

Completed papers must be returned to the hospital 7 days prior to admission

For more information about Manningham Day Procedure Centre see www.mdpc.com.au

Title: Mr Mrs Ms Miss Dr
Surname:
Given Name:
Preferred Name:

Surgeon Name:	Date of Procedure:
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Date of Birth:	Address:	
Gender:		
Marital Status:	Suburb:	Post Code:

Religion:	Home Phone:
Country of Birth:	Business Phone:
Occupation:	Mobile:

Resident of Australia? Yes / No	Torres Strait Islander or Aboriginal? Yes / No
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Full name of General Practitioner:
Name of GP Practice:
Address of GP Practice:
Phone Number:

Next Of Kin		Emergency Contact	
Relationship:		Relationship:	
Title: Mr Mrs Ms Miss Dr		Title: Mr Mrs Ms Miss Dr	
Full Name:		Full Name:	
Contact Phone:		Contact Phone:	
Address:		Address:	
Suburb:	Post Code:	Suburb:	Post Code:

Medicare Card Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pension Card Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Department of Veterans' Affairs	Health Insurance
Card Number:	Company:
Card Colour: GOLD ORANGE BLUE WHITE	Membership Number:

Work Cover	TAC
Insurance Company:	Claim Number:
Claim Number:	

*Payment maybe made by cash, bank cheque, credit card (Visa, Mastercard) or EFTPOS.
 Personal and business cheques are not accepted. Thank you.*

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Title:	Mr	Mrs	Ms	Miss	Dr
Surname:					
Given Name:					
Preferred Name:					

What is your height?:	What is your weight?:
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PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS	
<i>If you have had previous operations, please list dates and operation performed:</i>	
Date: / /	
Date: / /	
Date: / /	
Date: / /	
Have you or your family ever had a bad reaction to an anaesthetic? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Details:	
Have you ever had a blood transfusion? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Details:	

MEDICATIONS	Yes (Tick)	No (Tick)	Comments or further information		
Have you recently taken blood thinning/arthritis medication (Aspirin based)?					
Have you taken any steroids or cortisone tablets/injections in the last 6 months?					
If on Warfarin what was the date and result of your last INR?	Date: Pathology Company used:				
Result (to above):	Pathology Company:				
Are you taking any other prescription / non-prescription medication? No <input type="checkbox"/> Yes <input type="checkbox"/>					
<i>If yes, list dose and reason for the medication including herbal supplements and vitamins:</i>					
Medication	Frequency	Dose	Medication	Frequency	Dose

This information is necessary in order to help you plan a safe return to home after discharge			
DISCHARGE PLANNING	Yes (Tick)	No (Tick)	Comments or further information
Do you live alone?			
Are you a resident of a nursing home/hostel?			
Do you have an escort home?			Name: Contact No:
Where do you plan to go after discharge?			
Do you have someone to stay and look after you overnight?			Name: Contact No:

PLEASE TURN OVER

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GENERAL MEDICAL CONDITION	Yes (Tick)	No (Tick)	Comments or further information
Cancer			<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy
Stroke			
High Blood Pressure			
Migraines			
Heart Condition: murmur/palpitations/irregular			Date:
Tendency to bleed/blood clots/bruise easily			
Arthritis			
Asthma/Bronchitis/Pneumonia/Sleep Apnoea			
Diabetes (please indicate)			<input type="checkbox"/> Insulin <input type="checkbox"/> Diet <input type="checkbox"/> Tablet
Liver disease/Hepatitis (specify A,B,C)			
Have you ever had a test to show you had HIV, MRSA, or VRE?			
Kidney/Bladder problems			
Hiatus Hernia/Gastrointestinal Ulcers/Bowel Disorder			
Thyroid problems			
Depression/Dementia/Other Medical Illness			
Recent Cold or Flu			
Female Patients: Could you be pregnant?			Number of weeks:
Are you able to lie flat on your back for a length of time?			
Can you walk unaided?			
Do you have a pacemaker or any prosthesis devices?			
Have you been overseas in the past month?			
LIFESTYLE	Yes	No	Comments or further information
Have you ever smoked?			Daily amount Date ceased
Do you drink alcohol?			Daily amount Date ceased
Do you use recreational drugs?			Daily amount Type
Do you require an interpreter?			Language spoken:
QUESTIONS RELATING TO CREUTZFELDT JAKOB (CJD) DISEASE	Yes	No	Comments or further information
Have you ever had a dura mater graft between 1972 and 1989?			
Do you have a family history of 2 or more relatives with CJD or other specified progressive neurological disorder?			
Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?			
Have the patient suffered from a recent progressive dementia? (Physical or mental)			
ALLERGIES	Yes	No	Comments or further information
Are you allergic to medications?			
Are you allergic to foods?			
Are you allergic to tapes?			
Are you allergic to latex?			

Title: Mr	Mrs	Ms	Miss	Dr
Surname:				
Given Name:				
Date of Birth:				
Admitting Surgeon:				

I _____
Given name *Surname*

on behalf of _____
Relationship: eg. myself / my child

acknowledge that following a discussion of my/the patient's present condition including the nature and likely results of the procedure, I accept the professional opinion of

Dr _____
Name of Medical Practitioner

and that he/she has explained to me that following procedure to my satisfaction.

Description of procedure _____

- ◆ I also request and consent to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this procedure.
- ◆ I understand that other unexpected procedures may be necessary and I request that these be carried out if required, with the exception of

 specify or state "none"
- ◆ Although this operation/procedure is carried out with all due professional care and responsibility, I understand in some circumstance the expected result may not be achieved.
- ◆ I also understand that complications may occur with any operation/procedure/treatment and I accept the possible risks associated with this procedure.
- ◆ I understand that I am responsible for adhering to pre and post operative instructions and the need for a carer to take me home and stay for the night.
- ◆ I also consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV/Aids and Hepatitis should the contamination of any staff member, Doctor or myself occur during my hospital stay.
- ◆ I agree to be admitted to the Manningham Day Procedure Centre in full knowledge of my out of pocket expenses and my obligation to ensure that all fees incurred during my admission will be paid.
- ◆ I consent to my procedure being filmed and discussed for educational purposes.
- ◆ I release the hospital from any claims whatever loss, theft or damage to my personal property which may occur whilst a patient of Manningham Day Procedure Centre.

 Signature of patient/guardian/relative

 Date

SURGEON TO COMPLETE

Title:	Mr	Mrs	Ms	Miss	Dr
Surname:					
Given Name:					
Date of Birth:					
Admitting Surgeon:					

PROCEDURE	
Proposed procedure	
Indicate correct side	<input type="checkbox"/> Left <input type="checkbox"/> Right
Proposed Item numbers	
Date of procedure	
Type of Anaesthetic	<input type="checkbox"/> GA <input type="checkbox"/> Regional <input type="checkbox"/> LA <input type="checkbox"/> Topical

CLINICAL DETAILS	
Principal diagnosis (i.e. the condition which best accounts for patient's stay in MDPC):	
Other conditions present <input type="checkbox"/> Asthma <input type="checkbox"/> IHD <input type="checkbox"/> CVA <input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes	
Medications	
Allergies	

SPECIFY PRE-OPERATIVE INSTRUCTIONS (including tests required)	
<input type="checkbox"/> Preadmission nursing assessment	<input type="checkbox"/> Anaesthetic consultation
<input type="checkbox"/> Pathology	<input type="checkbox"/> Investigations
<input type="checkbox"/> Special Instructions	
DRUG ORDERS	
<input type="checkbox"/> Drug orders on admission	Time Given
Drug	Route
Frequency	

Signature: _____ Date: ____ / ____ / ____