SEAFORD Day Surgery

ADMISSION PACK

Ph: 08 7282 8011 | **Fax:** 08 6477 3648 | 4 Vista Parade, Seaford Heights 5169
reception@seafordaysurgery.com.au | www.seafordaysurgery.com.au

Online Submissions: www.seafordaysurgery.com.au

PLEASE RETURN FORMS TO RECEPTION 1 WEEK PRIOR TO PROCEDURE

ADMISSION DATE: _____ ADMISSION TIME: _____

PROCEDURE: _____

Thank you for choosing Seaford Day Surgery for your procedure. Seaford Day Surgery is a day hospital purpose built to provide premier and safe same day surgery for patients. Seaford Day Surgery uses modern state of the art theatre equipment and technology for conducting your procedure.

Our highly skilled and professional staff are dedicated to caring for adults across a wide range of specialties. We assure you that throughout your stay at Seaford Day Surgery your personal dignity and privacy will be respected and your individual wishes will be considered at all times.

Seaford Day Surgery offers a wide range of surgery, and is easily accessible for clients in Southern areas of Adelaide. Seaford Day Surgery is conveniently located at 4 Vista Parade, Seaford Heights. Free onsite car parking is available.

This information booklet has been prepared to provide information that we hope will make you visit to us as comfortable as possible.

PLEASE READ AND KEEP FOR YOUR INFORMATION

BEFORE ADMISSION

The date and time of your admission is arranged with your doctor. You will be here for approximately 2-3 hours. Please note you may experience a pre-procedure wait which at times is unavoidable.

Please ensure that you have someone ready to collect you when we call. We cannot keep patients for an extended period.

Plan to have someone drive you to Seaford Day Surgery. It is likely that your concentration will be affected after the anaesthetic. As a result, if you have had a **sedation** you may drive after a good night's sleep if you are well rested. If you have had a **general anaesthetic** you may not drive for 24 hours. It is important to check this with your Surgeon as each procedure is different. The nursing staff will also advise you on your discharge.

It is vital that you have a responsible adult collect and accompany you home for the day of surgery. Please understand that cancellation of your procedure may result if you do not have these arrangements in place.

FASTING & ADMISSION

YOUR DOCTOR WILL ADVISE YOU WHEN TO COMMENCE FASTING. DO NOT eat or drink anything on the day of surgery after this time. Take your normal prescribed medications on the morning of your procedure with a sip of water (unless advised otherwise by your doctor). You may brush your teeth but DO NOT swallow any water. DO NOT chew gum on the day of your surgery. DO NOT smoke on the day of surgery.

WHAT YOU NEED TO BRING

- A list of medications you are on
- Please DO NOT BRING large sums of money, jewellery or other valuables, as we cannot accept responsibility for security
- Please remove all make up and nail polish
- Wear loose comfortable clothing

PRIVATE HEALTH FUND EXCESSES

If your health insurance requires an excess payment or if you are not sure, please ring your health fund prior to admission to clarify matters. Please contact our reception if you have any queries regarding your hospital fees.

ACCOUNTS

Self-insured patients, those who only have basic health insurance and those with a health fund excess are required to pay these fees on admission. Credit card and EFTPOS facilities are available. We do not accept personal cheques, American Express or Diners Club. There is NO rebate from Medicare for Day Surgery Charges.

If you have Health Insurance or WorkCover, we will forward your account directly to your Health Fund.

PARKING

Seaford Day Surgery has free onsite parking.

SAFETY AND QUALITY

Seaford Day Surgery is licensed by SA Health and fully accredited with the National Safety & Quality Health Service Standards.

Seaford Day Surgery uploads a discharge summary to My Health Record if you do not wish this to occur, please notify our reception staff on arrival.

Seaford Day Surgery has a comprehensive infection prevention and control program in place. Our facility and staff are regularly audited for compliance with National Infection Prevention And Control Guidelines, Australian Standards for reprocessing of reusable instruments and the Australian Commission on Safety & Quality in Healthcare (AQSQHS) National Safety & Quality Health Service Standards.

Please note that information is readily available in the waiting rooms regarding:

- The Australian Charter of Healthcare rights
- The Private Patients' Hospital Charter

PATIENT ADMISSION INFORMATION

Affix Patient Label Here

THESE FORMS ARE URGENTLY REQUIRED ONE WEEK PRIOR TO ADMISSION

PERSONAL DETAILS

Have you been a patient at any hospital in the past month? NO ☐ YES ☐, where? _____

SURNAME: _____ GIVEN NAMES: _____

BIRTH DATE: _____ TITLE: Mr ☐ Mrs ☐ Ms ☐ GENDER: Male ☐ Female ☐

ADDRESS: _____

SUBURB: _____ POST CODE: _____ STATE: _____

TELEPHONE: Home: _____ Mobile: _____

OCCUPATION: _____ COUNTRY OF BIRTH: _____

INDIGENOUS: Aboriginal ☐ TSI ☐ Aboriginal/TSI ☐ Other ☐ _____ *(Required by the Dept. of Health)*

MARITAL STATUS: Single ☐ Married/De-facto ☐ Widowed ☐ Divorced ☐ Separated ☐

CONTACT PERSON: _____ RELATIONSHIP: _____

ADDRESS: _____

TELEPHONE: Home: _____ Mobile: _____ Work: _____

MEDICARE NUMBER: __ __ __ __ __ __ __ __ __ __ __ Ref: __ (N° before name) Expiry Date: _____

PENSION CARD NUMBER: _____ Expiry Date: _____

VETERANS AFFAIRS NUMBER: _____ Colour Card: ☐ White ☐ Gold

How will you claim this Admission? Please select one option only

☐ **Private Health Insurance:** Complete section A & C ☐ **Repat/Veterans affairs:** Complete section C

☐ **Workcover/Third Party:** Complete Section B & C ☐ **Uninsured:** Complete section C only

SECTION A: PRIVATE HEALTH INSURANCE

Fund Name: _____ Membership No: _____

Do you have an excess or co-payment: ☐ YES ☐ NO Amount _____

If excess is applicable: Excess must be paid at time of admission.

SECTION B: WORKCOVER OR THIRD PARTY

Please select appropriate cover: ☐ WorkCover ☐ Third Party

**Please include the insurance company approval letter for this admission*

Insurance Company: _____ Date of Accident/Injury: _____

Claim Number: _____ Employer Details: _____

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SECTION C: PAYMENT OF ACCOUNT.
All patients to complete. Informed financial consent.

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 Seaford Day Surgery will not accept any responsibility for loss or damage to patient property.
- I have read and understood the information, and accept the conditions set out on this form, and have no further questions.
- I agree to sign a patient estimate of expenses form on admission.
- 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 at time of admission.

Have you been advised of any 'out-of-pocket' expenses by your admitting specialist? ☐ Yes ☐ No

If No it is recommended you talk to your Admitting Specialist/Anaesthetist PRIOR to your admission to obtain information of any out of pocket expenses that may apply.

Signature of patient/guardian: _____ Date: _____

PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

Seaford Day Surgery upholds your rights to privacy in accordance with all applicable privacy laws including the Australian Privacy Principles set out in the Federal Privacy Act 1988. Seaford Day Surgery's obligation to maintain the privacy of your health information applies to the collection, use and disclosure of your personal and health information.

CONSENT: I provide my consent for health professionals of Seaford Day Surgery to collect, use and disclose my personal information as outlined above and in accordance with the Commonwealth Privacy Act 1988 (Dec 2001).

Signature of patient/guardian: _____ Date: _____

Name of patient/guardian: _____

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CONSENT TO MEDICAL PROCEDURE AND/OR OPERATIVE TREATMENT AND ADMINISTRATION OF ANAESTHESIA

I, _____ hereby consent to the Operation of

_____

being performed on _____ the nature,

purpose and risks which have been explained to me by _____
(Medical Practitioner's name)

Risks discussed: ☐ Yes ☐ No _____

_____

I ALSO CONSENT TO:

- I am satisfied with and understand the information I have received.
- Such further or alternative measures as may be found to be necessary during the operation.
- I understand that an anaesthetic and medicines may be required, and these do have risks
- The transfusion of blood or blood products when medically indicated.
- I consent to any recording, photographs, or filming of care.
- I consent to the use of ultrasound technology where appropriate for my procedure.
- I understand that I may withdraw my consent at any time prior to the procedure/treatment.
- The taking of a blood sample for appropriate testing of communicable diseases including HIV and Hepatitis should contamination of any staff member, Doctor or myself occur during my hospital stay.

Signature: _____ Date: _____

Please indicate: ☐ *Patient* ☐ *Parent* ☐ *Legal Guardian*

I confirm that I have explained to the patient / parent / legal guardian the nature, purpose and risks of this operation, including information on the therapeutic devices/ drugs.

Signature: _____ Date: _____
(Medical Practitioner's name)

Special Requirements: e.g. Prosthesis, tests, medication, VTE Prophylaxis:

_____

_____

_____

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PATIENT QUESTIONNAIRE

Surgeon:_____

Date of booked procedure: _____

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We rely on you to provide Seaford Day Surgery with accurate health screening information. Please complete this form. Please ensure height and weight completed.

HEIGHT: _____ cm **WEIGHT:** _____ kg

		CIRCLE the correct response		If yes, please comment
Anaesthetics	Have you had an anaesthetic before?	YES	NO	
	Have you, or any blood relatives, had problems with anaesthetics in the past?	YES	NO	
Cardiac	Have you ever had a heart attack?	YES	NO	
	Have you ever had heart problems/surgery?	YES	NO	
	Do you have a pacemaker or defibrillator?	YES	NO	
	Do you have angina?	YES	NO	
	Do you use GTN spray or a patch? **Please bring spray with you.**	YES	NO	
	Have you ever had a clot in the legs or lungs?	YES	NO	
	High or low blood pressure?	YES	NO	
	Have you ever had a stroke/mini stroke?	YES	NO	
Respiratory	Do you smoke?	YES	NO	
	Have you ever been a smoker?	YES	NO	
	Do you have asthma, emphysema, sleep apnoea?	YES	NO	
	Do you use a nebuliser, puffer or home oxygen? **Please bring puffers with you.**	YES	NO	
Medications	Do you take any medications? **Please list all medication below or attach a list**	YES	NO	
	Do you take any medication to thin your blood? E.g. Warfarin, Plavix, Aspirin	YES	NO	
	Have you discussed this with your doctor?	YES	NO	

Medication	Dose & Frequency	Medication	Dose & Frequency

Allergies Sensitivities	Have you ever had a reaction to drugs, food, latex or other? **Please list or attach a list**	YES	NO	
Endocrine	Do you have diabetes? ☐ Type 1 ☐ Type II Controlled by: ☐ Diet ☐ Tablet ☐ Insulin	YES	NO	
	If you take insulin have you spoken with your GP or diabetes specialist about your surgery? If no, please call them for advice.	YES	NO	

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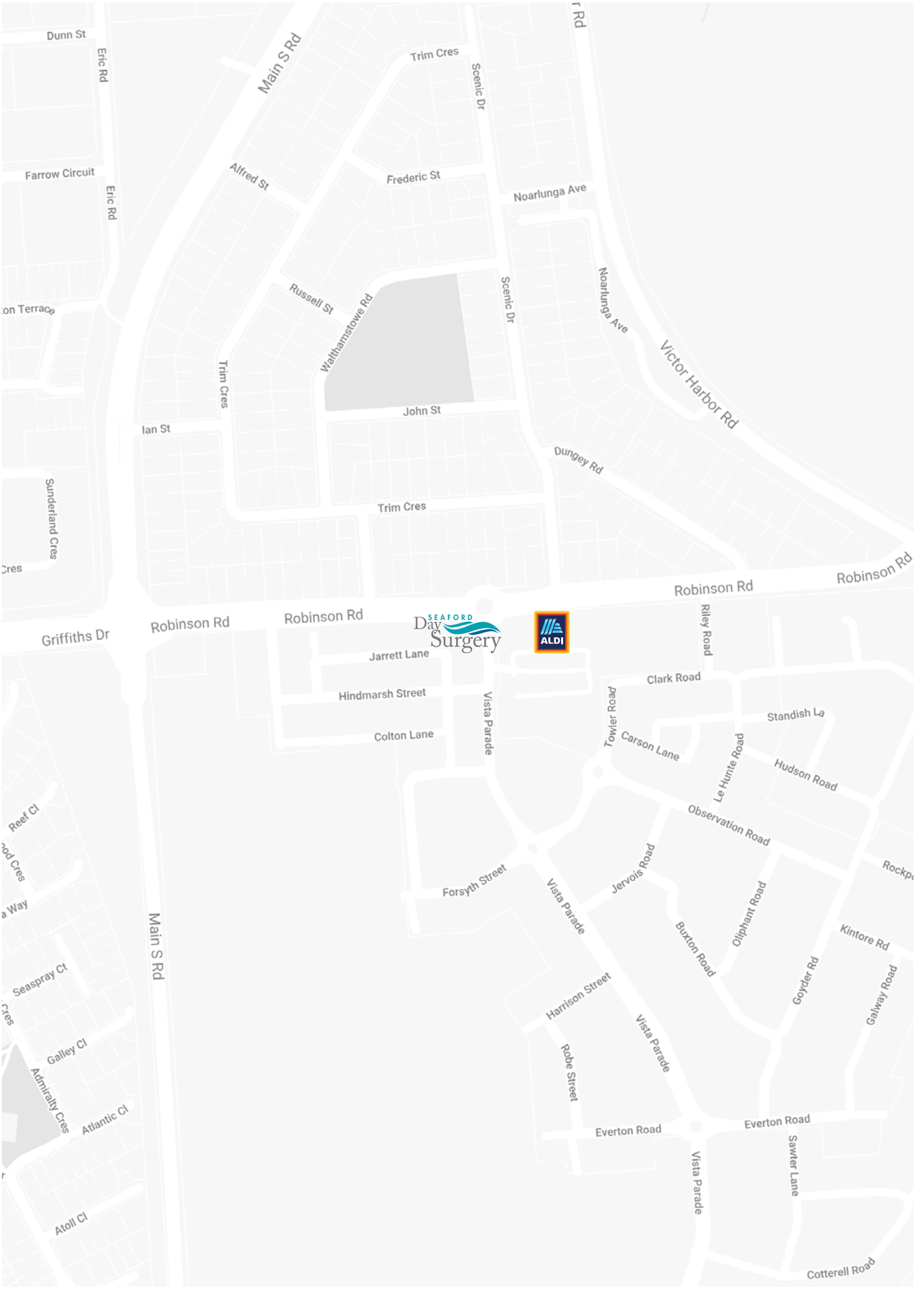
Gastrointestinal	Do you suffer from reflux/heartburn?	YES	NO	
	Do you have a gastric band?	YES	NO	
	Do you have any special dietary requirements?	YES	NO	
Skeletal	Do you have arthritis or osteoporosis?	YES	NO	
	Do you have back/neck/jaw problems?	YES	NO	
	Have you ever had back/neck/jaw surgery?	YES	NO	
	Have you had a joint replacement? E.g. hip, knee	YES	NO	
Mobility	Do you use any walking aids?	YES	NO	
	Do you need assistance to transfer?	YES	NO	
	Have you had a fall in the last 3 months?	YES	NO	
Other	Do you have an intellectual disability?	YES	NO	
	Do you have Alzheimer's/dementia?	YES	NO	
	Are you under a Guardianship or Medical Power of Attorney Order? If yes, please provide details.	YES	NO	
	Do you have an Advanced Care Directive?	YES	NO	
	Could you be pregnant?	YES	NO	
	Do you drink alcohol?	YES	NO	Glasses /day
	Do you currently have frail skin/ a wound?	YES	NO	
	Do you have any other medical/surgical history? E.g. Epilepsy/Liver/Kidney/Psychiatric _____	YES	NO	
	Have you ever been diagnosed with cancer? If yes, Primary site: _____ Year: _____	YES	NO	
	Do you know anyone in your family who had or has Creutzfeldt Jakob Disease?	YES	NO	
	Have you been involved in a CJD "look back" investigation?	YES	NO	
	Have you received growth hormone prior to 1986?	YES	NO	
	Have you had a brain or spinal cord surgery that included a dura mater graft prior to 1990?	YES	NO	
	Have you travelled overseas in the last 4-6 weeks?	YES	NO	Where: When:
	Have you had an overseas hospital stay in the last 12 months?	YES	NO	Where: When:
	Do you have a blood borne virus – E.g. HIV, Hepatitis B or Hepatitis C?	YES	NO	
	Have you ever been infected with a multi-resistant organism – E.g. MRSA/VRE/CPE?	YES	NO	
	Are you currently experiencing any type of infection or been exposed to a person suffering an infectious disease in the past 2 weeks? Explain in the box on the right to this question.	YES	NO	Explain:
Transport*	Name of an adult to collect you at discharge	Name:		
		Phone:		
Carer*	Name of an adult caring for you after discharge	Name:		
		Phone:		

***MANDATORY – Your procedure may be cancelled if you do not have arrangements in place.**

PATIENT COMPLIANCE STATEMENT

- I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify that I will have had nothing to eat or drink as instructed.
- I certify that I will have a responsible adult to accompany me home and stay overnight.
- I understand the importance of following instructions regarding my post-operative care and agree to follow these instructions.
- I am aware of the danger to myself/others and will not undertake to drive a motor vehicle as specified by my specialist following my anaesthetic.

Signature of patient: _____ Date: _____


Dunn St
Eric Rd
Main S Rd
Trim Cres
Scenic Dr
r Rd
Farrow Circuit
Eric Rd
Alfred St
Frederic St
Noarlunga Ave
Russell St
Walthamstowe Rd
Scenic Dr
Noarlunga Ave
Victor Harbor Rd
on Terrace
Trim Cres
John St
Ian St
Dungey Rd
Sunderland Cres
Trim Cres
Cres
Robinson Rd
Robinson Rd
Griffiths Dr
Robinson Rd
SEAFORD Day Surgery
ALDI
Riley Road
Jarrett Lane
Clark Road
Hindmarsh Street
Vista Parade
Towler Road
Standish La
Colton Lane
Carson Lane
Le Hunte Road
Hudson Road
Reef Cl
Observation Road
Forsyth Street
Vista Parade
Jervois Road
Olliphant Road
Rockp
Main S Rd
Buxton Road
Kintore Rd
Seaspray Ct
Harrison Street
Goyder Rd
Galway Road
Galley Cl
Vista Parade
Robe Street
Admiralty Cres
Atlantic Cl
Everton Road
Everton Road
Sawter Lane
Vista Parade
Atoll Cl
Cotterell Road

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