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 **14 DAYS** 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

SIR JOHN MONASH PRIVATE HOSPITAL

PAEDIATRIC FORM

PRE ADMISSION BOOKLET

PARENT/GUARDIAN TO COMPLETE THIS PAGE

Admission date:_____ Doctor's name: _____

Surname of patient:_____

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 ☐

Religion:_____

Address:_____

Suburb: _____ Post Code: _____

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

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

Expiry date:_____ Email: _____

Pension 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: _____

Uninsured Fee $_____

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

Workcare:_____

TAC:_____

HOSPITAL USE ONLY

Membership Check:_____

Excess: Yes / No $ _____

Ambulance Victoria Membership: Yes ☐ No ☐

If yes, Membership No.:_____

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

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

Please list:

(1) Parent/Guardian/Financial Responsible Person

Name:_____

Address:_____

Suburb: _____

Relationship to patient:_____

Telephone: Home:_____

Work:_____

Mobile:_____

(2) Emergency Contact Person

Name:_____

Address:_____

Suburb: _____

Relationship to patient:_____

Telephone: Home:_____

Work:_____

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: _____

PARENT /GUARDIAN TO COMPLETE THIS PAGE

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

1. 1.What operation is this child coming into hospital for? _____

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

OPERATION/ADMISSION	YEAR

5. List details of intellectual or physical disabilities or restrictions

   _____

   _____

   _____
6. What is this child's weight?_____
7. List all TABLETS/MEDICINES this child is currently taking including unprescribed drugs & herbal/complimentary drugs

NAME	DOSE	HOW OFTEN TAKEN

PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES		NO	YES	IF YES, PLEASE STATE DETAILS
8.	Has this child had any treatment for excessive bleeding or bleeding disorder? State type			
9.	Has this child or any relative ever experienced complications with an ANAESTHETIC?			
10.	Is this child ALLERGIC to any drugs, food, tapes, latex or rubber? If yes, give names you remember.			
11.	Have you any reason to believe that this child is in a high risk group for hepatitis or HIV (AIDS virus)?			
12.	Has this child ever had a test that showed he/she had Hepatitis B, Hepatitis C, HIV, VRE or MRSA?			
13.	Has this child ever had a Blood transfusion? If yes, did your child have a bad reaction to the transfusion?			
14.	Has this child had Heart Surgery? (including HEART VALVE REPLACEMENT, CARDIAC STENTS, PACEMAKER) If yes, when?			
15.	Has this child had Rheumatic fever?			
16.	Does this child have or have had Anaemia or low blood count?			

Continued next page

PARENT /GUARDIAN 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.	Does this child have a persistent cough or recent (last 2 weeks) cold, fever or chest infection?			
18.	Does this child suffer from ASTHMA? Do you use a puffer (eg. Ventolin?)			
19.	Has this child taken steroids/cortisone/prednisolone in the past? Is he/she taking them now?			
20.	Does this child suffer from Epilepsy, fits, blackouts or faints/drop attacks?			
21.	Is this child a diabetic? If yes, Type 1 or Type 2?			
22.	Does this child currently have any skin wounds, pressure sores or skin ulcers?			
23.	Was this child premature at birth? If yes, how many weeks?			
24.	Does this child have any special needs (eg, needle phobia) ?			
25.	Do you have a family history of 2 or more 1st degree relatives with Creutzfeldt-Jakob Disease (CJD) or other undiagnosed neurological illness?			
26.	In the past 2 weeks has your child been exposed to anyone with a communicable disease: e.g. chicken pox or measles?			

27. Please list any serious illness or medical condition not mentioned above?

_____

_____

_____

_____

_____

_____

28. Do you have any questions or concerns that you would like to ask the anaesthetist?

_____

_____

_____

_____

_____

_____

I have read and understood the information for my child's visit on pages 3 & 4. 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 parent/guardian 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 parent/guardian)

The doctor whose name appears in Part A above and I have discussed my child's/my charge's 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 treatments being carried out if required as long they are related to the primary procedure as set out in Part A.
- Even though the operation/procedure and/or treatment is carried out with all due 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 diseases including HIV/Aids or Hepatitis should the contamination of any staff member, Doctor or my child/charge occur during my hospital stay.

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

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

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

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