Surname:.....
Given Name:.....
D.O.B.:.....

Affix Patient Identification Label Here

Any known allergies?
(affix allergy label here)

.....
.....
.....

To be completed by consulting room:

ADMISSION DATE:.....

DOCTOR'S NAME:.....

Sir John Monash Private Hospital

"...excellence in Day Surgery..."

It is essential to complete this booklet and **return** to the address below at least **ONE WEEK** prior to your surgery.

SIR JOHN MONASH PRIVATE HOSPITAL
LEVEL 1, 212-220 CLAYTON ROAD
CLAYTON VIC 3168

OR

SIR JOHN MONASH PRIVATE HOSPITAL
P.O. BOX 5203
CLAYTON VIC 3168

REMEMBER:
Your surgery is not confirmed until Sir John Monash Private Hospital receives this booklet.

Phone: (03) 9562 9400
Facsimile: (03) 9544 4969
Email: reception@monash-hospital.com.au
Internet: www.monash-hospital.com.au

Please contact the hospital one day prior to your surgery to confirm your admission time and details.

Please notify the hospital if you change your address or phone number

Last Reviewed - November 2014

SIR JOHN MONASH PRIVATE HOSPITAL
ADULT FORM
PRE ADMISSION BOOKLET

PATIENT TO COMPLETE THIS PAGE

Admission date: _____ Doctor's name: _____

Surname of patient: _____ Mr ☐ / Mrs ☐ / Ms ☐ / Miss ☐ / Dr ☐

Given name/s of patient: _____ Male ☐ / Female ☐

Date of birth: _____ Age: _____ Country of birth: _____

State (if born in Australia) _____

Indigenous status: Aboriginal ☐ Torres Strait Islander (tick both if applicable) ☐ or neither ☐

Marital status: _____ Religion: _____

Address: _____

Suburb: _____ Post Code: _____

Contact number: Home: _____ Work: _____ Mobile: _____

Occupation: _____

Medicare number: _ _ _ _ _ _ _ _ _ _ _ _ Medicare reference number (next to name): _ _

Expiry date: _____ Email: _____

Pension card number: _ _ _ _ _ _ _ _ _ _ Type of card: _____

Veteran Affairs card number: _ _ _ _ _ _ _ _ _ _ _ Type of card: _____

Private health insurance for

HOSPITAL COVER? Yes ☐ No ☐

EXTRA'S COVER? Yes ☐ No ☐

If yes, name of health fund: _____

Membership number: _____

Schedule/Table: _____

HOSPITAL USE ONLY

Membership Check: _____

Excess: Yes / No $ _____

Uninsured Fee $ _____

(Extra time in theatre and procedure item numbers may vary Hospital cost)

Workcare: _____

TAC: _____

Ambulance Victoria Membership Yes ☐ No ☐

Have you been a patient at Sir John Monash Private Hospital before? Yes ☐ No ☐ If yes _____ (year)

If ENGLISH is not spoken, contact: _____ (Name) Phone No: _____

Please list 2 (two) emergency contact persons

Name: _____ Name: _____

Address: _____ Address: _____

Suburb: _____ Suburb: _____

Relationship to patient: _____ Relationship to patient: _____

Telephone: Home: _____ Telephone: Home: _____

Work: _____ Work: _____

Mobile: _____ Mobile: _____

Details of your care and treatment may be provided to the GP/care provider nominated below:

Local/family doctor's name: _____

Address: _____

Suburb: _____ Phone number: _____

PATIENT TO COMPLETE THIS PAGE

If you require assistance to complete this form, please see your local/family doctor

1. What operation are you coming into hospital for? _____

   _____

2. How do you plan to get home when you are discharged? _____
3. Who will be staying with you overnight? _____
4. List details of any previous OPERATIONS or ADMISSIONS to a hospital that you have had

OPERATION/ADMISSION	YEAR

5. List details of intellectual or physical disabilities including sleep apnoea or restrictions

   _____

   _____

   _____

6. What is your weight? _____ Height? _____
7. List all TABLETS/MEDICINES you are currently taking including unprescribed drugs and herbal/complimentary drugs

NAME	DOSE	HOW OFTEN TAKEN

PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES		NO	YES	IF YES, PLEASE STATE DETAILS
8.	Do you take ASPIRIN regularly? If yes, when did you have your last dose?			
9.	Are you currently on WARFARIN or "blood thinning" medication?			
10.	Have you had any treatment for excessive bleeding or bleeding disorder? State type			
11.	Have you or any relative ever experienced complications with an ANAESTHETIC?			
12.	Are you ALLERGIC to any drugs, food, tapes, latex or rubber? If yes, give names you remember.			
13.	Do you drink alcohol? If yes, indicate daily intake.			
14.	Did you smoke in the past or do you smoke now? When did you cease? ___/___/_____ How many per day? _____			
15.	Do you use or have used in the past year any recreational drugs (Including anabolic steroids)?			
16.	Have you any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?			

Continued next page

Patient To Complete This Page

If you require assistance to complete this form, please see your local/family doctor

	PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	NO	YES	IF YES, PLEASE STATE DETAILS
17.	Have you ever had a test that showed you had Hepatitis B, Hepatitis C, HIV, VRE or MRSA?			
18.	Have you ever had Hepatitis, jaundice or liver problems?			
19.	Have you ever had a Blood transfusion? If yes, did you have a bad reaction to the transfusion?			
20.	Have you had Heart Surgery? (including HEART VALVE REPLACEMENT, CARDIAC STENTS, PACEMAKER) If yes, when?			
21.	Have you had a heart attack or heart problem (including chest pain, ANGINA, heart palpitations?			
22.	Do you have or have had High Blood Pressure?			
23.	Have you had a Stroke?			
24.	Do you or have you had any kidney disease?			
25.	Have you had Rheumatic fever?			
26.	Have you had Blood clots in the brain, lungs, legs?			
27.	Do you have or have had Anaemia or low blood count?			
28.	Have you had a fall in the past 6 months?			
29.	Do you have or have had ankle or leg swelling?			
30.	Do you have or have had troublesome shortness of breath, persistent cough or difficulty climbing stairs?			
31.	Do you suffer from ASTHMA? Do you use a puffer (eg. Ventolin)?			
32.	Do you have stomach or peptic ulcers, Hiatus hernia , reflux, indigestion or heartburn?			
33.	Do you suffer from Epilepsy, fits, blackouts or faints/drop attacks?			
34.	Are you a diabetic? If yes, Type 1 or Type 2?			
35.	Do you currently have any skin wounds, pressure sores or skin ulcers?			
36.	Do you have any neck or jaw stiffness or surgery to your mouth, neck or throat? (comment)			
37.	Do you have any special needs (eg, needle phobia, CPAP machine)?			
38.	Is there a possibility that you may be pregnant?			
39.	Do you have a family history of relatives with Creutzfeldt-Jakob Disease (CJD) or other undiagnosed neurological illness?			
40.	Have you had a dura mater graft, corneal graft or received pituitary hormone therapy between 1980 and 1995 ?			
41.	Do you have any Advanced Care Directives or Treatment Limited Orders?			

I have read and understood the information for my visit on pages 3 & 4 and will adhere to discharge instructions.
The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

Signed _____ Date _____

REQUEST/CONSENT FOR MEDICAL TREATMENT/PROCEDURE

to be completed by patient/gaurdian and doctor

Part A: Provision of information to Patient (to be completed by medical practitioner)

I, doctor _____
(insert name of medical practitioner)

have informed: _____
(insert name of patient/parent/guardian)

of the nature, likely results, and material risks of the recommended operation/procedure and/or treatment. The agreed operation/procedure and treatment that the patient is to undergo is:

_____
(insert name of operation/procedure and/or treatment)

Interpreter required? ☐ Yes ☐ No I, _____ , an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to _____

_____ _____
(signature of medical practitioner) (signature of interpreter)

Date:...../...../..... Date:...../...../.....

Part B: Patient Consent (to be completed by the patient)

The doctor whose name appears in Part A above and I have discussed the present condition and the alternative ways in which it might be treated. The doctor has told me that:

- The administration of an anaesthetic, medicines , and/or blood transfusion may be needed in association with this operation/procedure and /or treatment and these carry some risks
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedures and/or treatment is carried out with allude professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carries some risks and complications can occur

I have been given the opportunity to ask questions of the doctor whose name appears in Part A above and understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risks.

I have been advised of the material risks associated with this operation/procedure and/or treatment and I am satisfied with the answers and information that I have received.

I consent to the taking of a blood sample for appropriate testing of communicable disease including HIV/Aids or Hepatitis should the contamination of any staff member, doctor or myself occur during the hospital stay.

I understand that I may withdraw my consent at any time prior to the operation/procedure and/or treatment.

_____ _____
(signature of patient/parent/guardian) (signature of witness to patient's/parent's/guardian's signature)

Date:...../...../..... Date:...../...../.....

_____ _____
(print name of patient/parent/guardian) (print name of witness to patient's/parent's/guardian's signature)

PRE-OPERATIVE EYE DROP MEDICATION ORDERS

Date	Time	Drug	Route	Dose	M.O. Signature	Nrs. Signature	Time Given