SEYMOUR DISTRICT MEMORIAL HOSPITAL
BRETONNEUX ST., SEYMOUR 3660
Phone: (03) 5793 6100 - Fax (03) 5792 4193

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PRE-ADMISSION CLINIC PATIENT INFORMATION

Please Read Carefully before you contact the Hospital

PRE-ADMISSION CLINIC IS COMPULSORY FOR ALL PATIENTS HAVING SURGERY AT THIS HOSPITAL.

Please contact the Hospital (03) 57936100 as soon as you receive your paperwork from your Doctor to book an appointment.

Pre-Admission Clinic is held at the Ambulatory Care Centre (opposite Gribbles Pathology) Bretonneux Street Seymour.

Admission Time

Please note that your actual admission time will not be known **until after 1pm** the working day prior to your scheduled procedure. Please ring us then to find out the time you need to arrive at the Hospital.

For Puckapunyal Defence Personnel Please contact the Nursing Staff at the Puckapunyal Health Centre (03) 57357655

Purpose

The purpose of this Clinic is to provide a high standard of education and preparation prior to your surgical intervention. The Clinic gives you the opportunity to discuss with the Pre-Admission Nurse, your medical history and any questions you may have regarding your procedure, anaesthesia and your recovery.

In addition, the Clinic allows you and the Health Care Team to identify any physical, social or psychological care needs you may have in preparing for discharge home.

What to bring to your Pre-Admission Clinic Appointment

- Completed patient details form **(attached)**
- Completed and signed Consent Form **(attached)**
- Pathology and X-Ray request forms if your Doctor has requested these
- Medicare Card
- Private Health Insurance details if applicable. (If you have Private Health Insurance, it is recommended that you check with your Insurance Provider prior to your admission that you are covered for your procedure or if any excess applies.)
- Blood Group Card (if you have one)
- A list of your current medications
- Pacemaker type and manufacturer details (if you have one)

Additional services offered at Seymour District Memorial Hospital

- Day Procedure Unit
- Community Nursing Service
- Post Acute Care
- Lower Hume Palliative Care
- Domiciliary Midwife Home Visits
- Antenatal Education Classes
- X-Ray, Ultrasound & CT Scanning (Seymour Medical Imaging)
- Pathology Services (Gribbles)
- Meals on Wheels
- Ambulatory Care Centre
  - Physiotherapy
  - Occupational Therapy
  - Social Worker
  - Diabetic Educator
  - Podiatrist
  - Cardiac Rehabilitation
  - Seymour Women's Health
  - Antenatal Clinic
- Respite facilities (occasional)
- Continence Advice
- Visiting Medical Specialists
- Seymour Women's Health

HAVING SURGERY AT SEYMOUR DISTRICT MEMORIAL HOSPITAL

Patient Information

in preparation for your elected procedure

Before Surgery

- If there is any change in your condition, such as a cold or fever, please contact the hospital prior to your admission
- Please assist our reception and nursing staff by having only ONE person telephone to make inquiries. Allow approximately four hours after the scheduled admission time before telephoning, (this allows time for both the procedure and recovery).
- **Have a shower or bath.** Wear comfortable clothes.
- **Remove Body Piercing Jewellery.** For your safety please remove all body jewellery.
- **Do not wear** powder, perfume, aftershave, make-up, nail polish or any jewellery. Long hair must be tied back. No clips or clasps.
- **If you wear Contact Lenses:** Please bring your container with soaking solution and advise our nurses if you are wearing contact lenses.
- **Leave Valuables at home:** rings, watches. You may require a small amount of money for television connection or crutches hire.
- **Bring your usual medications** to hospital with you. Check with your Doctor or the Pre-Admission Nurse if you should take any of your usual medications on the day of surgery.
- **If you are staying overnight or longer:** bring your nightwear, dressing gown, slippers, toiletries, tissues, sanitary needs and a book/magazine if desired.
- **Day Procedure Patients** should wear their own street clothes and may care to bring along something to read.
- **Crutches Hire:** If your procedure requires you to use crutches in the recovery phase, you can either bring in your own on the day of admission, or hire crutches from the hospital. There is a $50 deposit. A refund of $40.00 is payable on the return of the crutches. Please arrange this with admissions staff.

On the Day of Your Surgery:

Please follow these instructions carefully

FASTING

DO NOT EAT OR DRINK ANYTHING AT ALL FOR A MINIMUM OF SIX HOURS BEFORE YOUR ADMISSION TIME.

Morning Cases: This means nothing **at all** can be eaten or drunk from midnight the night before admission.

Afternoon Cases: You may have a light breakfast of tea/coffee and toast (NO CEREAL) by no later than 7.00am and then **NO FURTHER FOOD OR DRINK AT ALL.**

DO NOT SMOKE OR DRINK ALCOHOL FOR AT LEAST 24 HOURS PRIOR TO SURGERY

DISCHARGE

It is ILLEGAL FOR YOU TO DRIVE OR OPERATE MACHINERY OR MAKE MAJOR / LEGAL DECISIONS WITHIN 24 HOURS AFTER ADMINISTRATION OF AN ANAESTHETIC OR SEDATION.
Please organise for a family member/friend to drive you home from Hospital.

AFTER SURGERY

The Nursing Staff will provide you with patient information sheets relevant to the type anaesthetic administered and the operation or procedure performed.

10 am discharge is appreciated if an overnight stay is required. This enables the staff to prepare for the admission of other patients.

PREADMISSION INFORMATION

Seymour Health Bretonneux Street Seymour Vic 3660 Mail: Locked Bag 1, Seymour, Vic 3661 Tel: 03 57936100	UR NUMBER (Hospital use only)	SURNAME		
	GIVEN NAME	DATE OF BIRTH	AGE	SEX
	DOCTOR CODE	ADMITTING DOCTOR		
	DATE OF ADMISSION	TIME		

PATIENT TO COMPLETE

Have you previously been an inpatient of Seymour Hospital?	Yes	No	If Yes Year
Was your name the same?	Yes	No	If changed previous name
Have you been hospitalised anywhere else in the last 7 days	Yes	No	

PERSONAL DETAILS

Surname (Mr. Mrs. Miss Ms)		Given Names		Age	Sex
Date of Birth	State or Country of birth		Marital Status	Religion	
Address		Suburb		State	Post code
Phone mobile		Phone home		Phone Work	
Next of Kin (Full name)		Relationship		Address	
Suburb		State	Post code	Phone home	Phone mobile
Medicare Number		What is the number beside your name		Your local doctor	
Aboriginal/Torres Strait Islander Yes / No					

This section must be completed if applicable

Health Fund Details	Membership Number	Does you policy have an excess? Yes / No	If so how much is the excess? $	
Pension Number		Veterans' Number White card/Gold Card		
Workcover/TAC (Traffic Accident Commission) Please note: Approval must be obtained prior to admission • An additional charge may be payable by patients if a private room is requested and provided				
WORKCOVER Date Accepted	Claim Number	Employer Name	Phone	
Address	Suburb	State	Post code	
Insurance company				
Name	Phone	Address	Suburb	Post code
Transport Accident Commission Date of accident		Claim Number		
I understand that if the claim is denied by Workcover or the Transport Accident Commission that I am personally responsible for the payment of the entire hospital Signature Date				
Please bring: Fund membership details/book/card, Medicare Card & any relevant x-ray films Please do not bring valuables as Seymour Hospital accepts no responsibility or liability for loss or damage to personal property. I have been advised of my responsibility in relation to personal property Signature Date				

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CONSENT

Seymour Health Bretonneux Street Seymour Vic 3660 Mail: Locked Bag 1, Seymour, Vic 3661 Tel: 03 57936100	UR NUMBER (Hospital use only)	SURNAME		
	GIVEN NAME	DATE OF BIRTH	AGE	SEX
	DOCTOR CODE	ADMITTING DOCTOR		
	DATE OF ADMISSION	TIME		

I *(Insert Name)*

consent to the following operation(s)

being performed upon *(Myself/my dependent)*

Surname Given Name

Doctor

has explained and I understand the nature, effect and risk of the operation(s) state above to me
I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) stated above and to the required post-operative treatment.

- In conjunction with the above stated operation(s), I consent to the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable, with the exception of :

(state "none" or type of anaesthesia)

- I understand that my tissue(s) will be used for diagnostic and treatment purposes. I understand that it will be kept and may be used for ethically approved re search, education and laboratory quality purposes.
- I also consent to the testing of my blood for infections, including HIV (AIDS) or Hepatitis, if a medical practitioner determines that any person is or may be at risk of infection through contact with my blood.
- I further consent to the confidential use of any information contained in my medical records for the purposes of clinical and quality audits of medical records.

Signature :

(If parent or guardian consenting to treatment. designate relationship here)

Dated this day of 20

CONFIRMATION (By Doctor),
I

have explained to the ** patient/person legally responsible for the patient the nature, effect and risk of the above operation(s).
In my opinion, **he/she understands this explanation *(**please circle)*

Dated this

Signature of Doctor

ADMISSION HISTORY FORM

Seymour Health
Bretonneux Street Seymour Vic 3660
Mail: Locked Bag 1, Seymour, Vic 3661
Tel: 03 57936100

UR NUMBER (Hospital use only)	SURNAME
GIVEN NAME	DATE OF BIRTH
DOCTOR CODE	ADMITTING DOCTOR
DATE OF ADMISSION	TIME

Diagnosis / Procedure

Admission Details	Yes	No	Admission Details
Have you had any blood tests taken?			Date Company
Have you donated your own blood?			Number of units
Have you had any x-rays taken?			Blood group if known
ALLERGIES			
Medications			
Tapes / Lotions / Food			
Latex / Rubber			
Other			

MEDICATIONS					
Medication	Dose	Frequency	Medication	Dose	Frequency
Have you recently taken the following medications				Yes	No
Warfarin			Blood thinning/Aspirin based		
Anti Inflammatory, Arthritis			Cortisone/Steroids		
Have you recently stopped the above medication					

CURRENT & PAST MEDICAL HISTORY					
Have you had any of the following?	Yes	No	Have you had any of the following?	Yes	No
Diabetes /Type 1 / Type 2 / Unsure Managed with:			High Blood Pressure		
Heart attack / Angina / Chest pain			Palpitations / Irregular heart beat		
Heart Murmur / Atrial Fibrillation			Pacemaker / Heart Valve Replaced Bring pacemaker details with you or attach		
Heart Surgery			Rheumatic Fever		
Asthma / Bronchitis / Hay fever			Pneumonia / TB		
Stroke / TIA's			Tendency to bleed or bruise		
Anaemia			Blood clots in legs or lungs		
Liver disease / Hepatitis (ABC)			Do you have reason to believe that you may be at increased risk of HIV, Hepatitis?		
Recent cold / Flu / Other infections			Kidney or bladder problems		
Bowel problems			Gastric ulcers / Hiatus hernia		
Epilepsy / Fits			Depression / Anxiety / Other mental illness		
Female patients: Could you be pregnant?			Current /prior cancer diagnosis		
Have you had Chemotherapy/ Radiotherapy?			Any other medical conditions		

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PREVIOUS OPERATION *(include details & Dates)*	
Date	Operation

PAST ANAESTHETIC DETAIL			
	Yes	No	Details & dates
Have you or your family ever had a reaction to an anaesthetic			
Have you ever had a blood transfusion			
CREUTZFELDT JAKOB DISEASE (CJD)			
Have you had a dura mater graft prior to 1989?	Yes	No	
Do you have a family history of CJD?			
Have you received human pituitary (growth) hormone prior to 1985?			
Have you suffered from a recent progressive dementia the cause undiagnosed			
Infectious Diseases (H1N1)			
Have you travelled overseas lately and where to?	Yes	No	
Have you been back in Australia less than 14 days			
Do you have signs and symptoms of a respiratory infection or fever			
Prosthesis & Aids *(Circle as appropriate)*			
Visual impairment	Yes	No	Glasses Contacts
Hearing			Hearing aids Others
Dentures Top / Bottom / Caps / Crowns / Loose teeth			
Implants / Artificial limbs / pins & plates / Artificial joints			Walking Aids Frame/ Crutch / Stick

Lifestyle			
Have you ever smoked?	Yes	No	Amount Date ceased
Alcohol / Recreational drugs			Amount / Type
Special diet required			
What language do you speak?			Do you require an interpreter? Organized with

Discharge Planning			
Have you had a fall?	Yes	No	
Have you experienced fainting or dizziness recently?			
Do you live alone			
Are you a carer for another person?			
Do you currently receive community service?			Name of service
Do you require assistance with any aspect of day to day living			

Who will care for you after discharge from hospital	Relationship
Where do you plan to go after discharge	How will you get there
How long do you expect to stay in hospital	Person completing this form Patient/ Relative / Nurse / other
Admitting nurse signature	Print Name
Designation	Date

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SEYMOUR DISTRICT MEMORIAL HOSPITAL

REMOVAL, USE AND DISPOSAL OF HUMAN TISSUE

INFORMATION SHEET

Why is tissue being removed?

Tissue is removed during surgery or medical procedures so that doctors are able to diagnose what is wrong with you and can advise on the best way to treat you.

Who will remove the tissue?

Tissue is only ever removed by a registered medical practitioner. This is usually the doctor treating you.

Do I have to sign a separate consent form to have tissue removed?

No. The treating doctor will ask you to sign a consent form for the surgery or medical procedure that he/she will be performing. The form you sign may or may not refer to the removal of your tissue. You can refuse to have tissue removed.

What happens to tissue after it has been removed?

Your tissue will be used for diagnosis and treatment. It may also be used for:

- Approved research
- Training; and/or
- Laboratory quality procedures

There are strict guidelines for the removal and use of human tissue in Australia. All human tissue is treated with respect. All your details remain confidential.

Who regulates the use of tissue?

The National Pathology Accreditation Advisory Council produces guidelines that describe standards for the use of tissue for diagnosis in Australia. The use of tissue for research purposes is regulated by the National Health and Medical Research Council (NHMRC).

What about genetic information?

All tissue contains genetic information. This means that some of your tissue may be of use in genetic research. However, your tissue will never be used for these purposes without your consent.

How is tissue disposed of?

All tissue is disposed of with care and in accordance with the Environmental Protection Authority.

Department of Human Services
September 2001