Central Sydney Private Hospital
悉尼中央私立醫院
part of sms centres of surgery

Patient Admission General

UR: _____

Name: _____

DOB: _____ Gender: _____

(Affix patient label)

Planned Admission Date		**Treating Doctor**	

Patient Details

TITLE	GIVEN NAMES	FAMILY NAME
ADDRESS		POSTCODE
POSTAL ADDRESS *(If Different to Above)*		POSTCODE
TEL HOME	TEL WORK	MOBILE
EMAIL ADDRESS *please print clearly*		
DATE OF BIRTH / /	SEX FEMALE ☐ MALE ☐	PERMANENT RESIDENT YES ☐ NO ☐
MARITAL STATUS M ☐ S ☐ D ☐ W ☐ SEP ☐ DE FACTO ☐		
INDIGENEOUS ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ BOTH ☐ NEITHER ☐		
LANGUAGE SPOKEN AT HOME	COUNTRY OF BIRTH	OCCUPATION

EMERGENCY CONTACTS

NEXT OF KIN	RELTIONSHIP	TEL MOBILE
NAME OF ESCORT *(person driving you home)*		TEL MOBILE

YOU RISK YOUR PROCEDURE BEING CANCELLED IF YOU DO NOT HAVE SOMEONE TO TAKE YOU HOME AND STAY WITH YOU OVERNIGHT

Your Medicare Details, Health Fund and Referring GP

MEDICARE NO.: REFERENCE NO.	**EXPIRY DATE**
NAME OF FUND	**MEMBERSHIP NO.**
I HAVE NO HEALTH FUND COVER ☐	WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSIONOR FULL PAYMENT WILL BE REQUIRED ON ADMISSION.
I HAVE OVERSEAS INSURANCE ☐	
HAVE YOU BEEN ADMITTED TO HOSPITAL IN THE LAST 28 DAYS? YES ☐ NO ☐	

REFERRING LOCAL GP	**SUBURB OF LOCAL GP**
PENSION NO.	EXPIRY DATE
DEPT VETERANS AFFAIRS NO.	DVA CARD COLOUR
EMPLOYER	
ADDRESS	POSTCODE

TEL	CONTACT	DATE OF ACCIDENT
INSURANCE COMPANY	CONTACT	CLAIM NO.
ADDRESS		TEL POSTCODE

APPROVAL GIVEN YES ☐ NO ☐ (IF YES, PLEASE ATTACH CONFIRMATION LETTER)

WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSION OR FULL PAYMENT WILL BE REQUIRED ON ADMISSION

Your Medicare Details, Health Fund and Referring GP

To the best of my knowledge, the above informa□on is true and correct. I agree to pay any shor□all in reimbursement by my Health Fund; or, in the case of unfunded procedures, where the procedure takes longer than quoted or an□cipated. I also agree to cover the costs of any prosthesis or consumable items not rou□nely included in the es□mate or this admission.

PATIENT SIGNATURE	DATE

BINDING MARGIN - DO NOT WRITE

PATIENT ADMISSION GENERAL - Details & Medical History

MR 01A

Central Sydney Private Hospital
悉尼中央私立醫院
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Patient Admission General
RISK ASSESSMENT

UR: _____

Name: _____

DOB: _____ Gender: _____

(Affix patient label)

PATIENT ADMISSION GENERAL - Details & Medical History

MR 01A

BINDING MARGIN - DO NOT WRITE

RISK ASSESSMENT

MEDICAL HISTORY

Have you recently returned from travelling overseas (i.e. within the past 4-6 weeks) and / or have had an overnight stay at an overseas hospital or residential care facility in the past 12 months? YES ☐ NO ☐

Have you, or any of your family, experienced an adverse/allergic reaction during anaesthesia general or local? YES ☐ NO ☐

If yes, please specify.

Have you, or any of your family, had a history of malignant hyperthermia? YES ☐ NO ☐

MEDICATIONS / ALLERGIES

Please list current medications including any non-prescribed medications such as vitamins, herbs, natural or traditional therapies

MEDICATION / DRUG OR VITAMIN NAME	STRENGTH	NO. TAKEN	HOW OFTEN

Have you used steroid/cortisone medication in the past 6 months? YES ☐ NO ☐

BLOOD THINNERS Have you taken any blood thinning medication this week? e.g. Aspirin, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix, Brufen, Nurofen, Indocid) or Natural Thinners (eg Vitamin E, Chinese herbs, Ginkgo, Fish Oil, Garlic)? YES ☐ NO ☐

DIABETES Do you use insulin? YES ☐ NO ☐

Are you tablet controlled? YES ☐ NO ☐

Are you on a diabetic medication that contains Dapagliflozin, Empagliflozin or Ertugliflozin? YES ☐ NO ☐

If yes to the above, please contact your day hospital at least 5 days prior to admission

Are you diet controlled? YES ☐ NO ☐

Please bring ALL diabetic tablet medications AS WELL as your INSULIN on day of admission.

ALLERGIES/ MEDICAL ALERTS Do you have any known allergies to any medications, dressings, latex or food? If yes, please list

HEIGHT in cms _____ WEIGHT in kgs _____

If 140kgs or over please contact day hospital reception. A pre admit anaesthetic assessment will be conducted over the phone to ensure your utmost safety.

Alcohol: How much each day?_____Standard drinks

Tobacco: How many each day?_____

Have you ever used IV or recreational drugs? YES ☐ NO ☐

DO YOU HAVE, NOW OR IN THE PAST,ANY OF THE FOLLOWING?	YES	NO
CIRCULATION		
SEVERE HEART PROBLEMS Heart attack, heart failure, acute myocardial infarction. Any recent hospitalisation for heart disease. If YES, please contact the Day Hospital		
Have you ever had ANGINA (heart pain)?		
Do you have HEART STENT(S)? If yes, when?		
Have you had HEART SURGERY? If yes, what type of surgery?		
BLOOD PRESSURE		
Do you have high blood pressure now, or had in the past?		
Are you now on treatment for high blood pressure?		
A PACEMAKER OR DEFIBRILLATOR Please bring your Pacemaker/Defibrillator card with you		
BLOOD CLOTS (DVT/PE)		
Have you ever received blood/blood product (eg anti D). If YES, did you have a reaction?		
STROKE (TIA)		
Malignancy or recent fracture		
Anaemia		
RESPIRATORY		
SEVERE LUNG DISEASE		
Asthma. If YES, please bring your medication		
Recent respiratory infection (cold or flu) or signs or symptoms with a temperature over 38 degrees? If, YES please contact the Clinical Services Manager at your nominated hospital.		
Sleep apnoea		
SYSTEMS		
Vision impairment Hearing impairment		
Cochlear implant		
Bladder / kidney problems		
COMP CARE		
Epilepsy / seizures / fits / dizzy spells		
Anxiety / depression / panic attack		
Dlierium /Risk of harm		
INFECTION		
Tick if any apply to you Hepatitis A ☐ B ☐ C ☐ D ☐ E ☐ HIV ☐		
Tick if any apply to you TB ☐ MRSA ☐ VRE ☐ CRE ☐		
In the last 2 weeks, have you had, or been in contact with, anyone infectious with Chicken Pox or German Measles or influenza?		
Do you or any of your family suffer from or had exposure to Creutzfeldt jakob disease (CJD)?		
Received human pituitary hormone or had a dura mater graft between 1972 and 1989?		
DENTAL		
Crowns, bridges, dentures, caps, braces or retainers		
Dental problems (eg gum disease, loose teeth, cracks)		
MOBILITY		
Fallen in the past 12 months		
Medication in the past 24 hours that impairs your co-ordination / mental function		
Cognitive impairment (eg disorientation, dizziness, confusion, memory loss, inability to follow instructions)		
Back pain or injury / mobility problems Bed or wheel chair bound		
SKIN		
Skin rash, eczema, skin tear		
History of pressure areas		
OTHER		
If female, are you pregnant? If no, date of last period / /		
NEEDLE PHOBIA: If YES, please inform reception staff upon arrival		
Do you have an Advanced Care Plan/Health Care Directive? Any medical conditions/physical disability that may affect your procedure with us? If YES, please list		
I have read and agree with the Day Hospital's Privacy statement.		

PATIENT/GUARDIAN SIGNATURE | DATE

ADMISSION NURSE If YES to any of the above, record in COMMENTS section of Theatre Checklist

NURSE SIGNATURE | DATE