

# Ipswich Day Hospital

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## OFFICE USE ONLY

MRN: \_\_\_\_\_

Admission Number: \_\_\_\_\_

In Diary Yes / No

**PLEASE COMPLETE THIS FORM AND FORWARD TO IPSWICH DAY HOSPITAL  
AT LEAST 10 WORKING DAYS BEFORE YOUR PROPOSED DATE OF ADMISSION**

**If there is insufficient time for us to receive this form by mail, please telephone Reception staff, fax or email.**

ADMISSION DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ ADMITTING DOCTOR: \_\_\_\_\_

Procedure: \_\_\_\_\_

\_\_\_\_\_ Type of Anaesthetic: \_\_\_\_\_

REFERRING GENERAL PRACTITIONER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ GP Telephone number: \_\_\_\_\_

Have you ever been a patient at Ipswich Day Hospital? ☐ Yes ☐ No

### Patient Details

TITLE: ☐ Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐ Dr ☐ Other

MARITAL STATUS: ☐ Married / Defacto ☐ Never Married / Single ☐ Divorced ☐ Separated ☐ Widowed

FIRST NAMES (in full): \_\_\_\_\_ SURNAME: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ PREVIOUS NAME/S: \_\_\_\_\_

D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: ☐ Male ☐ Female

HOME ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

MAILING ADDRESS: (if different from above)

SUBURB: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

TELEPHONE: H: \_\_\_\_\_ W: \_\_\_\_\_ M: \_\_\_\_\_

Email: \_\_\_\_\_ RELIGION: \_\_\_\_\_

COUNTRY OF BIRTH: \_\_\_\_\_ LANGUAGE SPOKEN: \_\_\_\_\_ INTERPRETER REQUIRED: ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander origin? ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & TSI ☐ No

OCCUPATION: ☐ Child ☐ Employed ☐ Home Duties ☐ Retired ☐ Student ☐ Not Employed

### Next of Kin / Person of notification

Title Name

Relationship to Patient

Address

Telephone

H:

W:

M:

\$

Fee Estimate – Doctor/Office Use Only

**Medicare, Private Health Fund, Veterans ' Affairs Details - complete all that apply**

<b>Medicare Number</b>	<input type="text"/>	<b>Ref Number</b> <small>Number before patient name</small>	<input type="text"/>	<b>Expiry date</b>	<input type="text"/>
<b>Pension Number</b>	<input type="text"/>			<b>Expiry date</b>	<input type="text"/>
<b>Pension Type</b>	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Unemployed <input type="checkbox"/> Repatriation <input type="checkbox"/> Health Care Card <input type="checkbox"/> Seniors				

Do you have private health insurance?   ☐ Yes - Please provide details below   ☐ No

<b>Private Health Fund Name</b>	<input type="text"/>	<b>Membership Number</b>	<input type="text"/>
<b>Type of cover</b>	<input type="text"/>	<b>Excess / Co-Payment</b>	<input type="text"/>
<b>Have you changed your level of cover in the last 12 months?</b>	<input type="checkbox"/> Yes - Please specify when: <input type="text"/>		<input type="checkbox"/> No

**Veterans' Affairs**

<b>Veterans' Affairs Number</b>	<input type="text"/>	<b>Card Colour</b>	<input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Other
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**Workers Compensation / Third Party**

<b>Claim Number</b>	<input type="text"/>	<b>Contact Name</b>	<input type="text"/>
		<b>Branch/Location</b>	<input type="text"/>

**Australian Defence Force**

<b>Service Number / EP ID</b>	<input type="text"/>	<b>DAN (if known)</b>	<input type="text"/>
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**Uninsured / Self Paying**

<b>Fee Estimate</b>	\$ <input type="text"/>	<b>Patient informed</b>	<input type="text"/>
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<b>Payment details</b>			
<b>Title</b>	<b>Name</b>		
<b>Relationship to Patient</b>			
<b>Address</b>			
<b>Telephone</b>			
<b>H:</b>	<b>W:</b>	<b>M:</b>	
I accept responsibility for the payment of this account <b>Payer's Signature:</b> <input type="text"/>			

<b>Office Use Only</b>		
<b>Cover</b>	<b>Excess \$</b>	<b>Waiting Period</b>
	<b>Co-payment \$</b>	<b>Financial      Y / N</b>
<b>Date Fund checked</b>	<b>Completed by</b>	<b>Amount to be paid \$</b>
<b>Date Paid</b>	<b>Cash / Chq / Credit Card / EFTPOS</b>	<b>Receipt Number</b>

**Discharge planning**   Please select YES or NO

	YES	NO	Provide details
Do you live alone?	<input type="text"/>	<input type="text"/>	
Are you a "carer" for another person?	<input type="text"/>	<input type="text"/>	
Do you currently receive community service?	<input type="text"/>	<input type="text"/>	
Do you require assistance with day to day living?	<input type="text"/>	<input type="text"/>	
Who have you arranged for your transport home?	<b>Name:</b> <input type="text"/>  <b>Telephone:</b> <input type="text"/>		



**Do you or have you ever suffered any of the following? Please select YES or NO**

	YES	NO	Provide details
Heart attack			When:
Stroke / TIA			When:
Angina / Chest Pain / Palpitations			
Atrial fibrillation			
Heart Surgery			When:
Diabetes			Type: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin
Do you bleed or bruise easily?			
Blood clots / DVT / PE			
High Blood Pressure			
Low Blood Pressure			
Tuberculosis			
Rheumatic Fever			
Liver Disease			
Asthma			
Bronchitis			
Recent cold or flu			
Sleep apnoea			
Emphysema			
Chronic Obstructive Pulmonary Disease (COPD)			
Anaemia			
Eczema / Dermatitis			
Epilepsy			
Alzheimer's / Dementia			
Depression / Anxiety			
Autism Spectrum Disorder			
Intellectual disability			
Reflux / Heartburn			
Arthritis			<input type="checkbox"/> Osteo <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Other
Cancer			Type:
Family history of cancer (eg. Breast, prostate)			Who: Type:
Hepatitis			<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other
Have you ever had any of these infections?			<input type="checkbox"/> HIV <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Clostridium difficile (C.diff)
Other medical conditions you have			

## Medications: Pharmaceutical and Complementary

Please list all medications you regularly take including prescription, non-prescription, vitamins or herbal (eg. Krill Oil, Echinacea, Olive Leaf). **Attaching a current printout from your GP is also acceptable.**

[illegible]

(PLEASE PLACE PATIENT LABEL HERE)

NAME:

D.O.B:

ADMISSION DATE:

	YES	NO	Provide details
Do you take any blood thinning / anti-inflammatory medication? (eg. Warfarin, Coumadin, Marevan, Aspirin, Plavix)			Name of medication:
Have you been instructed to cease this medication?			Date stopped or plan to stop:

**Previous Operations or Procedures**

Have you had any previous operations or procedures?

☐ Yes - Please list below

☐ No

Procedure	Year

Have you or a close relative had an adverse reaction to anaesthetic?

☐ Yes - Please list below

☐ No

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**Other information**

	YES	NO	Provide details
Do you have a current Advance Health Directive?			Please attach a copy if you would like it included with your medical record.

## Privacy Declaration

Ipswich Day Hospital is required to release personal and health information for Statistical Data purposes to your Health Fund, the State and Federal Governments. The collection, storage, usage and disclosure of this information are done in accordance with the Privacy Act 1988 and the Australian Privacy Principles. It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide treatment.

## Post Operative Care Responsibility

I shall be accompanied home by a responsible person who is over the age of 16, is physically and mentally capable of caring for me and will stay with me until the following morning.

I undertake not to drive a car, motorcycle, ride a bicycle or operate machinery for 24 hours after my anaesthetic.

I shall not drink alcohol for 24 hours before and after the anaesthetic.

I agree to follow the post operative instructions provided to me.

I agree not to make any important decisions or sign legal documents within 24 hours of the anaesthetic.

I understand that in the event of any post operative complications arising from my surgery or anaesthetic, I will contact my doctor or attend an Emergency Department.

I also acknowledge the hospital disclaims any and all liability for any injury and / or other damage that I may cause or sustain in the event that I should ignore, overlook or not accept the advice, cautions or warnings that have been given to me in these matters.

I have read and understood the above, **Privacy Declaration** and **Post Operative Care Responsibility** and have completed the **Patient Health Questionnaire** to the best of my knowledge. I understand that failure to make a full disclosure may place me and others at undue medical risk and I hereby agree to take responsibility for the accuracy of the information I have given.

Name: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# Consent for Treatment

## PART A – PROVISION OF INFORMATION TO THE PATIENT

To be completed by the TREATING IPSWICH DAY HOSPITAL ACCREDITED PRACTITIONER

I have informed ..... and / or  
PRINT NAME OF PATIENT

..... / .....  
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE)      RELATIONSHIP (MOTHER, FATHER, SPOUSE ETC)

of their present condition, alternative treatments if available and have explained the nature, purpose, likely results and the risks of the following recommended procedure(s).

Procedure / Treatment:

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

Signature of Medical Practitioner:

.....  
MEDICAL PRACTITIONER      DATE

### OPHTHALMIC SURGERY USE ONLY:

Ipswich Day Hospital pre-operative eye drop protocol for the above procedure

☐ Yes    ☐ No

## PART B – PATIENT CONSENT

To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure / treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to the procedure / treatment detailed above and have had the opportunity to ask questions;
- I understand the procedure / treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s) / treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of the procedure / treatment;
- I also consent to the taking of a blood sample for appropriate testing of communicable diseases should there be an injury to any person involved with my care;

I **request and consent** to the procedure / treatment described above.

.....  
PATIENT / PERSON RESPONSIBLE SIGNATURE      DATE

.....  
PRINT NAME OF PATIENT / PERSON RESPONSIBLE      IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT (MOTHER, FATHER, SPOUSE ETC)

Item numbers