Central Coast Day Hospital

Suite 1, Fountain Corporate 2 Ilya Ave, Erina NSW 2250
Ph: (02) 4367 3880 Fax: (02) 4367 3881
Email: reception@ccdhospital.com.au

Place ID Label Here

PRE-ADMISSION FORM

TO BE COMPLETED BY PATIENT

PRE-ADMISSION FORM

Please indicate responses by crossing the appropriate box [X]

Surgeon: **Date of Admission** / /

Procedure: Right ☐ Left ☐

PATIENT DETAILS

Title	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Prof ☐ Dr ☐ Sr ☐ Fr ☐ Gender M ☐ F ☐
Given Name	Family Name
Street Address	
Suburb	State Post Code Date of Birth / /
Phone	Home Work Mobile
Email	
First admission to the hospital:	Please complete **both sides of this form** and return to the hospital with **the Consent Form** as soon as possible prior to your admission. Your responses are valuable to us in planning your admission and care. This form can also be completed online at www.ccdhospital.com.au
Subsequent admissions:	If your last admission was within the past three (3) months and there have been no changes to your personal details or medical condition since your last admission please cross here ☐ and sign at the bottom of this page

Marital Status	Married / De Facto ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐		
Ethinicity	Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐		
Language Spoken		Country of Birth	

PRIVATE HEALTH INSURANCE / MEDICARE / DVA / WORKCOVER DETAILS

Medicare, DVA, Pensioner	Medicare No. Ref No: Expiry Date / /
	Dept of Veterans' Affairs File No. Gold ☐ White ☐
	Pension No.
Private Health Fund	Are you in a Health Fund? Yes ☐ No ☐
	Health Fund Name Membership No.
Worker's Compensation MVA Third Party	Admission covered by WC Claim Yes ☐ No ☐ Date of Injury / /
	Name of Employer Employer Phone No.
	Admission covered by MVA Claim Yes ☐ No ☐ Claim No.
	Insurance Co. Contact No.

NEXT OF KIN / CARER DETAILS

Next of Kin	Relationship Given Name Surname	
	Address	Post Code
	Telephone No.	Home: Work: Mobile:

Do we have permission to speak to this person regarding your admission and care? Yes ☐ No ☐ **or Carer?** Yes ☐ No ☐
Will this person be your carer on the day of surgery (ie taking you home)? Yes ☐ No ☐

Carer's Details (if not Next of Kin above)	Name	Relationship
	Telephone No.	Home: Work: Mobile:

PATIENT PRIVACY INFORMATION FOR PERSONAL HEALTH INFORMATION

Central Coast Day Hospital (CCDH) ensures that your information is collected, stored and used in compliance to the Australian Privacy Principles (APP) (Privacy Act 1988 & Privacy Amendment Act 2012). Central Coast Day Hospital is committed to ensuring that the individual's information is used only for the purposes consented to by the individual. We may communicate with you or your referrer electronically using the highest standards of information security and privacy e.g. online registration, discharge information, patient satisfaction surveys & eNewsletters. You may opt out of this at any time.

I have carefully read all details on this form and confirm that all information given on the Admission forms is correct and true to the best of my ability. I have read the Patient's Rights and Responsibilities and Privacy information in the Patient Booklet, online at the website or on display in the hospital. I am aware that it is a requirement of my admission to have an escort home and a carer overnight following surgery

Patient / Guardian Signature	Patient / Guardian Name	Date ..... / ..... /.....

FADMITPRE1

TEAR ON PERFORATION

PRE-ADMISSION FORM MR2

MEDICAL ASSESSMENT FORM

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MEDICAL ASSESSMENT FORM

Patient's Name..... Date of Birth...../...../.....

GP's Name..... Phone .....

Referred to Surgeon by: GP ☐ Optometrist ☐ or Other Specialist ☐

Name ..... Suburb.....

MEDICAL HISTORY

Please indicate responses by crossing the appropriate box. ☐

	Yes	No		Yes	No		Yes	No
Heart Conditions	☐	☐	Diabetes	☐	☐	Cold Sores /Herpes Simplex	☐	☐
Cancer	☐	☐	Epilepsy / Fits or Faints	☐	☐	Recent Falls	☐	☐
Pacemaker or Defibrillator	☐	☐	Kidney Disease	☐	☐	Contact Dermatitis	☐	☐
High Blood Pressure	☐	☐	Organ Transplant	☐	☐	Latex / Rubber Allergy	☐	☐
Stroke &/or TIA's	☐	☐	Glaucoma / Cataracts	☐	☐	Asthma or Wheezing	☐	☐
Blood Clots	☐	☐	Retinopathy	☐	☐	COPD / CAL / Emphysema	☐	☐
Bleeding or Bruising	☐	☐	Mental Health Illness	☐	☐	Tuberculosis	☐	☐
Anaemia	☐	☐	Dementia or Alzheimer's	☐	☐	Persistent Cough /Breathlessness	☐	☐
Hepatitis or HIV	☐	☐	Spina Bifida	☐	☐	Are you pregnant?	☐	☐
Skin Ulcers or Open Wounds	☐	☐	Amputee	☐	☐	Do you Smoke?	☐	☐
Growth Hormone (pre 1985)	☐	☐	Paraplegia / Muscle Weakness	☐	☐	Overseas travel in last 3 months	☐	☐
Dura Mater Graft between 1972 - 1989	☐	☐	Arthritis or/ Limited Joint Movement	☐	☐	Current Chest Infection / Cold/ Fever	☐	☐
Do you or your family have a history of Cruetzfeldt Jacob Disease (CJD)	☐	☐	Gastrointestinal Ulcers/ Bowel Disorder	☐	☐	Do you drink Alcohol or take Recreational Drugs? Amount ..... per week	☐	☐

Have you, or your family, ever experienced any problems with anaesthetics? Yes ☐ No ☐

LIST OF CURRENT MEDICATIONS - INCLUDING VITAMINS, SUPPLEMENTS OR HERBAL PREPARATIONS

Please attach a GP Management Plan or list on a separate sheet if insufficient space.

I am not currently taking any medications ☐ | Is your surgeon aware that you are on all the medications listed? Yes ☐ No ☐

Warfarin Therapy Yes ☐ No ☐ If presently taking Warfarin, please provide below the details of the most recent INR test.

Date ...../...../..... INR..... Date ceased ...../...../..... Plavix ☐ Isocover ☐

Drug	Dosage	Frequency

ALLERGIES & ADVERSE DRUG REACTIONS

Nil Known ☐ Please Use Extra Sheet If Insufficient Space.

Drug or Other	Reaction Type	Date

ILLNESSES AND CONDITIONS

Please Use Extra Sheet If Insufficient Space.

OPERATIONS AND APPROXIMATE DATES

Please Use Extra Sheet If Insufficient Space.

Height ..... cm Weight ..... kg

Is there anything else you feel we should know?

Patient / Guardian Signature

Patient / Guardian Name

Date ...../...../.....

MR2A

TEAR ON PERFORATION

FADMITPRE2

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RECOMMENDATION FOR ADMISSION

MR3

TEAR ON PERFORATION

TO BE COMPLETED BY SURGEON

RECOMMENDATION FOR ADMISSION

Please indicate responses by crossing the appropriate box [X]

This confirms the arrangements for .....
(Patient Name)

to be admitted to the hospital on ...../...../..... for 1st eye ☐ or 2nd eye ☐

Provisional diagnosis	Right eye ☐ Left eye ☐
Proposed operation	Right eye ☐ Left eye ☐
Proposed anaesthetic	Topical ☐ Regional ☐ LA ☐ GA ☐
Specific medical history	
Bariatric status	..... Kg Weight > 120 kg ☐

MEDICAL HISTORY

I am aware of the patient's medical history, current medications and allergies ☐ Yes ☐ No

Has the patient been seen by their GP in the last 12 months? ☐ Yes ☐ No

If no, do they need to be seen preoperatively? ☐ Yes ☐ No

SURGERY

Procedure item numbers	
Specific pre-operative requirements	

Transfer to overnight care Yes ☐ No ☐

Courtesy Transport to & from Facility Yes ☐ No ☐

Acuity in other eye .....

Doctor's Signature.....

Doctor's Name..... Date ...../...../.....

FRECCONGEN1

CONSENT TO SURGICAL TREATMENT

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For CCDH use only

TO BE COMPLETED BY SURGEON

CONSENT TO SURGICAL TREATMENT

I, Dr (Doctor's Name) ..... have discussed with

(Patient's Name) ..... whose date of birth is ...../...../.....

the need for him / her to have the following procedure Right eye ☐ Left eye ☐ .....

.....

We have discussed what alternatives are available, the nature of the risks of the procedure, the risk that it may not give the expected result and the possibility of altered or additional procedures being required. We have also discussed the fact that the procedure may involve anaesthetics, medications and / or blood transfusions and that these all carry risks. On the basis of this understanding, we agree that I perform, and that he /she consent to this procedure.

Doctor's Signature.....

Doctor's Name..... Date ...../...../.....

Patient's Signature.....

Patient's Name..... Date ...../...../.....

Interpreter's Signature.....

Interpreter's Name..... Date ...../...../.....

CONSENT BY A RELATIVE OR LEGAL GUARDIAN TO SURGICAL TREATMENT

I, Dr (Doctor's Name) .....have discussed with

(Legal Guardian / Relative's Name).....the **Legal Guardian / Relative** of

(Patient's Name) ..... whose date of birth is ...../...../.....

need for him / her to have the following procedure.....

.....

We have discussed what alternatives are available, the nature of the risks of the procedure, the risk that it may not give the expected result and the possibility of altered or additional procedures being required. We have also discussed the fact that the procedure may involve anaesthetics, medications and / or blood transfusions and that these all carry risks. On the basis of this understanding, we agree that I perform, and that he /she consent to this procedure.

Doctor's Signature.....

Doctor's Name ..... Date ...../...../.....

Relative/Legal Guardian's Signature.....

Relative/Legal Guardian's Name .....Date ...../...../.....

Interpreter's Signature.....

Interpreter's Name..... Date ...../...../.....

FRECCONGEN2

MR3A

TEAR ON PERFORATION