Affix patient label here

PATIENT TO COMPLETE and RETURN

Please RETURN to CHERMSIDE DAY HOSPITAL via FAX on (07) 3120 3443 or in the self-addressed envelope

Admission details

Office/practice staff to complete

Admission date: _____/_____/_____ Admission time: _____ Proceduralist Doctor: _____

Procedure: _____

Patient to complete

Admitting Specialist:_____ Address: _____

Doctor who referred you to specialist: _____

Have you previously been admitted to Chermside Day Hospital? ☐Yes ☐No

If YES, when? _____

Have you been admitted to another hospital in the past 7 days? ☐Yes ☐No

If YES, where/when? _____

Patient details

Title: _____ Surname: _____ Given: _____

Address: _____ Postcode:_____

Telephone: Home: _____ Work: _____ Mobile: _____

Date of birth: _____/_____/_____ Sex: ☐Male ☐Female

Health fund details

☐**Medicare No.** |___|___|___|___| |___|___|___|___|___| |___|Ref no. _____ Expiry date _____/_____/_____

☐DVA No. _____ ☐White card ☐Gold card Expiry date _____/_____/_____

☐Pension No. _____ Expiry date _____/_____/_____

☐Self Insured: _____

☐**Private Health fund:** _____ Membership No. _____

☐Contributor's name: _____ Joined less than 12 months ago? ☐Yes ☐No

○**Do you have a My Health Record (previously PCEHR)** ☐Yes ☐No

Next of kin

Next of kin: _____ Relationship: _____

Address: _____ Postcode:_____

Telephone: Home: _____ Work: _____ Mobile: _____

Emergency contact name: _____ Telephone: _____

Office use only:

Total no. of pages scanned: _____ Date: _____ Initial: _____ DRG:_____

Affix patient label here

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Queensland Health information

We are required to request that you answer the following five (5) questions for Queensland Health requirements.

1. Country of birth: _____

2. Indigenous origin: ☐ Australian Aboriginal ☐ Torres Strait Islander ☐ Not applicable

3. Marital status: ☐ Never Married ☐ Married ☐ Defacto ☐ Divorced ☐ Seperated ☐ Widowed

4. Occupation *(if retired, please indicate previous occupation)*: _____

5. Are you an overseas visitor to Australia? ☐ Yes ☐ No

6. Language spoken at home? ☐ English ☐ Other _____

Financial consent

I agree, that in the event my health fund does not pay for all or part of my hospital and procedural fee, I agree to cover costs associated with my surgery at the facility where I will have my procedure.

_____ _____ _____

Person responsible for account signature *Print Name* *Date*

Relationship to patient *(if not the patient)*: _____

Address: _____ Postcode:_____

Telephone: Home: _____ Work: _____ Mobile: _____

Consent for the collection and use of personal information

In providing you with the best possible health care we need to collect and use personal information. We must also comply with laws that require us to collect or disclose personal information about you. Other uses and disclosures of personal information are set out below. If you do not want us to use your personal information in one of these ways please tick the **NO** box next to that item.

Uses of personal information

1. To train and educate professional staff. ☐ Yes ☐ No
2. To assist in the development of service delivery and planning. ☐ Yes ☐ No
3. To inform next of kin identified in my admission form of the outcome of treatment. ☐ Yes ☐ No
4. To obtain consent to necessary treatment when I am not able to provide such consent. ☐ Yes ☐ No

Disclosures of personal information

5. To other medical practitioners, hospital, health service providers or medical prostheses suppliers to assist in any current or future treatments that relate to the condition you are currently being treated for. ☐ Yes ☐ No
6. To enable this Day Hospital facility to provide access to information to your health fund if requested by the health fund to do so. ☐ Yes ☐ No
7. To provide Queensland Cancer Registry (if applicable) with details of your procedure. ☐ Yes ☐ No

You are entitled to obtain access to the personal information we hold about you. If you request access to a visiting medical practitioner's notes please advise the facility in writing.

I have read and understand this form and, except where indicated, I consent to the collection, use and disclosure of my personal information for the purposes set out in it

_____ _____ _____

Patient's signature *Print Name* *Date*

Affix patient label here

PATIENT TO COMPLETE and RETURN

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QUESTIONS TO BE ANSWERED ON BOTH SIDES BEFORE ADMISSION					
Please circle the appropriate response ..... E.g.				Ⓝ	Y
PATIENT HISTORY:					
Heart Conditions	N	Y	Stroke	N	Y
Chest Pain	N	Y	Could you be pregnant	N	Y
Asthma	N	Y	Do you smoke – how many per day……	N	Y
Diabetes	N	Y	Do you drink alcohol	N	Y
High Blood Pressure	N	Y	History of blood clots	N	Y
Epilepsy/Faints	N	Y	Recreational drug use	N	Y
Any infections / illnesses we should be aware of? MRSA/VRE/CRE	N	Y	**Falls Risk Screening Questions:**		
Hepatitis A, B, C, HIV	N	Y	Have you ever fallen in the last 6 months	N	Y
Rheumatic Fever	N	Y	Do you fear falling over	N	Y
Bleeding Tendencies	N	Y	Do you have periods of dizziness	N	Y
Fragile skin/skin disorders	N	Y	Weight over 120kg	N	Y
Have you been exposed to anyone with a communicable disease in the last 2 weeks	N	Y	Travelled overseas in the last 4 - 6weeks or been in hospital in the last 12 months	N	Y
If yes, to any of the above please comment / actions					
Do you have any allergies – drugs, latex or food? If yes, please comment / actions / outcomes	N	Y			
Any problems with anaesthetics? If yes, please comment / actions / outcomes	N	Y			
Do you have any artificial joints, lens implants, contact lens, dental appliances (i.e. dentures)? If yes, please comment / actions / outcomes.....	N	Y			
Do you have a language barrier?	N	Y	Do you need an interpreter?	N	Y
MEDICATIONS:					
Have you recently taken blood thinning/arthritis medication (Aspirin based)?	N	Y	If yes, Name of medication: ..... Date last taken: ..... Or still taking: Yes ☐		
Have you taken any steroids or cortisone tablets/injections in the last 6 months?	N	Y	If yes, Name of medication: ..... Date last taken: ..... Or still taking: Yes ☐		
LIST MEDICATIONS / HOMEOPATHIC / DRUGS					
Have you had previous operations, please list dates and operation performed in the last 5 years Date: ……/……/……					

CREUTZFELDT-JAKOB DISEASE (CJD)

The reason we ask these questions is to ensure special procedures are put in place when you go to the operating theatre, to minimise the risk of infecting you or other patients. Thank you.

What is CJD? CJD is a rare, fatal brain disorder, which causes rapid, progressive dementia. It can take 2-40 years before onset of disease.

Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990?	N	Y
Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prion disease, where a genetic cause has not been excluded?	N	Y
Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been diagnosed?	N	Y
Have you received human pituitary hormones for infertility or human growth hormone for short stature, prior to 1986?	N	Y
Have you been involved in a "Look Back" study for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD?	N	Y

ACTIVITIES OF DAILY LIVING:

Are you independent in all personal care? **YES** ☐ **NO** ☐ (If NO, please specify where you require assistance)

☐ Bath/Shower ☐ Toileting ☐ Grooming ☐ Other .....

Are you independent in ambulation? **YES** ☐ **NO** ☐ (If NO, please specify where you require assistance)

.....

Jewellery/money:

I acknowledge that Chermside Day Hospital recommends that valuables are **NOT** brought to the Day Hospital. I understand that any valuables retained by myself whilst in the Day Surgery will remain my responsibility.

Please initial .....

I have received information on my Rights and Responsibilities, and how to register a Compliment or Complaint regarding my visit to the Day Surgery.

Patient's Name: (print)..... Signature: .....

ADDITIONAL INFORMATION: Is there any additional information you would like the Medical / Nursing Staff to know? ..

.....

ENDURING POWER OF ATTORNEY:

Do you have a current Advance Health Directive? ☐ **YES** ☐ **NO**

Do you have enduring power of attorney – health and medical guardian? ☐ **YES** ☐ **NO**

Name: .....Relationship: ..... Phone:.....

PARKING

I acknowledge that after my procedure I am unable to drive (excluding local anaesthetic procedures) and that the CDH precinct enforces a two (2) hour parking limit in which a fine may be incurred if parked for longer. I agree to abide by all ParkPay conditions of entry. **Please sign** ……

DISCHARGE PLAN: As a Day Patient you **must** have someone at home and to stay with you at least overnight but preferably for the next 24 hours after surgery.

Who will escort you home? Name: ..... Phone No:.....

Who will stay with you overnight? Name: ..... Phone No:.....

Relationship: .....

Does Your Carer require help to care for you? ☐ **YES** ☐ **NO** .....

Do you have any concerns about your recuperation after surgery?

☐ **YES** ☐ **NO** If yes, please state .....

Signature: .....

Nurse Use Only: (Admitting nurse to check & correct as required)

Comments / Actions / Outcomes .....

.....

.....

.....

Signature	Designation	Print	Initials	Date & Time (Hrs)