Date ..... /..... /.....

Surname .....

Dr. .....

BDPC

BALLARAT DAY PROCEDURE CENTRE

Ophthalmology Admission Form

Doctors Instructions

Please complete the information on page 5 & 6

Give admission form to the patient for delivery to the Ballarat Day Procedure Centre

Patient Instructions

Please complete the information on pages 1,2, 3, and 4.

Deliver this form to Ballarat Day Procedure Centre once completed prior to admission or on day of procedure.

The pre admission nurse will contact you the business day prior to your procedure.

If you have any questions or problems relating to your admission please contact the Ballarat Day Procedure Centre as soon as possible.

1119 - 1123 Howitt Street, Ballarat VIC 3350

Ph 03 5338 2666 Fax 03 5339 5511

Postal Address:

PO BOX 262 WENDOUREE VIC 3355

www.bdpc.com.au

OFFICE USE ONLY

MRN: .....

OUT OF POCKET COST: $ .....

PATIENT LABEL

BOOKING FORM

PATIENT DETAILS

Procedure Date ...../...../..... Surgeon ..... Referring Dr: .....

Medicare Card Number ..... Ref No ..... Expiry Date ...../..... ☐ N/A

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mst ☐ Dr ☐ Other .....

Surname ..... Given Name/s .....

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

Residential Address .....

Suburb ..... Post Code .....

Postal Address (if different) .....

Suburb ..... Post Code .....

Tel. (H) ..... (W) ..... (M) .....

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ DeFacto

Occupation .....

Country of Birth ☐ Australia ☐ Other ..... Language used if other than English .....

Are you an Aboriginal or Torres Strait Islander? ☐ YES ☐ NO Religion .....

Do you have a My Health Record (previously PCEHR)? ☐ YES ☐ NO

Would you like to register with My Health Record? ☐ YES ☐ NO

PERSON RESPONSIBLE FOR YOUR COLLECTION

Surname ..... Given Name/s .....

Contact No.:..... Relationship to patient .....

NEXT OF KIN ☐ As Above

Surname ..... Given Name/s .....

Contact No.:..... Relationship to patient .....

PAYMENT DETAILS

Please tick appropriate box and complete details.

☐ **PRIVATE HEALTH INSURANCE**

Fund name ..... Member Number .....

☐ **WORKERS' COMPENSATION** ☐ **THIRD PARTY / T.A.C.** Claim Number.....

☐ **UNINSURED** Quoted amount $ .....

☐ **DVA** Card Number ..... ☐ Gold ☐ White

PATIENT LABEL

PATIENT CONSENTS

- Unless otherwise advised your pathology will be sent to your surgeons chosen provider which could incur addtional out of pocket costs.
- Did you receive a copy of the Australian Charter of Healthcare Rights? ☐ YES ☐ NO
- Do you have a better understanding of your healthcare rights after reading the brochure? ☐ YES ☐ NO
- BDPC welcomes feedback from its patients and their carers. Are you or your carer willing to participate in a review of our facitlity and its patient-related documents? ☐ YES ☐ NO

If yes, what is the best way to contact you? Tel .....

Email .....

PRIVACY INFORMATION ACCEPTANCE

- I hereby acknowledge that I have received and read a copy of the **Ballarat Day Procedure Centre Information Handling Procedures**
  - pg 8 of Information Booklet
  - CURA Privacy Collection Notice

  prior to my admission for treatment, as required by the Privacy Amendment (Enhancing Privacy Protection) Act 2012. ☐ YES ☐ NO

  If you have a My Health Record (previously called PCEHR), we will access this to assist in providing you with the best possible health care and unless you withdraw your consent at the time of your visit, we will upload our Discharge Summary to your My Health Record.

SURGICAL PATIENTS

- To ensure your safety in the immediate post-operative period, BDPC policy requires you to have a carer to:
  - Escort you from the facility after the procedure
  - Be in attendance for the first twenty-four hours post operatively

  BDPC reserves the right to refuse booked elective surgery to you if you are unable to comply with this requirement as it is an unacceptable risk to your safety.

  Are you able to comply with this safety requirement? ☐ YES ☐ NO

FINANCIAL DECLARATION by person responsible for payment of account

- I hereby acknowledge that I have received and read a copy of **Financial Information** (pg 5 of information booklet) and are liable for any treatment at the Ballarat Day Procedure Centre, irrespective of any claim I may have against any health fund or other third party.

Signature ..... Print name.....

Revision 5. November 2017

PATIENT LABEL

MEDICAL HISTORY

Please identify if you currently have or have had any of the following problems and provide relevant details in the section below.

			If yes, please specify
• Angina/Heart Attack/AMI	☐ YES	☐ NO	.....
• High Blood Pressure	☐ YES	☐ NO	.....
• Arrhythmia/Fibrillation	☐ YES	☐ NO	.....
• Heart Stents	☐ YES	☐ NO	.....
• Blood Clots in legs/lungs	☐ YES	☐ NO	.....
• Asthma	☐ YES	☐ NO	.....
• COAD/Emphysema	☐ YES	☐ NO	.....
• Sleep Apnoea	☐ YES	☐ NO	.....
• Stroke/TIA	☐ YES	☐ NO	.....
• Epilepsy/Seizures	☐ YES	☐ NO	.....
• Heartburn/Reflux	☐ YES	☐ NO	.....
• Liver Disease	☐ YES	☐ NO	.....
• Kidney Disease	☐ YES	☐ NO	.....
• Cancer/Malignancy	☐ YES	☐ NO	.....
• Prone to bleeding/bruising	☐ YES	☐ NO	.....
• Infectious diseases eg. Hep A, B, C, HIV, CRE, VRE	☐ YES	☐ NO	.....
• Tuberculosis	☐ YES	☐ NO	.....
• Malignant Hyperthermia	☐ YES	☐ NO	.....
• Creutzfeldt-Jakob Disease	☐ YES	☐ NO	.....
• Anxiety/Depression	☐ YES	☐ NO	.....
• Are you a diabetic?	☐ YES	☐ NO	☐ Type 1 ☐ Type 2 ☐ Diet ☐ Medication ☐ Insulin
• Do you smoke?	☐ YES	☐ NO	Cigarettes per day .....
• Have you ever smoked?	☐ YES	☐ NO	When did you stop? .....
• Do you consume more than 3 alcoholic drink per day?	☐ YES	☐ NO	If yes, how many .....
• Do you currently use recreational drugs on a regular basis?	☐ YES	☐ NO	
• Do you have any implanted devices eg. Pacemaker/defibrillator?	☐ YES	☐ NO	

Any further medical details .....

.....

PATIENT LABEL

SURGICAL HISTORY

☐ N/A

Please give details of past surgery

OPERATION	YEAR

MEDICATION INFORMATION

☐ N/A

Please list below any medications you are currently taking (include prescription and over the counter)

Alternatively please attach a copy of your current medications.

NAME OF MEDICATION	DOSE	WHEN TAKEN

ALLERGY INFORMATION

Do you have any allergies? ☐ YES ☐ NO

Medications:

....

....

....

Others:

....

....

ADVANCED CARE DIRECTIVES

☐ YES ☐ NO

Revision 5. November 2017

PATIENT LABEL

DILATING EYE DROP MEDICATION ORDERS

Date ..... /...../.....

Tick Operative Eye: ☐ RIGHT EYE ☐ LEFT EYE

Commence Eye Drops 1 hr pre op

Time:	.....	.....	.....	.....	.....	.....
Given By:						

VMO/Surgeons Signature: ..... Date..... /...../ .....

RN/EEN Signature :..... Date..... /...../ .....

PATIENT LABEL

CLINICAL DETAILS

TO BE COMPLETED BY ADMITTING DOCTOR

Provisional Diagnosis .....

Proposed Operation .....

Item Number ..... Estimated Time of Procedure .....

REQUEST FOR SURGICAL TREATMENT AND CONSENT TO PROCEDURE

REQUEST AND CONSENT

I,.....request and hereby consent to the following

procedure(s)# .....

being performed upon .....

The nature and effect of the above procedure(s) has been explained to me by

Dr.....

I also consent to such further procedures as may be found necessary to be performed during the course of the procedure(s) stated above and to transfer to an overnight stay facility should I require further post procedure treatment.

I specifically refuse to have any of the following treatments or procedures

.....

In conjunction with the above stated procedure(s), I consent to the administration of such anaesthetics as may be considered necessary or advisable by the anaesthetist.

I acknowledge that I have been advised that sedation and anaesthesia will interfere with my ability to drive a car, operate machinery and make complex decisions. I understand that these effects may last for 24 hours after my operation and that I should not undertake any of these tasks until after 24 hours has passed.

Signed ..... Relationship to patient .....

Date...../...../.....

CONFIRMATION

I,..... confirm that I have explained to the ***patient/person legally responsible for the patient,* the nature and effect of the above procedure(s). In my opinion he/she understood this explanation.

Signature of Doctor..... Date...../...../.....

Procedure includes operations and invasive procedures /+/- X-ray imaging

** Strike out where inapplicable