have you had an anaesthetic before	☐	☐		☐	☐
Have you had problems with Anaesthetics	☐	☐		☐	☐
Family history of Anaesthetic complications	☐	☐		☐	☐
Short term memory loss/ dementia	☐	☐		☐	☐
Have you had a recent respiratory illness	☐	☐		☐	☐

If you answered Yes to any of the above, please provide details

CURRENT MEDICATIONS

Please check with your Doctor prior to your procedure if your current medications need to be modified or ceased ie: Diabetic medicines, blood pressure medicines or blood thinners.

PREVIOUS SURGERY/PROCEDURES

DISCHARGE PLANNING

Do you live alone? ☐ Yes / ☐ No Do you have someone to look after you after discharge? ☐ Yes / ☐ No

Do you currently receive community support/nursing services? ☐ Yes / ☐ No

Do you have escorted transport from hospital? ☐ Yes / ☐ No

Details checked by Pre-Admission Nurse

_____ sign _____ print

CONSENT for MEDICAL

TREATMENT/SURGERY

Provision of Information to Patient (Part A)

To Be Completed by Medical Practitioner

I, Dr _____, have informed the *patient or their parent/guardian about the recommended
Name of Medical Practitioner
procedure or treatment detailed by me below, including its nature, likely results and material risks.

x _____
Signature of Medical Practitioner

If Interpreter present* x _____
Name & Signature of Interpreter

Patient Consent (Part B)

To Be Completed by Patient (except name of procedure/treatment)

Dr, _____ and I have discussed *my/my child _____'s
Name of Medical Practitioner *Name of Child (if applicable)*
present condition and the various ways in which it may be treated. The Doctor has recommended

Name of Procedure/Treatment (TO BE COMPLETED BY MEDICAL PRACTITIONER)

The Doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed and these may have some risks;
- additional procedures or treatments may be needed if the Doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

In the event that a team member involved in my care receives a needlestick or similar injury, I give my permission for blood to be drawn for the purpose of screening for transmittable diseases, including testing for HIV antibodies.

I understand that I may withdraw consent.

* I have been informed that the procedure/treatment or part thereof may be performed by another doctor.

I consent to the procedure/treatment described above for *me / my child. I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

SIGNATURE of * patient / parent / guardian

NAME of Patient / Parent / Guardian

DATE

Address

Delete if Not Required

While I Consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure/treatment:

Insert Objection (e.g. Blood Transfusion)

Practitioner's Acknowledgement (Signature)

Re: Children;

I note that the Children and Young Persons (Care and Protection) Act 1998 provides that such treatment may be provided, if it is necessary to prevent death or serious injury to my child, even if I object.

NOTES REGARDING CONSENT

A child aged 14 years and above may consent provided they adequately understand and appreciate the nature and consequences of the operation procedure or treatment. Where the child is 14 or 15 years of age, it is prudent for us to obtain the consent of the parent or guardian, unless the patient objects.

For patients 16 years or over, their own consent is sufficient.

Patients from non-english speaking backgrounds - an interpreter should be used when considering consent, the interpreters must sign the consent form to the effect that they have acted as an interpreter for the patient.

Patients who have a physical disability preventing them from being able to sign the consent form - the medical officer may sign the consent form for & in the presence of the patient and another staff member, along with the patient's next of kin/relative. It then must be documented the fact that the patient has given verbal consent.



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