

**YOU MUST RETURN THIS FORM TO
KAWANA PRIVATE HOSPITAL BEFORE
YOUR DAY OF SURGERY**

PRE-ADMISSION FORM -

**To be Completed by Patient,
Please Print Clearly**

Operation

Proposed operation/treatment

.....

.....

Your Doctor: Date of Admission Time to be admitted

Anaesthetist: Anaesthetic ☐ GA ☐ LA+Sed ☐ Topical+Sed

Assistant: ☐ Day Case ☐ Overnight? No of nights:

Referring Doctor:

Personal Details

Name: Title: Surname Given Names Preferred Name

Home Address:

Postal Address:

Telephone: H W M

Date of Birth: / / Sex: ☐ Male: ☐ Female Pension Card No:

ALLERGIES:

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

Language: Country of Birth

Family Doctor:

Person Responsible for Account

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

Name: Relationship to Patient:

Telephone: H W M

Person to Contact Whilst in Hospital

Name: Relationship to Patient:

Address Suburb

State Postcode Email address

Telephone: H W M

Second Contact/Power of Attorney Telephone

Person Collecting you from Hospital

Name Relationship

Telephone: H W M

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Entitlements

Medicare Card Number..... Ref. No Medicare Expiry Date

Pension/Health Care Card Number:..... Expiry Date:.....

Safety Net Number..... Repatriation Number (DVA):

Card Colour ☐ White ☐ Gold ☐ Blue

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

- | | |
|--|--|
| <input type="checkbox"/> Private Health Insurance -
Please complete Sections A and C | <input type="checkbox"/> Workcover/Third Party
Please complete Sections B and C |
| <input type="checkbox"/> Repat/Veterans' Affairs - Please complete
Entitlements (above) and Section C | <input type="checkbox"/> 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

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PATIENT HISTORY FORM -

To be completed by Patient or Doctor. Please **PRINT** clearly and use additional space in Left hand column if required.

PROVIDE DETAILS

What is your weight?	Kilos				
What is your height?	CM				
Anaesthetics	Have you had an anaesthetic before?	Yes	No		
	Have you, or any blood relatives, had problems with anaesthetics in the past?	Yes	No		
Previous Operations					
Allergies/ Sensitivities	Have you ever had a reaction to:	Drugs?	Yes	No	
		Food?	Yes	No	
		Latex?	Yes	No	
		Other	Yes	No	
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?	Yes	No	
		Bronchitis?	Yes	No	
		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			

PATIENT HISTORY FORM MR-09

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				PROVIDE DETAILS
Diabetes	Do you have diabetes?	Yes	No	
	If yes , <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Unsure	Yes	No	Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin
	If you take insulin has your Doctor given you instructions regarding your Diabetic Medication?	Yes	No	
	If No 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	
	Do you have any special dietary requirements?	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 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	
	Do you have problems weight bearing?	Yes	No	
	How many people need to help you transfer from your Wheelchair?			
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	

Do you have an advanced Health Directive? ☐ Yes ☐ No (please provide a copy to Kawana Private Hospital)

Are you under a Guardianship or a Medical Power of Attorney Order? ☐ Yes ☐ No (please provide a copy to Kawana Private Hospital)

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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 you 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 Yes , type of cancer?	Yes	No	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 (A print out from your GP is sufficient)	Please list any medications you take (prescription, non-prescription including herbal - Krill Oil, Echinacea, Olive Leaf / vitamins/ recreational):			
			
			
			
			
	Do you take any blood thinning/arthritis medication? eg. Warfarin, Plavix, Aspirin?	Yes	No	Name of Medication:
	Have you been instructed to cease this medication?	Yes	No	Date last taken:/...../..... Or Still taking:
	If NO please call your doctor for advice, as these medications may need to be stopped prior to admission			

If your admission to hospital is the result of an injury please answer the following questions.

What is your injury?

How did this injury happen?

Where did this accident occur?

What were you doing at the time of this injury?

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				PROVIDE DETAILS
Questions Relating to Crutzfeldt Jakob Disease (CJD)	Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorders?	Yes	No	
	Have you ever received Growth Hormone between the years of 1960-1985?	Yes	No	
	Have you ever had Neurosurgery between the year 1972-1989?	Yes	No	
Discharge Planning	Name of an adult available to collect you at the time of discharge	Yes	No	Name: Phone:
	Name of an adult who will care for you from your time of discharge	Yes	No	Name: Phone:

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 6 weeks prior to this admission? ☐ No ☐ Yes

Have you been an inpatient for any length of time overseas in the last 12 months? ☐ No ☐ Yes

Which Overseas Hospital?..... Dates?.....

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 undertake not to drive a motor vehicle for 24hrs following my anaesthetic.
5. 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.

.....
(Signature of * patient / parent / guardian)

.....
(Name of *patient / parent / guardian)(Date)

.....
(Address)

EMPTY BOX FOR BARCODE STICKER

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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 Kawana Private Hospital 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 of * patient / parent / guardian)

.....
(Name of *patient / parent / guardian)(Date)

.....
(Address)

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 CONSENT TO COLLECT & DISCLOSE INFORMATION CONSENT: I provide my consent for health professionals of Kawana Private Hospital to collect, use and disclose my personal information as outlined on P.21 and in accordance with The Australian Privacy Principles (12 March 2014). A copy of our Comprehensive Collection Policy is available on request.

.....
(Signature of * patient / parent / guardian)

.....
(Name of *patient / parent / guardian)(Date)

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