



# Adelaide day surgery

## PRE-ADMISSION BOOKLET

The following forms should be completed and returned as soon as possible prior to your admission:

- ☐ Request for Admission & Consent Forms (pages 9, 10 and 11) to be completed by your referring doctor.
- ☐ Pre-admission form (pages 13 & 14)
- ☐ Patient History form (pages 15 & 16)

Completed forms should be returned to:

Adelaide Day Surgery, 18 North Terrace, Adelaide SA 5000

OR

Fax: 08 8239 4910

OR

Email: [reception@adelaidedaysurgery.com](mailto:reception@adelaidedaysurgery.com)

ADMISSION DATE: .....

ADMISSION TIME: .....

FAST FROM: .....



## **Welcome to Adelaide Day Surgery.**

Adelaide Day Surgery is a modern, well equipped facility that caters for a wide range of surgical procedures ensuring comfort for patients, doctors and staff. We remain committed to the promotion and advancement of safe same day surgery.

Adelaide day Surgery is conveniently located at the West Terrace end of North Terrace in Adelaide's city centre.

In keeping with superior surgical techniques, Adelaide Day Surgery's nursing staff are highly trained, handpicked professionals who are committed to providing the very best nursing care in a friendly, relaxed atmosphere.

We assure you that throughout your stay at Adelaide Day Surgery your personal dignity and privacy will be respected and your individual wishes will be considered at all times.

Adelaide Day Surgery's performance as a Health Care Provider is regularly benchmarked against other like-minded facilities and its professional team keeps abreast of advances in technology via mandatory attendance at in-service training sessions and workshops.

Adelaide Day Surgery is proud to be fully accredited to ISO 9001:2008 and to have contracts with all Health Insurance Providers.

## **Anaesthesia and Your Procedure**

Virtually all surgical procedures require some form of anaesthesia which will be administered by an anaesthetist. You will be seen by your anaesthetist before your procedure. You may need to be seen by an anaesthetist before your day of admission.

Please carefully fill out the Patient History Form, as the information on these forms will be used by your anaesthetist to assess your specific anaesthetic requirements. Please take special care to record:

- All medications you are taking, the dose you are taking and how often you are taking the medications, including complementary (herbal/alternative) medicines.
- For women, if you are taking an oral contraceptive.
- Any serious medical problems such as heart disease, asthma or diabetes
- Any allergies or drug sensitivities
- Usage of recreational drugs, tobacco or alcohol
- Past anaesthetic experiences
- Loose or broken teeth, caps, plates, implants or dentures

All this is important in minimising risk and may influence the type of anaesthetic provided.

## **Preparing for your anaesthetic**

There are several simple things you can do to make your anaesthesia safer and improve your general condition prior to your procedure:

- Get a little fitter – moderate exercise such as walking will improve your general physical fitness and aid your recovery.
- DO NOT smoke on the day of your procedure – ideally stop six weeks prior to surgery
- Minimise alcohol consumption.
- Continue to take any drugs which have been prescribed but remember to let your anaesthetist and surgeon know what they are.
- Carefully follow the fasting instructions on page 4 of this booklet.
- Inform your anaesthetist if you use recreational drugs as these may interact with the anaesthetic.
- If you have any concerns about your anaesthesia, make an appointment to see your anaesthetist before admission to hospital to get the answers you need.

## Your medications

If you take any regular medication (including non-prescription medications) you should discuss this with your doctor. You may need specific instructions regarding which medications you should cease and which you should continue.

Generally, you should take your regular morning medication at 6:00am with a sip of water. If your procedure is in the afternoon and you usually take medication at lunchtime, you should take those at 11:00am with a sip of water.

Exceptions to this may be:

- **Blood Thinning Medications** (including Aspirin and anti-inflammatory medications)

If you are taking Aspirin, Clopidogrel (Plavix or Iscover), Warfarin or other anticoagulants Pradaxa (Dabigatran) or Exanta (Ximelagantran) for a heart condition or stroke prevention, you should **SEEK SPECIFIC INSTRUCTIONS FROM YOUR SURGEON AND CARDIOLOGIST AS TO WHEN OR IF** these medications should be ceased.

Patients with coronary artery stents, any vascular stent or cardiac implant should discuss with their cardiologist or surgeon before ceasing the drugs listed above.

- **Diabetic Medications**

For all patients taking diabetic medications it is important that you discuss your diabetic medication with your doctor prior to your admission.

- **Complementary (herbal/alternative) medicines**

If you are having a procedure, you should cease taking these medicines (in particular **FISH OIL**) for two to three weeks prior to your procedure unless otherwise instructed by your doctor.

## PRIOR TO ADMISSION

### Fasting

Your doctor will advise you when to commence fasting. Generally you should not eat for at least 6 hours prior to your admission. Clear fluid (water or clear lemonade only) may be taken up to 2 hours before your admission, with a limit of 200ml per hour. DO NOT chew gum or suck lollies/sweets on the day of your surgery.

**If fasting instructions are not followed, your procedure may have to be delayed or cancelled in the interests of your safety.**

### Children

If it is your child who is to be admitted, we encourage parental support and realise this is a stressful event. We are happy to arrange a pre-operative visit.

Your child may wish to bring a favourite toy or book. For infants we ask that you bring any baby formula, feeding equipment and nappies that may be required. We also recommend that you have two adults present for the journey home (one to drive and one to attend/comfort the child). It is also better for the child being admitted if other arrangements are made for siblings on the day of surgery.

**Further information on preparing your child for admission to hospital is available on our website <http://www.curagroup.com.au/adelaide-day-surgery>**

## ADMISSION TIMES AND PROCEDURE

The date and time of your admission is arranged through your doctor. You must have someone drive you to and from Adelaide Day Surgery.

The admission time indicated on the front of this form is the time you should arrive at Adelaide Day Surgery, Your arrival time does not necessarily reflect your position on the operating list.

We will endeavour to minimise your waiting time however, there may be longer than expected waiting times if unforeseen events arise with other patients.

If you are unable to keep your appointment for admission or if you have any questions about your admission process, please contact us as soon as possible on **(08) 8239 4900**

## ON THE DAY OF ADMISSION

- Please shower on the day of admission before coming to the day surgery.
- We recommend that you wear loose comfortable clothing with an open neck or button up top and flat comfortable shoes
- **DO NOT apply powder, creams, lotions, makeup or dark nail polish.**
- **Please remove acrylic nails and dark nail polish as they interfere with the reading of your oxygen levels.**

## What to Bring

- Bring your Medicare card, Health Insurance membership card, Repatriation/Veterans' Affairs card, Pension card/Health Care card, Pharmaceutical Entitlement card and concession cards.
- Any paperwork not already forwarded to Adelaide Day Surgery
- Any Advanced Care Directive forms - also known as living will, personal directive, advance directive, or advance decision, is a set of written instructions that a person gives that specify what actions should be taken for their health, if they are no longer able to make decisions due to illness or incapacity.
- Any Enduring power of guardianship forms - This is a legal document where you appoint a person of your choice to make medical and lifestyle decisions for you should you become incapable of doing so.
- Bring a list of all medication you take regularly. (Please ensure correct spelling)
- Bring any current x-rays, scans or films (if applicable).
- Payment for estimate of gap between fund benefits and hospital fees (excess payment), or total cost of hospitalisation if you have no health insurance.
- Reading material and/or something else to do.
- A hard case for your glasses.
- Coins for parking meter (Approx \$20.00 or credit card)

## Do Not Bring

- Large sums of money (apart from any payment required on admission),
- Jewellery (wedding ring and watch permitted) or
- Laptop computers

Adelaide Day Surgery will not accept responsibility for their security.

## AFTER YOUR SURGERY

The day surgery nursing staff will assist you by estimating your time of discharge on the day of your surgery. However, this is an estimate only and can change without notice.

Prior to leaving you will be given written instructions about your post operative care as required by your surgeon. These instructions will be given to you in the presence of your adult caregiver, who will be asked to sign a declaration indicating that the information is clearly given and understood.

You may also be given specific medications your doctor has prescribed. Please be aware that these medications incur an additional fee. A separate invoice will be included with the medications, which may be paid on the day at Adelaide Day Surgery or as per the instructions on the invoice.

Safety Net cardholders are exempt from payment.

**It is vital you have a responsible adult accompany you home and stay with you for 24 hours** following the surgery. It is also advised that you stay within one hour's journey of the day surgery unit. If either of these is not possible please contact Adelaide Day Surgery nursing staff to discuss possible options and note that your procedure may be cancelled if these arrangements are not in place.

For the first 24 hours after your procedure it is important that you:

- Do not drive a motor vehicle
- Do not drink alcohol
- Do not remain on your own
- Do not make complex or legal decisions

## Your hospital account

Your doctor will provide you with an Estimate of Hospital Fees which sets out the estimated total hospital fees, the estimated component of hospital fees covered by your private health insurer or another insurer, and the estimated remaining amount that you will be required to pay in advance directly to the hospital.

In addition to fees charged by the hospital, it is important to know that you will also receive separate accounts from others involved in your care. These will include your Surgeon, Anaesthetist, Surgical Assistant, other visiting doctors or medical specialists who become involved in your care, from Pathology companies, Diagnostic Imaging such as x-rays, Pharmacy and some Allied Health practitioners such as Physiotherapists, and Orthotic suppliers.

The Estimate of Hospital Fees does not include the costs of these separate services.

All patients are required to pay in advance that portion of the Estimate of Hospital Fees that will not be covered by a Health Fund, Department of Veterans Affairs, or third party insurer. This is required to be paid prior to your admission to the hospital.

If you do not have health insurance, you will be required to pay the full estimate of your account on or before the day of your admission.

The Estimate of Hospital Fees is subject to the following qualifications:

- It has been based upon information provided to the hospital by your doctor *prior to your admission*. Your doctor may need to vary your treatment from that anticipated prior to admission to ensure the best outcome for you. If your treatment does vary from that anticipated, there will likely be additional fees (including hospital fees) that you are required to pay;
- There may be specific limitations or exclusions in your health insurance policy that are not currently known to us, and therefore these are not taken into account as part of our estimate;
- While we take great care in preparation of the estimate, on occasion our estimate for particular items may differ from the final amount charged for that item; and
- There may be incidental expenses that you incur that are not possible to anticipate in this estimate.

The hospital is not bound by the estimate and reserves the right to recover the full hospital fees incurred over and above that contained in the Estimate of Hospital Fees.

It is a condition of your admission that you agree to meet the full amount of your hospital fees not covered by your health fund or other insurer. Payment for any of these additional costs not covered by an insurer is the responsibility of the patient and must be paid on or prior to discharge.

Out of pocket costs may include, but are not limited to:

- Excess or front end deductible under an insurance policy, which is the amount you are first required to pay before payments by your insurer
- Co-payments, which are the amount that you have agreed with your insurer to pay for every day that you spend in hospital
- Prosthetics - "Gaps" for Prosthetic Items – *if insured* or All Prosthetics - *if not insured or limitations*
- Medications – All medications supplied on discharge or not related to your admission
- High Cost, Non PBS Medications, including some drugs for treating cancer, and used in some emergencies, and Botox for example, may not be fully covered by your insurer.
- Allied Health Services- e.g. physiotherapy, occupational therapy, or complimentary therapies and services such as acupuncture
- Orthotic products such as splints and braces and specialised high cost surgical single use equipment used during surgery
- Additional procedures or surgery performed (*if not insured , cosmetic or limitations on your policy*)

**Veterans**

Adelaide Day Surgery will ensure prior approval is received for all White Card holders. Gold Card Veterans' Affairs patients do not require approval prior to admission.

If you require transport to or from hospital, you will need to contact the Department of Veterans' Affairs to make arrangements.

**Workers Compensation and third party patients**

All Worker's Compensation, public liability and third party patients require approval from their insurer prior to admission. If approval is not received, the patient is required to pay the estimated amount on or before the day of admission.

The telephone number for all accounts enquiries is (08) 8239 4900.

**Medical Certificates**

If you need a Medical or Carer's Certificate to cover the period of your stay, please indicate this on the patient questionnaire form on page 16.



## REQUEST FOR ADMISSION FORM To be completed by Doctor.

Please PRINT clearly  
PLEASE ADMIT

Mr, Ms Mrs, Miss, Master: ..... Date of Admission: .....  
Surname Given Names

Address: .....

Telephone: ..... Date of Birth: ...../...../..... Sex: .....  
Home Mobile

Admitting Doctor ..... Referring Doctor .....

### Clinical Details

Presenting Symptoms .....

Principle diagnosis i.e. the condition which best accounts for patients stay in hospital: .....

Other conditions present: (including dementia, known infectious conditions as per patient checklist)

Medications: .....

Known Allergies/Sensitivities: .....

### Operation

Proposed operation/treatment: .....

Anticipated CMBS Item Numbers: .....

Anaesthetist: ..... Anaesthetic: GA LAWS TAWS

Assistant: .....

Specific Pre-operative Instructions (including tests required): .....

Specific surgical equipment requirements i.e. loan sets/prosthesis/implants: .....

Specify who is responsible for ordering the above: **Rooms or ADS**  
(Please circle)

### Specific Orders On Admission:

Please list specific instructions you require i.e.: **Medications/ E.C.G etc**

### Admitting Doctor's Details

Name: ..... Signature: .....

PLEASE TURN OVER

## Additional Patient Information

Does the patient require the services of an Interpreter? Yes ☐ No ☐

Has this service been arranged / booked? Yes ☐ No ☐

If Yes, Please indicate time period the interpreter is booked for \_\_\_\_\_

Does the patient weigh more than 120 Kg? Yes ☐ No ☐

Does the patient require assistance with mobility (wheelchair, weight bearing)? Yes ☐ No ☐

If Yes, Please specify \_\_\_\_\_

**Is Ambulance transport to or from the facility required?** Yes ☐ No ☐

If Yes, Please arrange the Transfer and notify ADS of booking arrangements.

Is the patient under a Guardianship or Medical Power of Attorney Order? Yes ☐ No ☐

If Yes, Please arrange for evidence of Guardianship to be forwarded to ADS (copy of papers)

## CONSENT FOR MEDICAL PROCEDURE / TREATMENT FOR ADULTS AND CHILDREN INFORMATION TO BE PROVIDED BY DOCTOR TO PATIENT (PART A)

I, Dr ..... have informed.....  
(Name of Medical Practitioner) (Name of patient/guardian)

about the recommended procedure or treatment detailed by me below, including the nature, likely results and material risks.

.....  
.....  
(Name of Procedure/Treatment)

.....  
(Signature of Medical Practitioner) (Date)  
\*If Interpreter present .....  
(Name of Interpreter) (Signature of Interpreter) (Date)

(\*Delete where applicable)

## TO BE COMPLETED BY PATIENT OR GUARDIAN (PART B)

I ..... and  
(Name of patient or guardian)  
Dr ..... have discussed \*my/my child's ..... 's  
(Name of Medical Practitioner) (Name of Child)  
present condition and the various ways in which it may be treated. The Doctor has recommended the procedure/treatment detailed above.

The doctor has advised me that:

- The procedure/treatment carries some risks and that complications may occur;
- An anaesthetic, medicines or blood transfusion may be needed and these may have some risks;
- Additional procedures or treatment may be needed if the Doctor finds something unexpected and I consent to this if in the Doctors opinion this requires immediate management;
- The procedure/treatment may not give the expected results even though the procedure/treatment is carried out with due professional care

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks and I accept these risks.

I understand that it will be necessary to provide a sample of blood for appropriate testing of communicable diseases including HIV and Hepatitis, should contamination of any staff member, doctor, technologist or other person or myself occur during my hospital stay.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

<p style="text-align: center;"><b>DELETE IF NOT REQUIRED</b></p> <p>While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure or treatment:</p> <p>..... (Insert objection (e.g. blood transfusion))</p> <p>..... (Practitioner's acknowledgement)</p>	<p>For children: I note that the Children's Protection Act 1993 provides that such treatment may be provided if it is necessary to prevent death or serious injury to my child, even if I object.</p>
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## PATIENT COMPLIANCE STATEMENT

1. I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify that I will have nothing to eat or drink as instructed.
2. I certify that I have a responsible adult to accompany me home and stay with me for the first 24hrs.
3. I understand the importance of the following instructions regarding my post-operative care and agree to follow these instructions.
4. I am aware of the danger to myself/others and will not undertake to drive a motor vehicle for 24hrs following my anaesthetic.

I request and consent to the procedure/treatment described above for \*me/my child. I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

.....  
(Signature of \* patient / parent / guardian) (Name of \*patient / parent / guardian) (Date)  
.....  
(Address)

(\*Delete where applicable)



## PRE ADMISSION FORM - To be completed by patient

Please **PRINT** clearly. Your responses are valuable in planning your admission and caring for you during your stay

Admitting doctor .....

Date of admission..... Time to be admitted.....

### Personal Details

Title: ..... Surname ..... Previous Surname (If Applicable) .....

Given names.....Preferred Name: .....

Address..... Suburb..... State.....

Postcode..... Telephone: home ..... Work..... Mobile .....

Email address .....

Sex: ☐ Male ☐ Female Date of Birth: ...../...../..... Age: .....

Marital Status: ☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

Occupation..... Religion.....

Are you an Australian Resident? ☐ Yes ☐ No Country of birth.....

Are you of Aboriginal/Torres Strait Islander (TSI) descent? ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal and TSI

### Person Responsible for Account

Is the Patient responsible for this account? ☐ No (Complete this section) ☐ Yes (Go to next section)

Name: ..... Relationship to Patient: .....

Address: ..... Suburb ..... State.....

Postcode..... Telephone: home ..... Work..... Mobile .....

Email address: .....

### Person to Contact Whilst in Hospital

Name: ..... Relationship to Patient: .....

Address: ..... Suburb ..... State.....

Postcode..... Telephone: home ..... Work..... Mobile .....

Second Contact/Power of Attorney..... Telephone .....

### Entitlements

Medicare Card Number 

--	--	--	--	--	--	--	--	--	--

 Medicare Expiry Date .....

Pension/Health Care Card Number: 

--	--	--	--	--	--	--	--	--	--

 Expiry Date: .....

Safety Net Number 

--	--	--	--	--	--	--	--	--	--

Repatriation Number 

--	--	--	--	--	--	--	--	--	--

 Card Colour ☐ White ☐ Gold

### Previous Hospitalisation

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year .....

Is this admission for a child? ☐ No ☐ Yes

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes- Which Hospital? ..... Dates? .....

## How will you claim for this Admission? (please tick ✓ one box only)

- ☐ Private Health Insurance – Please complete Sections A and C    ☐ Repat/Veterans' Affairs – Please complete Entitlements and Section C  
☐ Workcover/Third Party – Please complete Sections B and C    ☐ Uninsured – Please complete Section C only

## Section A: Private Health Insurance

Fund Name: ..... Membership No: ..... Date Joined: ...../...../.....

Has this level of cover changed in the last 12 Months? ☐ No ☐ Yes

Type of Cover: ☐ Single ☐ Family ☐ Other Level of Cover (if known) .....

Do you have an excess? ☐ No ☐ Yes Amount \$ ..... Have you paid an excess this year? ☐ No ☐ Yes Amount \$ .....

Date aware of present symptoms/condition: .....

## Section B: Workcover or Third Party

☐ Workcover or ☐ Third Party (Please tick one box)

\*The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company: .....

Address Street: .....

Suburb: ..... State: ..... Postcode: .....

Telephone: ..... Claim No: ..... Authorised by: .....

Has your insurance company accepted liability? ☐ Yes ☐ No Please specify reason (if no) .....

Workcover Patients Only – Employer Details: Name of Employer: .....

Address Street: .....

Suburb: ..... State: ..... Postcode: .....

Telephone: ..... Date of Accident ...../...../.....

Has your employer completed a Report of Injury Form? ☐ Yes ☐ No Have you completed a Workcover Claim Form? ☐ Yes ☐ No

## Section C: Payment of Account – all patients to complete

By signing this form I acknowledge that:

- I certify that the information contained on this form is true and correct to the best of my knowledge.
- **I understand that Adelaide Day Surgery will not accept any responsibility for loss or damage to patients' valuables.**
- I have read and understood the information, and accept the conditions, set out in this form, and have no further questions.
- I have been advised of the estimates for hospital fees listed above.
- I understand the costs are estimates only and subject to change as a result of variations in the actual treatment received.
- I understand that other service providers may be involved in my care and this estimate does not include those fees.
- I acknowledge that it is my ultimate responsibility to confirm with my health insurer the level of cover held.
- I accept responsibility for full payment of all amounts for hospital fees and charges not funded by my insurer, and will finalise payment prior to or at discharge.
- I have agreed to the collection of an imprint of my credit card and authorise the debit of my credit card as described in the credit card policy detailed on this form.

Signature: ..... Date: .....  
(Signature of \* patient / parent / guardian)

## PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

CONSENT: I provide my consent for health professionals of Adelaide Day Surgery to collect, use and disclose my personal information as outlined above and in accordance with the Commonwealth Privacy Act 1988 (December 2001).

Signature: ..... (Signature of \* patient / parent / guardian) ..... (Name of \*patient / parent / guardian) ..... (Date)

**CREDIT CARD PAYMENT** - We accept credit card payment in order to assist in the processing of any fees incurred during your stay.

Card Holder's Name: ..... Please debit my: ☐ Visa ☐ Mastercard

Card No \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Expiry Date : ..... / .....      CCV \_\_\_\_

Card Holder's Signature: .....

PATIENT NAME

.....

# PATIENT HISTORY FORM

To be completed by Patient or Doctor

Please PRINT clearly

We depend on you to provide accurate health screening information to assist with planning for your admission and caring for you during your stay

Anaesthetics	Have you had an anaesthetic before?		Yes	No	
	Have you, or any blood relatives, had problems with anaesthetics in the past?		Yes	No	
What is your Weight:	kilos		Height:		cm
Cardiac	Have you ever had a heart attack?		Yes	No	Year?
	Have you ever had heart surgery?		Yes	No	Year?
	Do you have a pacemaker/internal defibrillator?		Yes	No	Make:                      Model: Last Checked   /   /
	Do you have a prosthetic heart valve?		Yes	No	
	Do you have cardiac stents?		Yes	No	Type: Bare Metal or Drug Eluting?      Date Implanted   /   /
	Do you have angina?		Yes	No	
	Do you use:	Glycerol Trinitrate Patches?	Yes	No	
		Sublingual Spray?	Yes	No	Please bring spray with you
	Do you have any other heart problems?		Yes	No	If Yes, please specify:
		Palpitations?	Yes	No	
		Irregular heart beat?	Yes	No	
		Rheumatic fever?	Yes	No	
	Tendency to bleed, clot or bruise easily?		Yes	No	
	Have you ever had high blood pressure?		Yes	No	
Respiratory	Do you Smoke?		Yes	No	Daily amount or date ceased   /   /
	Do you have:	Asthma, Bronchitis, Hay fever?	Yes	No	
		Emphysema?	Yes	No	
		Sleep Apnoea?	Yes	No	
	Do you use a nebuliser, puffer or EPAP/CPAP machine, home oxygen?		Yes	No	If yes, please specify: Please bring puffers with you
	Have you ever had throat, nose or lung surgery?		Yes	No	
	Have you ever tested Positive to Tuberculosis? (TB)		Yes	No	
Diabetes	Do you have diabetes?		Yes	No	
	If <b>Yes</b> , Type I <input type="checkbox"/> Type II <input type="checkbox"/> Unsure <input type="checkbox"/>				Controlled by: Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin <input type="checkbox"/>
	If you take insulin have you spoken with your GP or diabetes specialist about your surgery?		Yes	No	
	If <b>No</b> please call them for advice.				
Gastrointestinal	Have you ever suffered from reflux or heart burn?		Yes	No	
	Do you have hiatus hernia/ gastrointestinal ulcers?		Yes	No	
	<b>Do you have any special dietary requirements?</b>		Yes	No	
	Do you have a gastric band in place?		Yes	No	
	If Yes, is your admitting surgeon aware of this		Yes	No	
Skeletal/ Mobility	Do you have Back/Neck/Jaw problems?		Yes	No	
	Have you ever had Back/Neck/Jaw surgery?		Yes	No	
	Do you have arthritis?		Yes	No	
	Have you had joint replacement? E.g. Hip, Knee		Yes	No	
	Have you experienced fainting, dizziness or fallen in the last 12 months?		Yes	No	
	Do you use: Walking stick, Crutches, Walking frame?		Yes	No	
	Do you use a wheel chair?		Yes	No	
	Can you weight bear?		Yes	No	
	Level of assistance required to transfer from wheel chair?				

Prosthesis / Aids	Visual Impairment – glasses/contact lenses?	Yes	No	
	Hearing Aid or other hearing appliance?	Yes	No	
	Dentures/Caps/Crowns/loose teeth?	Yes	No	
	Artificial joints or limbs?	Yes	No	
	Metal Plates or pins?	Yes	No	
	Body Piercing?	Yes	No	
Other	Have you ever tested positive to Hepatitis A,B or C, HIV, TB, MRSA or VRE?	Yes	No	Please specify
	Do you have an Intellectual disability?	Yes	No	
	Do you have Alzheimer's/Dementia?	Yes	No	
	Female patients could you be pregnant?	Yes	No	Number of weeks:
	Do you drink alcohol?	Yes	No	Daily amount:
	Have you ever had a stroke?	Yes	No	Date: / / Residual Problems:
	Do suffer from migraines?	Yes	No	
	Have you had a recent cold, flu or unexplained temperature?	Yes	No	
	Do you have any other medical or surgical problems? E.g. Epilepsy, Liver, Kidney, Psychiatric.	Yes	No	Please List:
	Have you ever been diagnosed with Cancer?	Yes	No	
	If <b>Yes</b> , type of cancer? _____			
	Year diagnosed? _____			
	Do you require an interpreter?	Yes	No	Language spoken at home?
	Do you have someone to interpret for you?	Yes	No	Name of Person.
Medications	Please list any medications you take. (prescription, non-prescription including herbal/vitamins/recreational)			
	Do you take any blood thinning / arthritis medication? E.g. Warfarin, Plavix, Aspirin.	Yes	No	Name of Medication:
	Have you been instructed to cease this medication?	Yes	No	Date last taken / / or still taking Yes <input type="checkbox"/>
	If <b>No</b> please call your doctor for advice, as these medications may need to be stopped prior to admission.			
Allergies/ Sensitivities	Have you ever had a reaction to:			Specify details and Reaction
	Drugs?	Yes	No	
	Food?	Yes	No	
	Latex (rubber) ?e.g. rubber gloves, balloons	Yes	No	
	Other?	Yes	No	
Questions Relating to Crutzfeldt Jakob Disease (CJD)	Do you have a family history of 2 or more relatives with CJD or other unspecific progressive neurological disorder?	Yes	No	
	Have you ever received Growth Hormone between the years of 1960 - 1985?	Yes	No	
	Have you ever had Neurosurgery between the years 1972 - 1989?	Yes	No	
Discharge Planning	Name of an adult available to collect you at the time of discharge	Name:		
		Phone		
	Name of an adult who will care for you from your time of discharge:	Name:		
		Phone		
Certificate	Will you or your carer require a medical certificate?	Yes	No	

## HOSPITAL POLICIES

### NO LIFT POLICY

A “No Lift Policy” has been implemented at Adelaide Day Surgery to protect both patients and staff from injuries resulting from unsafe lifting practices and procedures. Please advise the hospital if you require any assistance with mobility.

### SMOKING

Please be advised that Adelaide Day Surgery is a smoke free environment. Smoking is not permitted in the Adelaide Day Surgery building or on its grounds.

### CREDIT CARD POLICY

1. As a condition of treatment we may require an “imprint” of your Credit Card. This imprint will be required on each occasion you receive treatment at the hospital. The imprint will be stored securely.
2. We will debit your Credit Card for all amounts in respect of your hospital fees that the hospital is not able to claim from your insurer, or outstanding amounts that are otherwise payable by you that have not been paid on discharge, as explained above. This includes those expenses not listed in the Estimate of Hospital Fees but which are incurred in the provision of your hospital admission or treatment.
3. We will not use the imprint for any purpose other than that set out in point 2 above.
4. Prior to using the imprint the hospital will issue you an invoice listing the total cost of your treatment, the portion we have successfully claimed from your insurer, and the remaining amount owed by you. We recommend that you keep the hospital invoice and check it against your credit card statement when it arrives.
5. By signing and providing the hospital with an imprint, you agree to and authorise the hospital to debit your Credit Card for all amounts in respect of your hospital fees as explained above that the hospital is not able to claim from your insurer, or outstanding amounts that are otherwise payable by you that have not been paid on discharge.
6. If there are no amounts owing the imprint of your Credit Card will be destroyed.

### MOBILE TELEPHONES

Do not use mobile telephones in patient areas. Please observe the signs asking you to turn off mobile telephones and other electronic communication items. Ask the staff where you can use your own mobile telephone.

### PATIENTS RIGHTS AND RESPONSIBILITIES

As a private patient you have the right to choose your own doctor, and decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to hospital. Even if you have private health insurance you can choose to be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital

#### Patient's Rights

- **Information about your treatment** - Your doctor should give you a clear explanation of your diagnosis, your treatment (and any associated risks), the associated cost, and other treatment options available. Except for in an emergency where it is not possible, they should obtain your consent prior to any treatment.
- **Informed Financial Consent** - Your doctor and other health service providers should provide you with information about the costs of your proposed treatment, including any likely out-of-pocket expenses, and obtain your agreement to the likely costs in writing before proceeding with the treatment.
- **Other medical opinions** - You can ask for referrals for other medical opinions (there may be additional costs associated with doing this that may not be covered by Medicare or your private health insurance).
- **Seek advice about costs** - As a patient with private health insurance, all your hospital treatment and medical bills may be covered by your insurance, or you may have to pay some out-of-pocket expenses (gaps). In some cases you may also have to pay an ‘excess’ or co-payment. Before you go to hospital, ask your private health insurer, doctor(s) and hospital about the expected costs of your treatment, including possible costs for surgically implanted medical devices and prostheses.

• **Confidentiality and access to your medical records** - Your personal details will be kept strictly confidential. However, there may be times when information about you needs to be provided to another health worker to assist in your care if this is required or authorised by law. You will need to sign a form to agree to your health insurer having access to certain information to allow payments to be made for your treatment. Under the Freedom of Information legislation you are entitled to see and obtain a copy of your medical records kept in a public hospital. Under the National Privacy Principles you also have a general right to access personal information collected about you by the private sector.

• **Treatment with respect and dignity** - While in hospital you can expect to be treated with courtesy and have your ethnic, cultural and religious practices and beliefs respected. You should also be polite to your health care workers and other patients and treat them with courtesy and respect.

• **Care and support from nurses and allied health professionals** - Nurses and allied health professionals provide vital care and support and are an important part of your treatment in hospital. Staff who attend you should always identify themselves and you should feel confident to discuss any issues in relation to your treatment or hospital experience with your health care workers.

• **Participate in decisions about your care** – Before you leave hospital you should be consulted about the continuing care that you may need after you leave hospital. This includes receiving information about any medical care, medication, home nursing or other community services you may need after you go home.

• **Comments or complaints** - If you are concerned about any aspect of your hospital treatment you should initially raise this with the staff caring for you or the hospital. If you are not satisfied with the way the hospital has dealt with your concerns, each State and Territory has an independent organisation that deals with complaints about health services and practitioners. If your query or complaint relates to private health insurance, you should first talk to your health insurer. If your concerns remain unresolved you can contact the Private Health Insurance Ombudsman on 1800 640 695 (free call).

• **Provide accurate information** - To help doctors/specialists and hospital staff provide you with appropriate care you will need to provide information such as family and medical history, allergies, physical or psychological conditions affecting you, and any other treatment you are receiving or medication you are taking (even if not prescribed by your doctor).

## **Patients' Responsibilities**

### **You have the responsibility to:**

- Find out about your condition and treatment, including the range of treatments that may be available to you
- Know your medical history including details of any medication you are taking
- Answer questions about your health frankly and honestly
- Discuss any problems you may feel may be affecting your health and medical condition
- Provide comprehensive and accurate health information to enable optimum care
- Cooperate fully with the doctor and clinical team in all aspects of your treatment
- Follow your treatment and inform your provider when you are not able to do so
- Keep appointments or let the provider know when you are unable to attend
- Pay the fees of the hospital and your attending doctor
- Consider the rights of other patients and staff members.

If you are aware of any particular condition that may cause undue harm to other patients or staff, this should be disclosed at time of admission.

When a health care worker becomes aware that a risk to public safety exists while managing a patient, they will be excused from breaching confidentiality when they disclose information about this risk in order to protect public safety.

## **Personal Information and privacy for patients**

Adelaide Day Surgery recognises and respects every patient's rights to privacy. We will collect and use the minimum amount of personal information needed for us to ensure you receive a high level of health care. Adelaide Day Surgery will always endeavour to manage your information to protect your privacy.

Adelaide Day Surgery may hold the following information about you:

- Your name, address, telephone number(s) and email contact details
- Date and country of birth
- Health Fund details
- Next of Kin
- Marital Status
- Occupation
- Health information
- The name and contact details of your General Practitioner and your Referring Doctor
- Returned Service Organisation
- Religious beliefs or affiliations (if provided)
- Transaction details associated with our services
- Indigenous status and language spoken at home (for the Department of Health)
- Additional information provided to us by you
- Any information you provided to us through patient surveys

### **What we do with personal Information**

1. We will collect it discreetly.
2. We will store it securely
3. We will only provide your personal information to people involved in your care.
4. We will provide relevant information to your Health Insurance Fund, or the Dept of Veterans' Affairs, Medicare, Cancer Council, SA Department of Health or to other entities when we are required to do so by law.
5. After removing details that could identify you, we may use personal information to assist with research and service improvement projects. We are also required to provide this information to government agencies.
6. We will destroy our record of your information when it has become too old to be useful or when we are no longer required by law to retain it.
7. We may use the information to contact you. By providing your mail address, we assume permission to use this address for administrative communications (receipts) regarding your hospital visit. We will not send your information via email.

### **Your rights**

1. You may give consent for us to use your personal information to provide you with health care services, or you may withdraw your consent at any time.

If you withdraw consent for Adelaide Day Surgery to use your personal information, this may reduce our ability to provide services to you.

2. You may ask us to limit access to your information. If you have a specific requirement for restricting access by someone to your information, please inform us about this as soon as possible.
3. You may ask us to give you (or another individual) access to personal information. In most cases we will allow you to have access to your personal information. We may charge a fee for providing printed copies of reports. We may not provide you (or your responsible person) with access to your personal information if a doctor feels that it may be harmful to do so.
4. You may ask us to correct any error in your personal information.
5. You may make a privacy-related complaint if you feel that Adelaide Day Surgery has not kept your information confidential or has not maintained your privacy – by telephoning the Director of Nursing (08) 8239 4900.

Or you can write to:  
The Director of Nursing  
Adelaide Day Surgery  
18 North Terrace  
Adelaide SA 5000

You may contact the Privacy Commissioner if you are not satisfied that the Hospital has resolved your complaint.

## Feedback

Adelaide Day Surgery recognises that patients may wish to express their opinion about the treatment and care they receive. Complaints are welcomed, received, investigated and resolved as this aids the day surgery in improvement in customer care.

Compliments from satisfied customers encourage ongoing high standards of care.

If you, your family, or your carer wish to comment about any aspects of care of treatment received, this can be done either verbally or in writing. Information on how to make a comment or complaint is on display in our waiting rooms and is also available from any member of our staff.

If you are not happy with any aspect of our service please direct your complaints and suggestions to our Facility Manager.

Director of Nursing  
Adelaide Day Surgery  
18 North Terrace  
ADELAIDE SA 5000

**Email:** [reception@adelaiddaysurgery.com](mailto:reception@adelaiddaysurgery.com)

**Phone:** (08) 8239 4900

**Fax:** (08) 8239 4910

You may also wish to contact the Health Quality & Complaints Commission if you do not believe that you have received the attention you deserve.

## Getting to Adelaide Day Surgery PARKING

A 15 minute drop off zone is available at the front of Adelaide Day Surgery and two “pay and display” car parks are located in Newmarket Street. See location map below.

## LOCATION

Adelaide Day Surgery is conveniently located in Adelaide’s city centre.

**18 North Tce**  
**ADELAIDE, SA 5000**

