SUNSHINE COAST DAY SURGERY

Cnr Memorial & Second Avenues,
Maroochydore QLD 4558
T: (07) 5294 6516
E: scdreception@scds.net.au

Office use only – Affix patient label here

URN:

Patient Admission Form

Please complete and return as early as possible prior to admission

Patient admission details

Admission date: ../../.. Admitting doctor:

Procedure:

Have you been a patient at this hospital before? ☐ Yes ☐ No

Have you been admitted to hospital in the last 28 days? ☐ Yes ☐ No

If *Yes* – Name of hospital:

Reason for admission:

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: Work phone: Mobile phone:

Best form of phone contact: ☐ Home ☐ Work ☐ Mobile

May we leave a voicemail message? ☐ Yes ☐ No ☐ Opt out SMS

Email address:

Marital status: ☐ Married (including de facto) ☐ Never married/single ☐ Divorced ☐ Separated ☐ Widowed

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown/no answer

(QLD hospitals only) Are you of Australian South 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 ☐ Employed ☐ Unemployed ☐ Home duties ☐ Retired ☐ Pensioner ☐ Other

Referring doctor/general practitioner (GP)

Referring doctor surname: Referring doctor first name:

Practice address: Practice phone number:

Is your referring doctor your GP? ☐ Yes ☐ No If *No*, please complete below.

GP surname: GP first name:

Practice address: Practice phone number:

Informing GP/my health record

Do you consent to uploading your admission details to My Health Record? ☐ Yes ☐ No

Would you like us to inform your GP of your admission? ☐ Yes ☐ No

Next of kin

Title: Surname: Given name(s):

Relationship to patient: Best contact number:

Emergency contact

Title: Surname: Given name(s):

Relationship to patient: Best contact number:

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Entitlements (complete for all that apply)

Medicare number: Reference number: Expiry date: /

☐ Australian Resident ☐ Eligible (reciprocal rights) ☐ Overseas visitor ☐ Ineligible ☐ Not known

Do you have any types of pension/concessional benefits card?

☐ Pension card Number: Expiry date: / /
☐ Concession card Number: Expiry date: / /
☐ Safety Net card Number: Expiry date: / /
☐ Other *(specify)*: Number: Expiry date: / /

Veteran's Affairs number: Card Colour: ☐ Gold ☐ White Expiry date: / /

Australian Defence Force – Service Number/EP ID: DAN (if known):

How will you claim for this admission (please tick one box only)

☐ Private Health Insurance – *complete Section A and C*
☐ Department of Veteran's Affairs/Australian Defence Force – *complete entitlements above and Section C*
☐ Worker's Compensation, Third Party, Motor Vehicle – *complete Section B and C*
☐ Self-funded – *complete Section C only*
☐ Overseas Insurance – *complete Section B and C*
☐ Public – *continue to Patient health history*

Section A: Private health insurance

Insured patients: It is recommended you contact your health fund prior to admission to confirm whether the reason for admission is covered under your selected level of cover. Informing the health fund of the item numbers provided by your doctor's rooms will assist your fund with confirming eligibility. You may wish to ask them if there are any additional costs you should expect, such as an excess or co-payment which will be payable on admission.

Health fund name: Membership number:

Do you have an excess or co-payment to pay? ☐ Yes ☐ No If *Yes*, how much?

Have you changed your level of insurance in the last 12 months? ☐ Yes ☐ No

Section B: Worker's compensation, motor vehicle or other third party

Claim number: Date of accident: / /

Insurance company name: Contact number:

Address:

Worker's compensation only – *Approval letter for admission (from your insurance company) must accompany this form.*

Employer name: Contact number:

Address:

Section C: Person responsible for account

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:

Best form of phone contact: ☐ Home ☐ Work ☐ Mobile

Email address:

Relationship to patient:

Confirmation details

Patient/guardian name: Signature: Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

Cura CMR2.0 2/2 v1.00 06/06/2021

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Patient Health History

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: M F I

Please complete and return as early as possible prior to surgery

Admission date: ../../.. Admitting diagnosis:

Patient details

Title: Surname: Given name(s):

Sex: Date of birth: ../../..

Please indicate if you ever had any of the following conditions and provide relevant 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)*:

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(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐M ☐F ☐I

Musculoskeletal and mobility *(continued)*

Do you take four or more prescribed medications per day?	☐No	☐Yes	
Arthritis (e.g. osteoarthritis, rheumatoid arthritis)	☐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 ulcers	☐No	☐Yes	
Bowel problems (e.g. Crohn's, IBS, stoma, incontinence)	☐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 duration:
Eczema/dermatitis	☐No	☐Yes	

Endocrinology

Thyroid problems (e.g. goitre)	☐No	☐Yes	
Diabetes	☐No	☐Yes	If *Yes*: ☐Type 1 ☐Type 2 ☐Gestational How is it managed: ☐Insulin ☐SGLT-2 inhibitors ☐Diet controlled ☐Other *(specify)*:

Anaesthetic risk and other conditions

Have you had an adverse reaction to anaesthetics?	☐No	☐Yes	If *Yes*, type:
Has a close relative had an adverse reaction to anaesthetics?	☐No	☐Yes	
Have you ever had a difficult intubation?	☐No	☐Yes	
Do you have dentures, caps, crowns, loose teeth, implants or veneers?	☐No	☐Yes	
Cancer conditions	☐No	☐Yes	If *Yes*, type:
Any other condition(s) we should be aware of?	☐No	☐Yes	If *Yes*, specify:
Have you had any previous operations or procedures?	☐No	☐Yes	If *Yes*, complete procedure and date performed below.

Procedure	Date performed	Procedure	Date performed
1.	../../..	4.	../../..
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?	☐No	☐Yes	If *pregnant*, number of weeks:
Do you live alone?	☐No	☐Yes	
Are you a carer for another person?	☐No	☐Yes	
Do you currently receive community service?	☐No	☐Yes	If *Yes*, specify service:

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FPATHLTH12

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Patient Health History

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URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

General health and lifestyle *(continued)*

Do you require assistance with day to day living?	☐ No	☐ Yes	If *Yes*, specify assistance required:
Do you require a special diet?	☐ No	☐ Yes	If *Yes*: ☐ Diabetic ☐ Coeliac ☐ Lactose intolerance ☐ 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 ☐ Metal plates or pins ☐ Intra-ocular lens ☐ Pacemaker ☐ Defibrillator ☐ Lap band ☐ Stent ☐ Other *(specify)*:

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 reaction

Medications: pharmaceutical and complementary

Do you take any medications, including all over-the-counter medications and vitamins?	☐ No	☐ Yes	If *Yes*, please enter details below or attach/upload a medication list.

Medication name	Dose	Frequency	Taking for

If you are taking any blood thinning or arthritis medication (e.g. Warfarin, Plavix, Aspirin) please ensure you have advised your doctor and have received advice on whether you will need to stop any medications prior to admission.

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 contact with anyone who has had an infectious illness (e.g. measles, chicken pox, shingles)?	☐ No	☐ Yes	
Have you had vomiting or diarrhoea in the past 48 hours?	☐ No	☐ Yes	

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FPATLTH21

Office use only	URN:	Name:	DOB:

Infection risk and screening *(continued)*

Have you travelled in the last 4–6 weeks?	☐ No	☐ Yes	
Have you had an overnight stay in an overseas hospital in the past 12 months?	☐ No	☐ Yes	
Complete the additional question below if you are being admitted to a hospital 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 12 months?	☐ No	☐ Yes	

Creutzfeldt Jacob Disease (CJD) risk assessment

Complete these questions on CJD if you are having an operation on your eye, brain, 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	
Have you taken human pituitary hormone (growth hormone/gonadotrophin) prior to 1986?	☐ No	☐ Yes	
Do you have a family history of CJD?	☐ No	☐ Yes	
Have you received a 'look back or medical in confidence' letter for CJD?	☐ No	☐ Yes	
Have you had an unexplained progressive neurological illness of less than 12 months?	☐ No	☐ Yes	

What matters

Is there anything that matters to you, specifically regarding your hospital stay that we need to know? ☐ No ☐ Yes

If *Yes*, specify:

Do you understand your healthcare rights *(see Preadmission Booklet)*? ☐ No ☐ Yes

Legal documentation (please attach or bring a copy of any relevant documentation)

An Advance Care Directive is a set of written instructions that a person gives that specifies what actions should be taken for their health if they are no longer able to make decisions because of illness or capacity.

Do you have a current Advance Care Directive?	☐ No	☐ Yes	If *Yes*, please attach or bring a copy if you would like it included with your medical record, or note below where a copy may be obtained if required.
Name (please print):			Contact number:
Enduring Power of Attorney or legally appointed medical treatment decision-maker.			
Do you have an Enduring Power of Attorney or legally appointed medical treatment decision-maker?	☐ No	☐ Yes	If *Yes*, please complete details below.

Name (please print):			
Relationship to patient:		Contact number:	
Details:			

Discharge planning

You must not engage in the following activities for 24 hours following your operation/procedure or as directed by your doctor:

- drive a motor vehicle, ride a bicycle or operate machinery or potentially dangerous appliances;
- make any important decisions or sign legal documents;
- drink alcoholic beverages.

You must arrange and advise the hospital of a responsible adult to drive you home and stay with you overnight. As this is important for your safety after receiving an anaesthetic, failure to do this may result in your procedure being cancelled or postponed.

Details of responsible adult collecting you/the patient:

Escort name (please print):			
Relationship to patient:		Contact number:	

Patient agreement

I certify that the information provided is true and accurate to the best of my knowledge and I have read and understood the discharge planning requirements as above.

Patient name (please print):			
Signature:		Date: ... / ... / ...	

Nurse use only

Comments/actions/outcomes:				
Name (please print):		Designation:		
Signature:		Date: ... / ... / ...	Time (24hr): ... : ...	

Email

Submit