Ipswich Day Hospital

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Email: idhbookings@curagroup.com.au

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: _____

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

ADMISSION FORM MR2

(PLEASE PLACE PATIENT LABEL HERE)

NAME:

D.O.B:

ADMISSION DATE:

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

Medicare Number		**Ref Number** Number before patient name		**Expiry date**	
Pension Number				**Expiry date**	
Pension Type	☐ Age ☐ Disability ☐ Unemployed ☐ Repatriation ☐ Health Care Card ☐ Seniors				

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

Private Health Fund Name		**Membership Number**	
Type of cover		**Excess / Co-Payment**	
Have you changed your level of cover in the last 12 months?	☐ **Yes** - Please specify when: ☐ **No**		

Veterans' Affairs

Veterans' Affairs Number		**Card Colour**	☐ Gold ☐ White ☐ Other

Workers Compensation / Third Party

Claim Number		**Contact Name Branch/Location**	

Australian Defence Force

Service Number / EP ID		**DAN (if known)**	

Uninsured / Self Paying

Fee Estimate	$	**Patient informed**	

Payment details
Title **Name**
Relationship to Patient
Address
Telephone **H:** **W:** **M:**
I accept responsibility for the payment of this account **Payer's Signature:**

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

Discharge planning Please select YES or NO

	YES	NO	Provide details
Do you live alone?	☐	☐	
Are you a "carer" for another person?	☐	☐	
Do you currently receive community service?	☐	☐	
Do you require assistance with day to day living?	☐	☐	
Who have you arranged for your transport home?	**Name:** **Telephone:**		

Patient Health Questionnaire

(PLEASE PLACE PATIENT LABEL HERE)

NAME:

D.O.B:

ADMISSION DATE:

Current Height (cm)		*Patients weighing over 130kg cannot be admitted to Ipswich Day Hospital*	Hospital Use Only BMI =
Current Weight (kg) Note: Domestic scales may be limited to 120 kg			
Have you lost weight recently?	☐ **Yes** - Please specify how much:		☐ **No**

Lifestyle Please select YES or NO	**YES**	**NO**	**Provide details**
Do you currently smoke?	☐	☐	Daily amount:
Have you ever smoked?	☐	☐	Date ceased:
Do you use recreational drugs?	☐	☐	Type: Frequency:
Do you drink alcohol?	☐	☐	Amount:
Do you speak English at home?	☐	☐	Language:
Do you have any special dietary requirements?	☐	☐	Specify:

Prosthesis / Aids / Implants Please select YES or NO	**YES**	**NO**	**Provide details**
Visual impairment (eg. glasses, contact lenses)	☐	☐	
Hearing impairment (eg. hearing aid, other appliance)	☐	☐	
Implants / Joint prosthesis (eg. artificial joints, metal plates or pins, intra-ocular lens)	☐	☐	
Mobility aids (eg.wheelchair, walking frame or stick)	☐	☐	
Pacemaker / Cardiac implants / Defibrillator	☐	☐	
Other (eg. Gastric band)	☐	☐	

Patient History Please select YES or NO	**YES**	**NO**	**Provide details**
Have you had a fall in the past 12 months?	☐	☐	
Have you experienced fainting, dizziness?	☐	☐	
Do you have a family history of 2 or more relatives with Creutzfeldt Jakob Disease (CJD) or other unspecified progressive neurological disorder?	☐	☐	
Have you received a human pituitary hormone (growth hormone, gonadotrophin) between the years of 1960 - 1985?	☐	☐	
Have you had a dura mater graft prior to 1989?	☐	☐	
Have you travelled overseas recently?	☐	☐	Where:
If so, have you been back in Australia for 14 days or less?	☐	☐	
Do you have any signs and symptoms of an infection or fever?	☐	☐	

Allergies and Adverse Drug Reactions (ADR) eg. Medications, Tapes, Latex, Foods

Do you have any known allergies? ☐ **Yes** - Please list below ☐ **No**

Allergy/ADR	**Reaction**

(PLEASE PLACE PATIENT LABEL HERE)

NAME:

D.O.B:

ADMISSION DATE:

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.

Medication	Dosage

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: ☐ Type 1 ☐ Type 2 ☐ Unsure Controlled by: ☐ Diet ☐ Tablet ☐ 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 / PTSD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Intellectual disability	☐	☐	
Reflux / Heartburn	☐	☐	
Arthritis	☐	☐	☐ Osteo ☐ Rheumatoid ☐ Other
Cancer	☐	☐	Type:
Family history of cancer (eg. Breast, prostate)	☐	☐	Who: Type:
Hepatitis	☐	☐	☐ A ☐ B ☐ C ☐ Other
Have you ever had any of these infections?	☐	☐	☐ HIV ☐ MRSA ☐ VRE ☐ Clostridium difficile (C.diff)
Other medical conditions you have	☐	☐	

(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**

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: _____