Patient Admission Form

WYNDHAM CLINIC
PRIVATE HOSPITAL

IMPORTANT INFORMATION ABOUT YOUR PROCEDURE

Prior to your procedure, you will be contacted by our office staff to inform you of any out of pocket expenses for your procedure. Our nursing staff will also contact you to advise you of your admission and fasting times. If you are having a general anaesthetic or sedation you will be fasting for 6 hours prior to your procedure. Because you are having an anaesthetic it is important that you follow fasting instructions provided by the nurse. If you are taking oral medications and are instructed to continue to take these within the fasting time directed, take it with a small sip of water only. Should you not follow these guidelines, please note your surgery may need to be cancelled.

Please contact admissions office on 9731 6646 if you are having difficulties completing these forms

Please complete and return to: Wyndham Clinic Admissions
242A Hoppers Lane
Werribee VIC 3030

PATIENT ADMISSION DETAILS

Admitting Doctor:			
General Practitioner (Name & Address):			
Date of Admission:	Time:	Date of Procedure:	
Operation/Procedure:		Fasting from:	
Have you been hospitalised anywhere in the last seven days? Yes ☐ No ☐ If yes, where:			
PATIENT DETAILS-Please print as your name appears on Medicare Card			
Title:	Surname:	Previous Surname:	
Given Names:			
Address:		Postcode	
Phone (H)	Phone (B)	Phone (M)	
Sex: Male ☐ Female ☐	Date of Birth:	Marital Status:	
Country of Birth (if Australia, which state)? Language spoken at home: Religion:		Are you an Australian Resident? Yes ☐ No ☐ Are you of Aboriginal/Torres Strait Island Descent? Yes ☐ No ☐	
Medicare Number:	Reference No:	Expiry Date:	Veteran's Affairs No:
Pension No: Full ☐ Part ☐			Expiry Date:
Health Care Card: Yes ☐ No ☐			Expiry Date:
HEALTH FUND INSURER / DVA			
Fund:		Membership Number:	
Level of Cover:	Date joined:	Previous Fund:	
WORKCOVER / TAC INSURER Claim Number:		**Insurer:**	
Employer Contact Details:			
DAY SURGERY DISCHARGE PLAN **All patients undergoing day procedures must have an escort home and a carer overnight**			
Who is taking you home?	Name:	Phone:	
Who is staying with you overnight?	Name:	Phone:	
NEXT OF KIN			
Title:	Surname:	Given Name:	Relationship:
Address:			Postcode:
Contact Number:		Alternative contact number:	

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MEDICAL POWER OF ATTORNEY (or copy)	
Surname:	Given name:
Address:	Phone:
Do you have an Advanced Care Directive? ☐ Yes ☐ No (if yes please provide a copy)	

DECLARATION CONCERNING ADMISSION FORM (the accurate answers to these questions are an essential part of this claim)	
I authorise Wyndham Clinic Private Hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing health insurance in accordance with the fund's privacy policy. I hereby declare and warrant that all information provided on this Admission Form is true and correct.	
Patient's/Guardian's Signature:	Date:

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PATIENT PRE-ADMISSION HISTORY

ADMISSION DIAGNOSIS: What condition are you being admitted to hospital for?

ALLERGIES

Do you have any allergies? Yes ☐ No ☐

☐ Medication or natural remedy Allergy	☐ Latex/Rubber Allergy	☐ Adhesive Tapes Allergy
☐ Food Allergy	☐ Lotions Allergy	☐ Other Allergy
☐ Drug/Medication Allergy	Details (if applicable):	

Do you have x-rays, blood tests ultrasound, relevant to your admission? ☐ Yes, please bring on admission ☐ No

MEDICAL HISTORY: Patient to complete. Please tick to indicate whether you have ever had any of the following:

	Y	N		Y	N		Y	N
Asthma / Bronchitis			Heart Problems			Pneumonia		
Epilepsy or Fits			Anaemia			Gastro Oesophageal Reflux		
Pacemaker			Bleeding disorder			Tuberculosis		
CPAP machine – Please bring machine and a mask			Rectal Bleeding			Rheumatic Fever		
Taking Blood Thinners			Stomach Ulcer			History of anaesthetic problems		
Kidney Disease			Jaundice/hepatitis			Psychiatric Treatment		
Blood Transfusion			Mobility issues / Falls If you use an aid – bring in			Are you or could you be pregnant?		
CVA (stroke)			High Blood Pressure			Blood clot leg / lungs (circle if applicable)		
Diabetes Type 1 / Type 2 (circle if applicable)			Controlled by Diet ☐ Tablet ☐ Insulin ☐ Pump ☐			Specialist details:		
Do you have instructions on how to manage your diabetes before surgery?								
Are you suffering from any pre-existing health care associated infection or communicable disease?								
1. Have you had a dura mater graft? (between 1972 and 1989)								
2. Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD)								
3. Have you received human pituary hormones (growth hormones, gonadotrophins) prior to 1985?								

Please give details:

SURGICAL HISTORY

Have you ever had previous surgery? Yes ☐ No ☐

Please give details (state year)

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GENERAL				
	Y	N		
Do you smoke?			How many per day?	
Do you consume alcohol?			How much per week?	
Do you take any sedatives or sleeping medications?			Details:	
Have you been in hospital in the last 2 months?			Reason:	Duration:
Do you require an interpreter?			Language:	
Form completed by:	☐ Patient	☐ Parent	☐ Staff member	☐ Relative / Carer, specify_____

ANAESTHETIC HISTORY	Y	N
Have you ever had any previous anaesthetics?		
Have you or any member of your family had problems with anaesthetics?		

CURRENT MEDICATIONS		
Please list ALL current medications including complementary medications – bring medications in with you		
Drug name	**Dose**	**Frequency/Time**

INFECTION CONTROL ASSESSMENT					
	Y	N		Y	N
Have you had a cough / cold / chest infection recently? (circle if applicable)			Currently taking antibiotics?		
			Surgeon aware?		
			Colonised infected with MRSA/VRE?		
Have you had an infective illness such as gastroenteritis or been in contact with someone who has had severe viral illness for (eg: measles or chicken pox) in the last 14 days?			Specify:		

NURSES TO COMPLETE				
Nurse Admission			**Alerts - please tick**	
Medical History checked			☐ Escalate falls risk ☐ Skin integrity check ☐ Advanced care directives ☐ NFR	☐ Infection risk ☐ Hearing ☐ Vision ☐ Allergies
Observations documented				
Prep as instructed			**Other specific alert as identified:**	
Suitable escort arrangements				
Nurse Signature:			**Print Name:**	

Consent Form

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CONSENT TO OPERATIVE TREATMENT AND/OR MEDICAL TREATMENT AND ADMINISTRATION OF ANAESTHETIC

Note: Both sections must be completed

CONSENT

I, …… ……

GIVEN NAME SURNAME

Hereby consent to the following operation(s)……...
(Proposed procedure – to be completed by Medical Officer)

and/or medical treatments as required being performed/given upon myself/my ……..

*Relationship to patient

The nature and effect of the above operation(s) and/or medical procedures have been explained to me by ……
I also consent to further operative procedures as may be found necessary to be performed during the operation stated above and to any required post-operative treatment.

I DECLARE I **HAVE/HAVE NOT** A TREATMENT LIMITING ORDER

Dated this…… day of …… year ……

Signed…… *Relationship to patient……

CONSENT FOR PROCEDURE

I, …… have explained to the patient/person legally responsible for the patient, the nature of the above operation(s) and/or medical treatment and anaesthetic(s). In my opinion he/she understands this explanation.

Dated this…… day of …… year ……

Signature of Surgeon/Medical Officer ……

CONSENT TO ANAETHETIC SERVICES

In conjunction with the above stated operation(s), I also consent to the administration of such anaesthetics as may be considered by the Anaesthetist to be necessary or advisable.

The risks and benefits of the relevant anaesthetic options have been discussed with me.

I understand to my satisfaction the following anaesthetic techniques to be used:

……
(Proposed anaesthetic – to be completed by anaesthetist)

All of my questions and specific concerns regarding the anaesthetic have been addressed satisfactorily. I hereby confirm that I understand the anaesthetic/s and associated risks and I consent to the same.

Patient's signature ……

I, Dr ……

declare that I have explained the risks, benefits and alternatives of the proposed anaesthetic.

I provided the patient with the opportunity to ask questions and express specific concerns and these have been addressed.