CROWS NEST DAY SURGERY
BOOKING FORM

Level 1, 22 Clarke Street
Crows Nest NSW 2065
Phone: (02) 9955 5677
Fax: (02) 9966 4869
info@crowsnestdaysurgery.com.au

To be completed by the ADMITTING SURGEON only

ADMITTING MEDICAL OFFICER'S NAME: .....

DATE OF ADMISSION: ...../...../..... Estimated length of procedure: .....

PATIENT IDENTIFICATION

SURNAME: ..... GIVEN NAME(S): .....

CONTACT NUMBERS: Home: ..... Mobile: .....

CLINICAL INFORMATION

Proposed Surgery: .....

.....

Expected Item Numbers: .....

Other clinical conditions and relevant medical history: .....

.....

Current Medications: .....

.....

.....

Weight: ..... kg Height: ..... cm Date of Birth: ...../...../.....

Anaesthetic Type: General ☐ Block ☐ Sedation ☐ Local ☐

Allergies? NO ☐ YES ☐ Give Details: .....

Known Infection Risk? NO ☐ YES ☐ Give Details: .....

Pacemaker? NO ☐ YES ☐ Give Details: .....

ADMISSION / PRE-OPERATIVE INSTRUCTIONS

Specific instructions / investigations / requirements on admission: .....

.....

Medication orders for admission: .....

Are there any special needs relating to your patient's physical, intellectual, psychological, religious or emotional status (including premature births)? .....

.....

Does your patient require a Pre-Anaesthetic Consultation? NO ☐ YES ☐

.....

Admitting Medical Officer's Signature: ..... **Date:** .....

CONSENT FORM

REQUEST FOR SURGICAL OPERATION / PROCEDURE

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PART A - to be completed by the ADMITTING ACCREDITED PRACTITIONER

I, Dr ..... have informed .....

(Print name of patient Guardian/ Person responsible and relationship to patient)

of his/her present condition, alternative treatments available, and have explained the nature, purpose, likely results and the risks of the operation/procedure being consented to.

Procedure / Operation: .....

.....

Treating Accredited Practitioner: ..... / .....

Signature Print Name & Date

PART B - Patient Consent - to be completed by the PATIENT / PERSON RESPONSIBLE

Dr ..... and I have discussed treatment of my / my child's condition (as above).

I acknowledge that I have given my consent for an admission to Crows Nest Day Surgery for the following operation:

.....

I acknowledge that:

- ☐ I understand the explanation I have been given by my doctor. I am fully informed of the nature of my/ my child's planned procedure / operation and have agreed to the above procedure / operation.
- ☐ I consent to the administration of anaesthetics, medicines or other forms of treatment normally associated with this procedure / operation.
- ☐ I understand that complications may occur with any procedure / operation / anaesthetic.
- ☐ I hereby consent to the collection and use of my personal information for the purposes of my care and well-being and in accordance with reporting requirements under legislation.

....

Signature of Patient/Parent/Guardian Date Signature of Witness Date

.....

Full Name of Witness (please print)

.....

Address of Witness

CROWS NEST DAY SURGERY
PATIENT ADMISSION FORM

Level 1, 22 Clarke Street
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Instructions: Patient to complete in full

PERSONAL DETAILS

Have you (the patient) been admitted to Crows Nest Day Surgery before? YES ☐ or NO ☐

PATIENT SURNAME: ..... TITLE: .....

GIVEN NAME(S): ..... PREVIOUS NAME: .....

DATE OF BIRTH: ..... GENDER: Male ☐ or Female ☐

RESIDENTIAL ADDRESS: .....

SUBURB: ..... POST CODE: .....

HOME TELEPHONE: (.....)..... BUSINESS TELEPHONE: (.....).....

MOBILE TELEPHONE: ..... FACSIMILE: (.....).....

EMAIL ADDRESS: .....

Please indicate the best number for one of our Registered Nurses to call you about your fasting guidelines and admission information between the hours of 3.00-5.00 p.m. the day before your surgery:

Home Telephone ☐ Business Telephone ☐ Mobile Telephone ☐ Other: ☐ .....

Name of person to be contacted (if other than the patient): .....

DEMOGRAPHICS

Country of Birth: ..... Language spoken at home: .....

Occupation: ..... Religion: ..... Are you an Australian resident? YES ☐ or NO ☐

Marital Status: Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐

Are you of Aboriginal/Torres Strait Islander Descent? Neither ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Reference Number: ..... Expiry Date: ..... / .....
(10 digits only)

Local Doctor's Name (GP /telephone): .....

PERSON TO CONTACT (this is the person we may contact about your admission)

SURNAME: ..... FIRST NAME: .....

CONTACT ADDRESS: .....

RELATIONSHIP TO PATIENT: .....

HOME TELEPHONE: (.....)..... MOBILE TELEPHONE: .....

STAFF USE ONLY: Pre-Admission by RN ☐ Data Entered ☐ HF/Approve/Estimates ☐ IFC letter sent ☐

PAYMENT OF ACCOUNT (this is the person responsible for payment of this account)

Self (as above) ☐ Next Of Kin ☐ Other ☐

NAME: .....

ADDRESS: ..... POST CODE: .....

HOME TELEPHONE: (.....) ..... MOBILE TELEPHONE: .....

ESTIMATION OF FEES

Crows Nest Day Surgery will provide you with an estimate of costs for this admission. The portion of your estimated day surgery fees not covered by a health fund must be paid on admission. Self Insured patients must pay the total fee upon admission. Any additional fees incurred during your stay are payable on discharge.

☐ I accept full responsibility for payment on the day of admission for accounts rendered by Crows Nest Day Surgery including any shortfall in reimbursement by my fund gap following settlement by a health fund.

Signature of person responsible for the account: .....

DEPARTMENT OF VETERANS' AFFAIRS (DVA) AUTHORITY

Tick if applicable: ☐

DVA Authority Number: ..... Gold Card ☐ White Card ☐

DVA Patient or Agent's Signature: ..... Date: .....

Agent's Name (if patient unable to sign): .....

DEFENCE PATIENTS

Tick if applicable: ☐

PRIVATE HEALTH INSURANCE DETAILS

Are you self-insured? ☐ (please tick if you are not in a Health Fund - we will contact you with an estimate of your admission costs)

Name of Health Fund: ..... Contributor to Health Fund: .....

Membership Number: .....

Level of Cover: ..... Years of Membership: .....

STAFF USE ONLY:	E=	TAP=	Restrictions?	Y ☐	N ☐	Financial?	Y ☐	N ☐	Served Waits:	Table:

PHARMACY CONCESSIONS

Are you eligible for pharmacy concessions? YES ☐ or NO ☐

Entitlement Number: .....

Type of Entitlement: Pension ☐ DVA / Repatriation ☐ Pharmaceutical Concession Card ☐

CROWS NEST DAY SURGERY
ANAESTHETIC QUESTIONNAIRE

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Instructions: Patient to complete in full

Patient Name: ..... Date of Birth: ...../...../.....

PERSONAL MEDICAL HISTORY

		If yes, please provide details:
Have you been admitted to any hospital in the last 28 days?	NO ❑ YES ❑	Date: ..... Hospital: ..... Reason: .....
Have you had any previous operations?	NO ❑ YES ❑	Operation(s): .... Date(s): .....
Do you have any allergies? (especially to medications, sticking plasters or other substances)	NO ❑ YES ❑	Allergies: ..... Reactions: ....
Have you, or any of your blood relatives, had any reactions to anaesthetic, including at the dentist?	NO ❑ YES ❑	Details: ....
Are you currently taking **ANY medications**? (Please also provide a list of your medications from your local GP or pharmacist) *If the list is extensive, please attach a separate medications list.*	NO ❑ YES ❑	Medications List: ....
Are you currently taking any vitamins, supplements or herbal preparations?	NO ❑ YES ❑	List: ....
Do you take anti-inflammatory medications, blood thinners or arthritis medications? *If the list is extensive, please attach a separate medications list.*	NO ❑ YES ❑	Medications List: ....
Female patients: could you be pregnant?	NO ❑ YES ❑	How many weeks? .....
Do you smoke?	NO ❑ YES ❑	How many per day? .....
Do you drink alcohol?	NO ❑ YES ❑	How much per day? .....

GENERAL MEDICAL CONDITION

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?		If yes, please provide details:
Recent cold or flu?	NO ❑ YES ❑	
High blood pressure?	NO ❑ YES ❑	
Diabetes?	NO ❑ YES ❑	
Asthma or wheezing?	NO ❑ YES ❑	
Sleep apnoea? *If yes, bring your CPAP machine.*	NO ❑ YES ❑	

GENERAL MEDICAL CONDITION (continued)

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?		If yes, please provide details:
Chest pain or angina?	NO ❑ YES ❑	
Shortness of breath? Chronic bronchitis?	NO ❑ YES ❑	
Persistent cough or sputum?	NO ❑ YES ❑	
Muscle weakness?	NO ❑ YES ❑	
Anaemia?	NO ❑ YES ❑	
Epilepsy/fits?	NO ❑ YES ❑	
Deep vein thrombosis?	NO ❑ YES ❑	
Heart attack/coronary?	NO ❑ YES ❑	
Palpitations/irregular heart beat/heart murmur?	NO ❑ YES ❑	
Tendency to bleed/blood clots/bruise easily??	NO ❑ YES ❑	
Arthritis?	NO ❑ YES ❑	
Impairment? E.g. vision, hearing, mobility	NO ❑ YES ❑	
Any concerns about your anaesthetic?	NO ❑ YES ❑	
Is there any other information you would like us to know about you?	NO ❑ YES ❑	

DISCHARGE PLANNING

		If yes, please provide details:
Do you require assistance with any aspect of day-to-day living?	NO ❑ YES ❑	
Do you have multiple health problems?	NO ❑ YES ❑	
Do you live alone?	NO ❑ YES ❑	
Do you have any sole caring responsibilities for others/children when you go home after surgery?	NO ❑ YES ❑	
Have you ever required community services prior to this admission?	NO ❑ YES ❑	
Where do you plan to go after discharge?	Home ❑ Other ❑	

PRIVACY STATEMENT / CONSENT TO COLLECT & USE 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 a limited number of other purposes according to the Privacy Act (1988) and Crows Nest Day Surgery's Privacy Policy.

Personal information is released under legislation to the State Health Authority, Health Funds and the Private Hospital Data Bureau.

- ❑ I understand that my health fund or a third party insurer may require details of my admission and care, including information on my medical condition(s) and treatment given by the Day Only Facility, to enable payment of benefits for my hospitalisation.
- ❑ Please acknowledge receipt of our Privacy Statement and provide your consent to our collection and use of your personal information as described in our Privacy Statement by signing and dating below.
- ❑ I hereby authorise the Day Only Facility, and/or my treating doctor, to provide this information for this purpose to the health fund/insurer nominated by me on this form.

Signature: ..... Date: ...../...../.....

(Patient/Person Responsible)

PLEASE RETURN YOUR COMPLETED PRE-ADMISSION FORMS AS SOON AS POSSIBLE TO:

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