sunshine private

145 Furlong Road St. Albans, VIC 3021
Ph: (03) 9366 0666 Fax: (03) 9366 0777

FORM MUST BE RETURNED PRIOR TO ADMISSION TO CONFIRM BOOKING.
IF THERE IS INSUFFICIENT TIME TO POST THE FORM, PLEASE TELEPHONE THE HOSPITAL.

MEDICAL ADMISSION DETAILS

Doctor:_____ Procedure:_____

Date:_____ Time:_____ Reception Staff

Surname:_____ Contacted Patient: _____

Given Names:_____ M ☐ F ☐ Have you previously been a

Address:_____ patient at the Centre before? Yes ☐ No ☐

Suburb:_____ Postcode:_____

Telephone Home:_____ Mobile:_____

Email:_____

Date of Birth (DD/MM/YY):_____ Country of Birth:_____

Are you Torres Strait Islander/ Aboriginal? Yes ☐ No ☐ Australians only. State Born:_____

Marital Status ☐ Never Married ☐ Married ☐ Widow ☐ Divorced ☐ Seperated

Next of Kin:_____ Relationship:_____

Phone Number:_____

GP/ Family Doctor's Name:_____

Address:_____

_____

Phone Number:_____

Transport Home / Carer:_____

Phone Number:_____

Please contact me by: Phone ☐ or SMS ☐

Did you receive a copy of the Australian Charter of Health Care Rights in Victoria: Yes ☐ No ☐

Medicare Number:_____ Ref No:_____ Expiry Date:_____

Pension Number:_____ DVA Number:_____

Private Health Fund:_____

Table:_____

Membership No:_____

Excess Applicable Yes ☐ No ☐

Confirmed: Yes ☐ No ☐

Health Fund Contact Name:_____

Date Joined:_____

I am electing to be admitted today:
(date and time above)

Insured Patient ☐

Uninsured Patient ☐

Patient Signature _____

Financial Consent::

I agree that I am personally responsible for payment of all hospital treatment (including pathology services where necessary) irrespective of any claim I may have against any health funds or third party. I agree that I am personally responsible for payment of any additional doctors or anaesthetists fees. I agree that I am personally responsible for the costs of transfer to another hospital if necessary. I understand that Sunshine Private will not be liable for any valuables I bring to the Centre. Failure to cancel procedures 24 hours prior will incur a fee of $100 charged to patient.

Patient Signature: _____ Date:_____

PATIENT LABEL

THE USE OF CONSENT FORMS FOR ELECTIVE PROCEDURES

Consent forms are required to be used for all elective procedures including:

- Those requiring general, spinal, epidural or regional anaesthesia or intravenous sedation.
- Invasive procedures or treatments where there are known significant risks or complications.
- Blood transfusions or the administration of blood products.
- Experimental treatment to which the approval of an ethics committee is required.
- Administration of medication with a known high risk of complications.
- Administration of unusual or non standard use of medications which increases the risk of complications.

Consent forms must be completed before the treatment or procedure is commenced and before the administration of any sedation or drugs which alter the patient's conscious state.

Consequences if a consent form is not completed:

- If an adequate consent form is not completed prior to premedication then any procedure or treatment should be delayed until written consent is validly obtained.
- Non compliance with this requirement must be reported to the local Patient Care Review Committee.
- If a treating doctor carries out a procedure or treatment without an adequate written consent the matter should be reported to the Medical Advisory Committee.

DISCHARGE AT OWN RISK

I am leaving/removing _____

from Sunshine Private on my own responsibility against the advice of my doctor.

_____ Date: _____

Signed

_____ Date: _____

Signed (Witness)

MEDICAL HISTORY

PATIENT LABEL

Have you ever suffered from the following:	Yes	No
High blood pressure	☐	☐
Heart disorder	☐	☐
Chest Pain	☐	☐
Pacemaker or Stent	☐	☐
Stroke	☐	☐
Rheumatic Fever	☐	☐
Blood clot - Lungs / Legs	☐	☐
Kidney disease	☐	☐
Diabetic Insulin Tablet Diet	☐	☐
Asthma/Bronchitis	☐	☐
Sleep Apnoea/CPAP	☐	☐
Chest Infections	☐	☐
Epilepsy/Fits	☐	☐
Heartburn/Reflux	☐	☐
Recent Cold/Cough/Sore Throat	☐	☐
Hepatitis - are you Hep B or Hep C positive	☐	☐
Recent Dental Treatment	☐	☐
Pressure Ulcers	☐	☐
Fallen/Nearly Fallen in past 12 months	☐	☐
Tuberculosis	☐	☐

SURGICAL HISTORY

Please List Previous Operations:

Have you or your family suffered from Complications from Anaesthetic? ☐ ☐
If yes, please give details:

Height: Weight: BMI:

ALLERGIES	Yes	No
Are you allergic to Latex/Rubber?	☐	☐
Are you allergic to any drugs/tapes/food/lotion or any other substances? Please List:	☐	☐
Have you been given any cortisone/steroids in the past 3 months? If yes, were you given cream/tablets/injections?	☐	☐
Do you bruise easily or have bleeding tendency?	☐	☐
Have you taken an aspirin in the last 7 days?	☐	☐
Are you currently taking Warfarin, Plavix, Isocover or any other anti-placelet drugs?	☐	☐
Do you smoke? If yes, how many per day?	☐	☐
Do you drink? If yes, indicated daily alcohol intake.	☐	☐

FEMALE PATIENTS

Is there a possibility that you may be pregnant?	☐	☐
Are you currently breast feeding?	☐	☐

Drug	Dose	Frequency

Declaration:

The answers I have given are to the best of my knowledge and true. I have not withheld any information. I have arranged for a responsible adult to accompany me home following my procedure and to stay with me overnight. I understand that the following my procedure my judgement may be impaired for several hours due to the anaesthetic administered.

Signed: Date:

Checked by /RN Signature Print: Designation:

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PATIENTS CONSENT

I, _____ hereby request
(given name) *(surname)*

the following operations(s) procedure(s) _____
(specify)

_____

and such further operative procedures found to be necessary to be performed during the course of the operation(s)/procedures(s) and or medical and nursing care including examinations, tests, blood transfusions and drugs as deemed necessary during the stay in hospital being performed upon,

_____
(given name) *(surname)*

I confirm that I understand, the nature and effect of the above operations(s)/procedures(s) which have been explained to me by the doctor
In conjunction with the above stated operation(s)/procedure(s) I request the administration of such anaesthetic(s) as may be considered by the anaesthetist to be necessary or advised..

Dated this _____ day of _____ 20 _____

Signed Patient/Next of Kin _____ Relationship to patient* _____
**eg mother, son, friend*

Signed (witness to signature only) _____

DOCTORS CONFIRMATION OF CONSENT

I, Doctor _____, have explained to the patient/person responsible for the patient, the nature and effect of the above operation(s)/procedure(s) and the anaesthetic(s) involved. In my opinion he /she understood this explanation.

Dated this _____ day of _____ 20 _____

Signature of Doctor _____

ANAESTHETIST CONFIRMATION OF CONSENT

I, Doctor _____, have explained to the patient/person responsible for the patient, the nature and effect of the above operation(s)/procedure(s) and the anaesthetic(s) involved. In my opinion he /she understood this explanation.

Dated this _____ day of _____ 20 _____

Signature of Doctor _____

HEALTH INFORMATION COLLECTION

All personal and health information obtained during this admission is held securely and confidentially by Sunshine Private. I understand that I can access and obtain health information held pertaining myself upon completion of Request for Access form at an additional cost.

Patient Signature: _____ Date: _____