Townsville DAY SURGERY

ABN: 95 098 766 888
ACN: 098 766 888

1 Martinez Avenue, West End, QLD 4810

Phone: 07 4725 4500 | Fax: 07 4725 4566

Email: reception@townsvilledaysurgery.com.au

www.townsvilledaysurgery.com.au

Reception Hours

Monday to Friday 7am to 6pm

Saturday by appointment

PRE-ADMISSION INFORMATION AND PATIENT REGISTRATION FORM

This form should be returned as soon as possible and no later than a week prior to your admission date.

YOUR ADMISSION INFORMATION:

ADMISSION DATE: ____ / ____ / ____

ADMISSION TIME: _____

FAST FROM: _____

IF YOU WOULD LIKE TO SUBMIT YOUR FORM ELECTRONICALLY

1. Go to www.townsvilledaysurgery.com.au
2. Click the 'patient info' tab.
3. Scroll down to and click on 'prepare for your admission'.
4. Scroll down to and click on the 'pre-admit' link
- this will take you to the pre-admit site.
5. Log in or create a new form.
6. Fill in all the information and at the very end submit your form.

You will receive a confirmation email once the form has been submitted correctly.
If you have not received the email please return to the website and resubmit.

PLEASE READ AND KEEP FOR YOUR INFORMATION

Before your admission:

The date and time of your surgery is arranged through your Surgeon's Rooms. Please contact Surgeon's rooms directly if you are unsure.

Plan to have someone drive you to Townsville Day Surgery on the day of admission. It is likely that your concentration will be impaired for a few days after the anaesthetic. **As a result, you are legally not allowed to drive a vehicle for 24 hours after an anaesthetic. You will need someone who we are able to contact to pick you up and discharge you into their care. If you are unable to provide adequate information regarding this, your procedure may be cancelled and re-scheduled.**

Please be aware that it is necessary for you to have a responsible adult accompany you home and stay with you for the first 24 hours following your surgery. It is also advised that you stay within 1 hour's journey of a Hospital following some procedures. If either of these is not possible, please discuss alternatives with your surgeon and notify nursing staff of your arrangements on the day of admission.

Please understand that cancellation of your procedure may result if you do not have the appropriate measures in place.

***Please have a shower on the day of your procedure.**

Giving Informed Consent:

You will be asked to acknowledge your understanding of, and give your informed consent to, tests, therapies or other procedures required for your care. If you have any questions or concerns about your treatment or your consent, please speak to the doctors and nurses caring for you.

Fasting Instructions:

YOUR SURGEON WILL ADVISE YOU WHEN TO COMMENCE FASTING.

DO NOT eat or drink on the day of your surgery after the advised time of fasting given by your surgeon. Take your normal prescribed medications on the morning of the procedure with a sip of water (unless you have been advised otherwise by your GP or Surgeon). You may brush your teeth but DO NOT swallow any water. DO NOT chew gum on the day of your surgery.

Smoking:

DO NOT smoke on the day of your surgery. Smoking is not permitted on Townsville Day Surgery premises.

Doctors' Fees:

Please note that you will also receive an account direct from the Doctors involved in your procedure (Surgeon, Anaesthetist and Assistant where required). Please contact your Surgeon and Anaesthetist Rooms directly regarding these fees.

Fees and Health Fund Information

Before your visit to Townsville Day Surgery, we strongly advise that you contact your health fund to verify your level of cover and whether you will be covered for your surgery in a private hospital setting.

Please be aware that all health funds place their new members in waiting periods, regardless of whether you are joining private health insurance for the first time or you have changed over from another health insurer.

Most health fund policies have excesses, co-payments, exclusions and restrictions.

Exclusions: you agree not to be covered at all for certain services. No benefits are payable for the excluded service by your health fund at all.

Restrictions: you agree to receive only limited benefits for certain services. This is usually enough to cover you as a private patient in a public hospital, but will leave you with large expenses if you are treated in a private hospital.

Most exclusions are complex and it is important that you understand how they may impact upon your cover. If the procedure is an excluded item on the level of cover you hold, your health insurer will not cover any costs associated with the hospital.

If you have joined your health insurance fund less than 12 months ago or you have recently changed levels of cover:

Any time you join a health fund for the first time, you are subject to waiting periods on hospital benefits for the first 12 months and pre-existing ailment conditions may apply.

What is a waiting period? A waiting period is an initial period of health fund membership during which no benefit is payable for certain procedures or services.

What does "Pre-Existing Ailment" mean? A pre-existing condition is defined as any ailment, illness, or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. The pre-existing condition waiting period applies to new members and members upgrading their policy to any higher level benefits under the new policy.

Please be aware if you have changed/upgraded your level of cover, your health insurance provider will often place you in a 2 month waiting period.

Questions we recommend you ask your health insurer prior to your admission:

- **What level of cover do I hold?**
- **Have I been a member for more than 12 months?**
- **Does my policy cover me for this procedure?**
  (You may require 'item numbers' which can be given by your Surgeon)
- **Do I have an excess or co-payment for Day Surgery admissions?**

Uninsured, Work Cover and Third Party Patients:

If your hospital stay is not covered by your health insurance or if it is a Workcover claim and has not been approved for payment prior to the admission date, you are fully responsible for the costs associated with the hospital.

If you are a self funded patient, we advise you contact Townsville Day Surgery on (07) 4725 4500 to obtain an estimate of fees and charges. You will require an item number for your procedure which will be provided by your Surgeon's rooms. **The quote we give you is an estimate only**. If there are variations from the proposed treatment or unforeseen complications, the costs may vary

Plastic and Reconstructive Surgery

Health Insurance fund will not pay any benefits towards the hospital account if the procedure is not deemed medically necessary.

If you are admitting for a Plastic or Reconstructive procedure and your health insurance will not pay any benefits, please contact Reception at Townsville Day Surgery for an estimate of hospital fees.

Payment of Day Surgery Fees:

Self-insured patients are required to pay full fees on admission.

Any excess payable under your Private Health Insurance Fund is payable on admission.

Townsville Day Surgery has EFTPOS and Credit Card facilities (Bankcard, Visa, Mastercard, Amex, Diners Club). Cash and Cheque are also accepted.

What you need to bring:

Please bring your Medicare card, Health Insurance membership card and any Pension/Concession cards you may hold.

Bring any current X-Rays (if applicable) and any medications or a list of your current medications.

What not to bring:

Please DO NOT bring large sums of money, jewellery or other valuables, as we cannot accept responsibility for their security.

We recommend that you wear loose, comfortable clothing with an open neck or button top.

Please remove all make-up and nail polish prior to your admission. If you have acrylic or gel nails, please ensure a toenail is free of nail polish.

Please do not wear strong smelling perfume or deodorant.

Parking:

A drop off / pickup zone is available at the front of the building for arrival and departure. There are a number of parking spaces for longer stays.

Due to the possibility of unpredictable delays, it is difficult for our staff to provide you with time frame for your stay with us.

Our nursing staff will endeavour to contact Escort/Carer prior to your discharge time, to advise them of when you will be ready to leave our care.

BARCODE LABEL

DEMOGRAPHIC LABEL

THIS COMPLETED FORM IS URGENTLY REQUIRED ONE WEEK PRIOR TO YOUR DATE OF ADMISSION

If there is insufficient time for us to receive this form please fax or phone the hospital between the hours of 7am to 6pm. Thank you.

ADMISSION DETAILS

Admission date:_____ /_____ /_____ Time:_____am/pm Admitting doctor:_____

PATIENT DETAILS (*please print*)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other (e.g. Rank)_____

Surname: _____ First name: _____ Middle name: _____

Residential address:_____ Postcode:_____

Postal address:_____ Postcode:_____

Phone (home):_____ Phone (work):_____ Mobile:_____

Date of birth:_____ /_____ /_____ Sex: ☐ Male ☐ Female ☐ Indeterminate Religion:_____

Marital status: ☐ Married/defacto ☐ Never married ☐ Divorced ☐ Separated ☐ Widowed

Indigenous Status: ☐ Non-indigenous/Torres Strait Islander ☐ Indigenous ☐ Torres Strait Islander

Country of birth:_____ Email: _____

Occupation:_____ If Retired previous occupation:_____

NEXT OF KIN DETAILS (*please print*)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other (e.g. Rank)_____

Surname: _____ First name: _____ Middle name: _____

Relationship to patient:_____

Address:_____ Postcode:_____

Phone (home):_____ Phone (work):_____ Mobile:_____

CONCESSION CARDS

Pension: ☐ Yes ☐ No Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Valid to:_____ /_____ /_____

Veterans' Affairs file number:_____ Card colour: ☐ Gold ☐ White

MEDICARE

Medicare card no.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Number beside 'Patient on card': ___ Valid to:____ /____ /____

HEALTH INSURANCE DETAILS

We recommend you contact your Health Fund prior to your admission date. Please refer to Health Fund section for further information. If self-insured, please contact Townsville Day Surgery (07 4725 4500) for an estimate of hospital fees.

Name of fund:_____ Membership no._____

☐ Workcover / Third Party Liability - Have you lodged a claim yet? ☐ Yes ☐ No Claim no.: _____

☐ Defence Force - ☐ Army ☐ RAAF ☐ Navy

Rank:_____ Unit:_____ EP ID:_____ Defence Approval no.:_____

DECLARATION (REQUIRED FOR ALL PATIENTS)

I certify that the above information is true to the best of my knowledge and agree to its release in support of my insurance claim.

Signature: _____ Date: _____

(Patient or parent/guardian)

PATIENT COMPLIANCE STATEMENT

- I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify I have had nothing to eat or drink from the fasting time instructed.
- I certify that I have a responsible adult to accompany me home and to stay with me overnight.
- I understand the importance of following instructions regarding my post-operative care and agree to follow these instructions
- I am aware of the danger to myself and others and will not drive a motor vehicle for 24 hours following anaesthetic.

Name of escort/carer: _____ Phone: _____

Patient Signature: _____ Date: _____
(Patient or parent/guardian)

Nurse to review: Is there a proforma required for this? ☐ Yes ☐ No

PATIENT MEDICATIONS

CURRENT MEDICATIONS

Medication Name	Dosage

Please read each question below and tick the appropriate answer.
Use space provided for any further information.

Have you had any Aspirin in the last week? ☐ Yes ☐ No

How many and when: _____

Are you currently on Warfarin or anti-platelet drugs? ☐ Yes ☐ No

Have you had any Cortisone / Steroids in the past 3 months? ☐ Yes ☐ No

If yes, state whether tablets, injection or cream: _____

Do you take any un-prescribed drugs or other substances? ☐ Yes ☐ No

Details: _____

Please see your GP if you have any questions regarding your current medications

PATIENT MEDICAL HISTORY

Please read each question and tick or circle the appropriate answer. Use the space provided for any further information.

DEMOGRAPHIC LABEL

Do you have an Advanced Health Care Directive? ☐ No ☐ Yes *Please provide copy*

Do you have an Enduring Power of Attorney? ☐ No ☐ Yes *Please provide copy*

Name of Attorney:_____

Phone:_____

Do you have a Guardian? ☐ No ☐ Yes *If yes, Guardian must be present during pre-procedure checks*

ALLERGIES AND REACTIONS

Do you have any allergies or reactions?	☐ YES	☐ NO

Please document any known allergies or reactions eg. Medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit.

Have you been allergic to latex? ☐ Yes ☐ No	Reaction
Drug Allergy ☐ Yes ☐ No	Reaction

Allergy / Sensitivity	Reaction

PHYSICAL	Estimated Height (cm)	Estimated Weight (kg)	BMI (office use only)

PAST SURGICAL/MEDICAL HISTORY: Surgery and medical conditions to be listed below

Year	Surgery/Medical Condition

Have you had any previous Hernia or Scrotal surgery? Details:_____	Y / N
Have you or a member of your family ever had any problems with either local or general anaesthetic? Details:_____	Y / N

CARDIAC (circle answer)

Hypertension / High blood pressure	Y / N	Rheumatic Fever	Y / N
High Cholesterol	Y / N	Blood clot on lungs / legs (DVT)	Y / N
Heart Attack When:.....	Y / N	Anaemia	Y / N
		Clotting or Coagulation Disorder	Y / N
Irregular heart beat / palpitations / heart murmur	Y / N	Chest pain / Angina	Y / N

Do you have a joint or heart valve replacement, angioplasty / stent, pacemaker / defibrillator or eye implant?	Y / N

RESPIRATORY (circle answer)

Bronchitis / Asthma / Emphysema / COPD / Shortness of breath / Bronchiectasis / Asbestosis / **Active Pulmonary Tuberculosis** / None

Have you recently had a cough, cold or sore throat?	Y / N

VASCULAR (circle answer)

Peripheral Vascular Disease	Y / N	Pressure ulcer / injury Where:_____	Y / N

ENDOCRINE (tick answer)

Diabetes: ☐ Yes ☐ No **If yes, year diagnosed:**_____ ☐ Type 1 ☐ Type 2
Controlled by: ☐ Insulin ☐ Diet ☐ Tablet

Thyroid problems ☐ Yes ☐ No

GIT / GUT (circle answer)

Indigestion or Reflux	Y / N	Hepatitis or Jaundice	Y / N
Kidney Disease	Y / N	Liver Disease	Y / N

NEURO (circle answer)

Stroke / TIA When:.....	Y / N	Back or neck problems	Y / N
Epilepsy or other fits	Y / N	Stress - related conditions	Y / N
Fainting / Dizziness	Y / N	Sleep Apnoea	Y / N

FALLS RISK ASSESSMENT (circle answer)

A fall or falls within the last 6 months	Y / N	Difficulty walking / unsteady on feet	Y / N

INFECTION CONTROL (circle answer)

Do you have a wound / infection?	Y / N
Have you ever been admitted to hospital for a period exceeding one week?	Y / N
Have you been admitted overnight to any overseas hospital/facility in the last 12 months?	Y / N
Have you been told that you have MRSA, VRE, CRE or an ESBL in the past?	Y / N
Have you travelled overseas within the last 21 days to areas with increased prevalence for diseases such as Ebola, or other acute infectious diseases such as Measles?	Y / N
Do you have either of the following?: > Fever, myalgia, headache, vomiting, diarrhoea, abdominal pain, unexplained bleeding or bruising - Consider Ebola; OR > Fever and a rash - Consider Measles	Y / N
Do you have a family history of 2 or more first-degree relatives with Creutzfeldt-Jakob disease or other undiagnosed neurological illness?	Y / N
Do you have Hepatitis or HIV (AIDS virus)?	Y / N
To your knowledge, did you receive pituitary hormone injections before 1986?	Y / N
Overseas last 6 months? Where & when? _____	Y / N
Are you fully vaccinated against Covid 19? Details?_____	Y / N
Reaction (if any)? _____	Y / N

PSYCHOSOCIAL (circle answer)

Depression / Anxiety	Y / N	Do you have Dementia?	Y / N
Diagnosed Mental Illness		Are you having thoughts to harm yourself or others?	Y / N
PTSD - Post-Traumatic Stress Disorder			

SPECIAL NEEDS (circle answer)

Primary Language:_____		Cultural consideration:_____	
Interpreter required	Y / N	Specify:_____	

OTHER (circle answer)

Hay fever	Y / N	FEMALES: Are you pregnant?	Y / N
Have you ever had a blood transfusion? *If yes, have you had a reaction?*	Y / N Y / N	Do you have a: Dental Appliance / Cap / Plate / Crown / Bridge ?	Y / N
Do you drink alcohol? Daily intake:_____			Y / N
Do you smoke? How many per day?:_____ If stopped, how long ago?_____			Y / N

HEALTH ASSESSMENT FORM

PATIENT MEDICAL HISTORY

Please read each question and tick or circle the appropriate answer. Use the space provided for any further information.

DEMOGRAPHIC LABEL

HEALTH ASSESSMENT FORM

OTHER (tick or circle answer)

Do you use, or have you used in the past year, recreational drugs? Details:_____	Y / N
Do you have or have you had cancer? Year of diagnosis:_____ Type:_____ (e.g. adenocarcinoma) Site(s):_____ (e.g. leg, liver, lung) Treatment: ☐ Surgery ☐ Radium ☐ Last chemo: _____ /_____ /_____	Y / N

Arthritis	Y / N	Skin conditions Specify:_____	Y / N

Do you tend to bleed or bruise easily? Details:_____	Y / N
Any other medical disease or illness? Details:_____	Y / N

PATIENT SIGNATURE

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature:	Print name:
Date: _____ /_____ /_____	

NURSE REVIEW

Reviewed by Admitting Nurse Date: _____ /_____ /_____	Y / N
Nurse:	Signature:

CLINICAL NOTES