SUNSHINE COA DAY SURGER	

Cnr Memorial & Second Avenues, Maroochydore QLD 4558 T: (07) 5294 6516

E: scdreception@scds.net.au

Office use only – Affix patient label here
URN:

	ete and return as early as possible prior to admission
Patient admission details	
Admission date:/ / Admission date:	dmitting doctor:
Procedure:	
Have you been a patient at this hospital befo	ore? Yes No
Have you been admitted to hospital in the las If Yes – Name of hospital: Reason for admission:	st 28 days? Yes No
Admission date://	Discharge date://
Patient details	
Title: Surname:	Given name(s):
Previous name(s):	
Preferred name:	Sex: Date of birth://
Residential address:	
Postal address (if different to above):	
Home phone: Wo	/ork phone: Mobile phone:
Best form of phone contact: Home \(\subseteq \)	Work Mobile
May we leave a voicemail message? 🗌 Yes	s No Opt out SMS
Email address:	
Marital status: Married (including de fac	cto) Never married/single Divorced Separated Widowed
	es Strait Islander □ Both Aboriginal and Torres Strait Islander or Torres Strait Islander □ Unknown/no answer
(QLD hospitals only) Are you of Australian Sc	outh Sea Islander Ancestry? Yes No Unknown/no answer
Country of birth:	State (if born in Australia):
Preferred language:	Interpreter required: Yes No
Religion (optional):	
Employment status: Child not at school Student Empl	oloyed Unemployed Home duties Retired Pensioner Other
	r (GP)
Referring doctor/general practitioner	
Referring doctor/general practitioner Referring doctor surname:	Referring doctor first name:
	Referring doctor first name: Practice phone number:
Referring doctor surname:	-
Referring doctor surname: Practice address:	Practice phone number:
Referring doctor surname: Practice address: Is your referring doctor your GP?	Practice phone number: No If <i>No</i> , please complete below.
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address:	Practice phone number: No If No, please complete below. GP first name:
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission	Practice phone number: No If No, please complete below. GP first name: Practice phone number: n details to My Health Record? Yes No
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record	Practice phone number: No If No, please complete below. GP first name: Practice phone number: n details to My Health Record? Yes No
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission	Practice phone number: No If No, please complete below. GP first name: Practice phone number: n details to My Health Record? Yes No
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission Would you like us to inform your GP of your a	Practice phone number: No If No, please complete below. GP first name: Practice phone number: n details to My Health Record? Yes No
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission Would you like us to inform your GP of your a Next of kin	Practice phone number: No If No, please complete below. GP first name: Practice phone number: n details to My Health Record? Yes No admission? Yes No
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission Would you like us to inform your GP of your a Next of kin Title: Surname:	Practice phone number: No If No, please complete below. GP first name: Practice phone number: Practice phone number: details to My Health Record? Yes No admission? Yes No Given name(s):
Referring doctor surname: Practice address: Is your referring doctor your GP? Yes GP surname: Practice address: Informing GP/my health record Do you consent to uploading your admission Would you like us to inform your GP of your a Next of kin Title: Surname: Relationship to patient:	Practice phone number: No If No, please complete below. GP first name: Practice phone number: Practice phone number: details to My Health Record? Yes No admission? Yes No Given name(s):





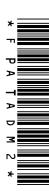
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JRN:

Patient Admission Form

Entitlements (complete for all t	nat apply)	
Medicare number:	Reference number	er:/
Australian Resident Eligible	e (reciprocal rights) 🔲 Overseas visit	or 🗌 Ineligible 🔲 Not known
Do you have any types of pension,		
Pension card Number:		y date:/
	Expir	
	Expir	
		Expiry date: / /
		Gold White Expiry date: / / / DAN (if known):
	admission (please tick one box only)	
Private Health Insurance – con	s/Australian Defence Force – <i>complete</i>	entitlements above and Section C
	Party, Motor Vehicle – complete Sectio	
Self-funded – complete Section		
Overseas Insurance – complete	•	
☐ Public – continue to Patient he		
Section A: Private health ins	surance	
		admission to confirm whether the reason for
		ealth fund of the item numbers provided by your
	or co-payment which will be payable o	vish to ask them if there are any additional costs you
Health fund name:		embership number:
		how much?
	surance in the last 12 months?	
	sation, motor vehicle or other t	
Claim number:		Date of accident://
Insurance company name:		Contact number:
Address:		
	proval letter for admission (from your i	nsurance company) must accompany this form.
Employer name:		Contact number:
Address:		
Section C: Person responsible		
Is the patient responsible for this	account? Yes (go to next section)	No (complete this section)
Title: Surname:		Given name(s):
Previous name(s):		
Residential address:		
Postal address (if different to above		
Home phone:	Work phone:	Mobile phone:
•	Home Work Mobile	
Email address:		
Relationship to patient:		
Confirmation details		
Patient/guardian name:	Signature:	Date:
		//



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	(Affix identification	label he	re)		
URN:					
Family name:					
Given name(s):					
Address:					
Date of birth:		Sex:	М	F	

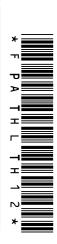
Please complete and re	eturn as e	arly as p	ossible prior to surgery
Admission date:/ / Admitting diagno	sis:		
Patient details			
Title: Surname:			Given name(s):
Sex:		Date of I	birth://
Please indicate if you ever had any of the following conditio	ns and p	rovide rel	evant details where prompted.
Cardiac			
Heart attack	□No	Yes	If Yes, year:
Angina or chest pain	□No	Yes	
Heart failure or heart/valve disease	□No	☐Yes	
Atrial fibrillation	□No	Yes	
Palpitations or other irregular heartbeat	□No	Yes	
High blood pressure	□No	Yes	
Low blood pressure	□No	☐Yes	
Rheumatic fever	□No	☐Yes	
Cardiac surgery (e.g. pacemaker, internal defibrillator, prosthetic heart valves, grafts, stents, other implants/ devices)	□No	Yes	If Yes, operation(s)/date(s):
Family history of heart disease	□No	Yes	
Haematology			
Blood clots in legs (DVT)/lungs (PE)	□No	Yes	
Blood disorders (e.g. anaemia)	□No	Yes	
Tendency to bleed or bruise easily	□No	Yes	
Respiratory and sleep disorders			
Asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asbestosis, pneumonia or shortness of breath	□No	☐Yes	If Yes, do you use: ☐ Nebulisers ☐ Puffers ☐ Home oxygen
Tuberculosis	□No	Yes	
Sleep apnoea	□No	☐Yes	If Yes, do you use CPAP machine: Yes No
Neurology and mental health			
Epilepsy or fits	□No	Yes	
Anxiety, depression, PTSD or other mental health disorder	□No	Yes	
Parkinson's, multiple sclerosis or motor neuron disease	□No	Yes	
Stroke (CVA) or TIA	□No	Yes	If Yes, year:
			List any impairments:
Dementia, Alzheimer's	□No	Yes	
Difficulties with problem solving, attention span or understanding	□No	Yes	
Delirium or confusion when ill or in hospital	□No	☐ Yes	
Renal impairment/incontinence			
Kidney disease, renal impairment	□No	☐Yes	If Yes, on dialysis: Yes No
Bladder problems (e.g. incontinence)	□No	☐Yes	
Musculoskeletal and mobility			
Fainting, dizziness or fallen in the last 12 months?	□No	☐Yes	
Do you require a mobility aid?	□No	☐Yes	If Yes: ☐ Wheelchair ☐ Walking frame ☐ Stick ☐ Other (specify):

Do you currently receive community service?

	(Affix identification	n label her	e)		
URN:					
Family name:					
Given name(s):					
Address:					
Date of birth:		Sex:	M	F	

Cnr Memorial & Second Avenues,		Family	name:					
Maroochydore QLD 4558 T: (07) 5294 6516		Given	name(s):					
E:SCDRECEPTION@SCDS.NET.AU								
Patient Health Histor	V	Addres	SS:					
Patient Health Histor	y	Date o	f birth:	Sex:	MFI			
Musculoskeletal and mobility (continu	ed)							
Do you take four or more prescribed medicat	ions per day?	□No	☐Yes					
Arthritis (e.g. osteoarthritis, rheumatoid arthr	itis)	□No	☐Yes					
Osteoporosis		□No	Yes					
Back or neck injury or problems		□No	Yes					
Previous back, neck or jaw surgery		□No	Yes					
Gastrointestinal								
Reflux/heartburn/hiatus hernia/stomach ulco	ers	□No	☐Yes					
Bowel problems (e.g. Crohn's, IBS, stoma, inc	continence)	□No	Yes	If Yes, specify:				
Liver disease, jaundice, hepatitis	,	□No	Yes					
Skin integrity								
Pre-existing wounds or breaks on your skin?		□No	Yes	If Yes, specify wound type and dura	ation:			
Eczema/dermatitis		□No	☐Yes					
Endocrinology								
Thyroid problems (e.g. goitre)		□No	☐Yes					
Diabetes		□No	Yes	- 1 - 1 -				
				How is it managed:	75'			
				☐ Insulin ☐ SGLT-2 inhibitors ☐ Other (specify):	_ Diet controlled			
Anaesthetic risk and other conditions								
Have you had an adverse reaction to anaesth		□No	☐Yes	If Yes, type:				
Has a close relative had an adverse reaction to		□No	Yes					
Have you ever had a difficult intubation?		□No	Yes					
Do you have dentures, caps, crowns, loose te	eth, implants							
or veneers?		∐No	Yes					
Cancer conditions	_	□No	Yes	If Yes, type:				
Any other condition(s) we should be aware or	i?	□No	Yes	If Yes, specify:				
Hove you had any proving a superior	oodures?	□No	Yes	If Von complete presenting and the	o porformed belevi			
Have you had any previous operations or pro Procedure	Date perforn		res	If Yes, complete procedure and date Procedure	Date performed			
1.	//		4.	rioccadic	//			
2.			5.					
3.			6.					
General health and lifestyle								
Have you ever smoked?		□No	□Yes	If current smoker, daily amount:				
				If former smoker, year ceased:				
Do you use recreational drugs?		□No	Yes	If Yes, specify type and frequency:				
-								
Do you drink alcohol?		□No	☐Yes	If Yes, daily amount:				
What is your weight, height and BMI?				Weight (kg): Height (cm):	:BMI:			
Are you pregnant or breastfeeding?								
Are you pregnant or breastfeeding?		□No	☐Yes	If <i>pregnant</i> , number of weeks:				
Do you live alone?		□ No	☐ Yes	If pregnant, number of weeks:				

DO NOT WRITE IN THIS BINDING MARGIN



☐ No ☐ Yes If Yes, specify service:

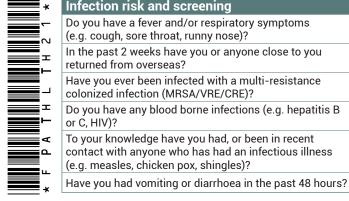
Cura CMR8.0 3/4 v1.00 24/06/2021



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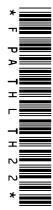
	(Affix identification	label her	re)		
URN:					
Family name:					
Given name(s):					
Address:					
Date of birth:		Sex:	M	F	

Patient Health History	Date of	birth:	S	Sex:	M	F	
General health and lifestyle (continued)							
Do you require assistance with day to day living?	□No	☐Yes	If Yes, specify assistance rec	quired:			
Do you require a special diet?	□No	□ No □ Yes □ If Yes: □ Diabetic □ Coeliac □ Lactose intolera □ Vegetarian □ Vegan □ Kosher □ Other (specify): □ Please note any foods excluded from your diet (if applicable):					
Do you have any cultural or religious needs?	□ No □ Yes If Yes, specify need(s):						
Prosthetics and aids							
Visual aids or visual impairment (e.g. glasses, contact lenses)	□No	Yes					
Hearing aids or hearing impairment (e.g. hearing aid, cochlear implant)	□No	☐Yes					
Implanted devices	□No	Yes	If Yes: Artificial joint Intra-ocular lens Defibrillator Other (specify):	F	Metal p Pacema Lap bar	aker	or pins
Allergies and adverse reactions (ADR)							
Do you have any allergies or adverse reactions to medication, tapes, latex, skin solutions or food??	□ No □ Yes If Yes, please enter details below.						
Allergy			Reaction		Date/	year of	f reaction
Medications: pharmaceutical and complementary							
Do you take any medications, including all over-the-counter		Yes	If Yes, please enter details be	elow or	attach	/uploa	d a
medications and vitamins?			medication list.				
Medication name	D	ose	Frequency	Та	aking fo	or	
If you are taking any blood thinning or arthritis medication (e have received advice on whether you will need to stop any m				have a	dvised	your d	octor and
Infection risk and screening							
Do you have a fever and/or respiratory symptoms (e.g. cough, sore throat, runny nose)?	□No	☐Yes					
In the past 2 weeks have you or anyone close to you returned from overseas?	□No	☐Yes					
Have you ever been infected with a multi-resistance colonized infection (MRSA/VRE/CRE)?	□No	☐Yes					
Do you have any blood borne infections (e.g. hepatitis B or C, HIV)?	□No	Yes					
To your knowledge have you had, or been in recent	□No	☐Yes					



☐ No ☐ Yes

Office use only	URN:	Name:	ame:			DOB:	
Infection risk	and screening (continued)						
Have you travelled in the last 4–6 weeks?							
the past 12 mon			No	Yes			
	Iditional question below if you are beir				l in Western Australia.		
Have you been an inpatient in a hospital, resided in a residential care facility or worked in a hospital or residential care facility outside of Western Australia in the past] No	☐Yes			
12 months?	<u> </u>						
Creutzfeldt Ja	acob Disease (CJD) risk assess	ment					
	questions on CJD if you are having ar		_	_	orain, spinal cord, pituitary gland	or nerve root ganglia.	
Have you had brain or spinal cord surgery that included a dura mater graft prior to 1990?			No	Yes			
	human pituitary hormone (growth lotrophin) prior to 1986?		No	☐ Yes			
Do you have a fa	amily history of CJD?		No	Yes			
Have you receive letter for CJD?	ed a 'look back or medical in confiden	ice'] No	Yes			
Have you had an illness of less th	n unexplained progressive neurologica an 12 months?	al] No	Yes			
What matters							
Is there anything	g that matters to you, specifically rega	arding your	r hosp	ital stay	that we need to know? 🗌 No	☐Yes	
If Yes, specify:							
Do you understa	and your healthcare rights (see Preadr	mission Bo	ooklet))? 🗌 No	Yes		
Legal docume	entation (please attach or bring a co	ppy of any i	releva	nt docur	nentation)		
An Advance Care	e Directive is a set of written instruction	ons that a	perso	n gives t		d be taken for their health	
•	nger able to make decisions because of urrent Advance Care Directive?		or capa No	□ Yes	If Yes, please attach or bring a cincluded with your medical reco	rd, or note below where a	
N	• ,,				copy may be obtained if require	d.	
Name (please pr	,	1			Contact number:		
	of Attorney or legally appointed medion Enduring Power of Attorney or legally		,		пакег. If Yes, please complete details b	polow	
	cal treatment decision-maker?		No	∐Yes	ii res, piease complete details t	eiow.	
Relationship to p	,				Contact number:		
Details:	Janent.				Contact number.		
• drive a motor	ngage in the following activities for 24 vehicle, ride a bicycle or operate mach portant decisions or sign legal docume	hinery or p				by your doctor:	
You must arrang	ge and advise the hospital of a respon r receiving an anaesthetic, failure to do						
	nsible adult collecting you/the patient		Toour	· · · your			
Escort name (ple	ease print):						
Relationship to p	patient:				Contact number:		
Patient agree	ment						
	information provided is true and accu	ırate to the	e best	of my kr	nowledge and I have read and un	derstood the discharge	
Patient name (pl	lease print):						
Signature:					Date://		
Nurse use or	nlv						
Comments/action	•						
Name (please pr	rint):				Designation:		



Time (24hr):

Date:

Signature: