

LIVERPOOL EYE SURGERY

"Excellence in eye surgery"

P: (02) 9734 7000 F: (02) 9734 7001

Ground Floor

1-7 Moore Street (Corner of Bigge Street)

Liverpool NSW 2170

E: reception@liverpooleyeyesurgery.com.au

www.liverpooleyeyesurgery.com.au

PARKING – 15 minute parking available for patient pick up/drop off in our basement. Access from Warren Serviceway. First garage on the left. Press intercom to open the roller door and come up in the lift to the ground floor. Longer term parking available in council carpark.

TRAIN / BUS – Liverpool Train Station is on Bigge Street, and only two minutes walking distance.



.....
PATIENT'S NAME

DATE OF SURGERY

PREPARING FOR YOUR PROCEDURE

We will contact you 1-2 days before your procedure to give you an arrival time, take you through all the preparations required and answer any questions you may have.

DO NOT eat, drink (including water) or smoke anything for at least six hours before your procedure. If you are diabetic, you will need special instructions from your doctor before fasting.

- Wear loose, clean clothes
- Do not wear make-up or jewellery
- Leave your valuables at home
- **For your own safety you must arrange for a responsible adult or carer to pick you up after your surgery and to stay with you overnight**
- Please ensure that you bring with you:
 - ☐ This original form (completed and signed)
 - ☐ Your Medicare card
 - ☐ All your medications in original packaging

WHAT TO EXPECT DURING YOUR STAY

- On arrival, you will be greeted by the reception staff and have your paperwork completed.
- A nurse will then take you into an admission room to go through your medical history, answer any questions you may have and check your pulse, blood pressure and temperature. You will then be asked to wear a gown over your clothes and escorted to the patient lounge area.
- Before your procedure, you will be assessed by your anaesthetist. You will also have an opportunity to ask any questions you may have about the anaesthetic process.
- Following your procedure, you will spend a short time in the recovery area and offered light refreshments. Please indicate your preference for refreshments:

<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Hot chocolate
<input type="checkbox"/> Apple Juice	<input type="checkbox"/> Orange Juice	<input type="checkbox"/> Water
<input type="checkbox"/> Sweet snack	<input type="checkbox"/> Savoury snack	
<input type="checkbox"/> Dietary restrictions, details:		
- Once your recovery is complete, you will be discharged into the care of the responsible adult taking you home. The nursing staff will call your carer by phone and let them know when you will be ready to be picked up.
- You will be provided with written instructions by the nursing staff, and both you and your carer will be able to discuss any questions you may have directly with the nursing staff before going home.
- Your whole stay is expected to take around 3-5 hours, however, this is only an estimate and may vary.

INTERPRETER SERVICES

If you have difficulty speaking or understanding English, you will need to have a relative who can speak English available on the day of surgery at all times throughout your stay. If this is not possible, then you will be required to arrange for your own professional interpreting services before the day of your surgery.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY, AND SIGN

- I consent to the collection of my personal information from various sources for the primary purpose of my medical management, and for it to be only disclosed to third parties as part of mandatory reporting requirements. A copy of Liverpool Eye Surgery's *Privacy Policy* is available upon request.
 - I understand that as a patient of Liverpool Eye Surgery I have the right to feel welcomed, comfortable and fully informed throughout my stay and be treated with the highest standards of clinical care. I also accept that as a patient I have important responsibilities including providing complete and accurate information to all questions asked of me on this form and throughout my stay. A copy of the *Australian Charter of Healthcare Rights* is available on display at the day surgery.
 - **Following my procedure, I will have a responsible adult take me home and be available to care for me overnight.**
 - I understand that I am not to drive a motor vehicle, operate dangerous equipment, or sign legal documents for 24-hours after my procedure.
 - **Financial consent:** I acknowledge that I have been provided with an estimate of your out-of-pocket costs based on the known information about the procedure you are having. Payment will be required before your procedure. All forms of payment are accepted, except for personal cheques.
- Please note that in the event of unforeseen variations with the actual procedure performed and/or the level of coverage with your health insurance fund, the actual costs may vary.
- I fully understand and agree to all the above statements.

Signature of Patient/Guardian:

Print name:

Date:

Signature of Witness:

Print name:

If you have any questions or concerns please contact the day surgery on (02) 9734 7000.

YOUR SAY – We would be most grateful if you would take the time to complete the satisfaction survey provided to you on discharge and return it to us at your convenience. Should you be unhappy about any aspect of your care, please ask to speak with the Director of Nursing or Practice Manager at any time during your stay or afterwards. If you have an unresolved issue, you may contact the Health Care Complaints Commission on (02) 9219 7444, or write to Locked Mail Bag 18, Strawberry Hills NSW 2012.

COMPLETE PRIOR TO SURGERY

TO BE COMPLETED BY THE PATIENT'S GP (OR PATIENT) PRIOR TO SURGERY

You should make an appointment to see your GP at least 1-2 weeks before your scheduled procedure to complete the form below and discuss any questions or concerns that you may have.

GP's Name		GP's Address
GP's Phone Number		

Do you have OR have you ever had any of the following?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Any infections including MRSA or VRE | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> HIV, Hepatitis B or C | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or fits | <input type="checkbox"/> Heartburn, stomach problems |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Stroke or blackouts | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Fear of falling |
| <input type="checkbox"/> Pressure areas | <input type="checkbox"/> Had a fall in last 6 months | <input type="checkbox"/> Use a walking/mobility aid | <input type="checkbox"/> Open wounds/skin breaks |

Are you allergic to anything? (e.g. Medications, iodine, latex, food, etc):

☐ No ☐ Yes If Yes, provide details:

Have you or anyone in your family had any problems with an anaesthetic?

☐ No ☐ Yes If Yes, provide details:

Have you taken any aspirin (Cartia), anti-inflammatory or other blood thinner medications, including Warfarin, in the past 2 weeks?

☐ No ☐ Yes If Yes, provide details:

Do you have a pacemaker, defibrillator or replacement heart valve? ☐ No ☐ Yes If Yes, provide details:

Do you smoke? ☐ No ☐ Yes If Yes, how many each day:

Do you drink alcohol? ☐ No ☐ Yes If Yes, how many standard drinks each day:

Do you take recreational drugs? ☐ No ☐ Yes If Yes, provide details:

Are you or could you be pregnant? ☐ No ☐ Yes If Yes, provide details:

Have you been prescribed prednisone, cortisone or steroids in the past six months?

☐ No ☐ Yes If Yes, provide details:

Have you had a cold or flu in the past two weeks? ☐ No ☐ Yes If Yes, provide details:

Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990? ☐ No ☐ Yes

Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jacob Disease (CJD) or other prion disease? ☐ No ☐ Yes

Do you suffer from a recent progressive dementia illness (physical or mental), the cause of which has not been diagnosed? ☐ No ☐ Yes

Have you received human pituitary hormones for infertility or human growth hormone for short stature, prior to 1986? ☐ No ☐ Yes

Have you been involved in a "Look Back" study for CJD or are you in possession of a "Medical in Confidence Letter" regarding risk of CJD? ☐ No ☐ Yes

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (attach separate sheet if required):

Name of medication	Strength	Times daily	Name of medication	Strength	Times daily

LIST ALL PAST HEALTH PROBLEMS AND OPERATIONS, INCLUDING DATES (attach separate sheet if required):

Health problem or operation	Date	Health problem or operation	Date

Patient/Guardian's Signature		Date	
Patient/Guardian's Name		If Guardian, state relationship to patient (e.g. Parent)	