Patient Details / Consent Form

IMPORTANT!

Please complete BOTH SIDES of this form in the shaded areas and forward immediately to Southbank Day Surgery.

southbank day surgery

NM & IG Day Surgery Pty Ltd T/a Southbank Day Surgery
ABN 87 107 603 396

General Enquiries
8.00am – 5.00pm
Monday to Friday

38 Meadowvale Avenue
South Perth WA 6151

PO Box 662
South Perth WA 6951

Telephone: (08) 9368 7344
Facsimile: (08) 9368 7399
Email: bookings@southbankdaysurgery.com.au

Doctor's name

Operation date

Anaesthetist's name

Patient details

Mr / Mrs / Miss / Ms / Mast

Surname

First names

Preferred name

Residential address

Postcode

PO Box address

Postcode

Telephone (H) (M)

Email address

Age Sex Date of Birth

Country / State of Birth

Marital status Occupation

Weight Height BMI

*** EXCLUSION POLICY OF 120kgs APPLIES.**

Important

Have you had a procedure at Southbank Day Surgery before?
☐ Yes ☐ No

Have you been hospitalised or worked in a Health Care facility in the last 12 months? ☐ Yes ☐ No

If yes, which hospital?

*** It may be necessary for us to obtain Microbiology Test Results.**

Next of kin, friend or guardian

Name

Address

Postcode

Relationship to patient

Telephone (H) (W)

Name of person collecting patient

Name

Telephone (H) (Mobile)

Private Health Insurance details

☐ **Fund name**

Membership No.

Do you have Hospital Cover on this Policy? ☐ **Yes** ☐ **No**

Please check with your Health Fund that you are covered for Hospital Admission.

☐ **Not Privately Insured**

Payment of Accounts

Self insured patients and those with an excess or gap are required to pay the assessed account in full on admission.

☐ Medicare No.

Number on card

☐ **Workers Compensation** ☐ **MVIT**

Insurance Company

Claim No.

Email address

Telephone Number

FOR HOSPITAL USE

☐ Online check ☐ Excess / co payment $........................

☐ Qualified ☐ Quoted price $........................

☐ Financial

Name of contact

Method of contact:

☐ Telephone ☐ Email ☐ SMS ☐ Message left

Date Time

Staff member

Please turn over: Complete BOTH SIDES of this form

HR100

Patient details / Consent

General Health questions

IMPORTANT! **PLEASE ANSWERS ALL THESE QUESTIONS to help medical staff assess your fitness for anaesthesia, surgery or procedure.**

	Yes	No
Have you had any unusual reaction to an anaesthetic?	☐	☐
Please specify ______		
Has a relative had any unusual reaction to an anaesthetic?	☐	☐
Please specify ______		
Family history of Malignant Hyperthermia ______	☐	☐
Please specify ______		
ALLERGIES: Drugs: ______	☐	☐
Foods: ______	☐	☐
Others: ______	☐	☐
Asthma / Bronchitis / TB / recent Cold ______	☐	☐
Back / Neck problem ______	☐	☐
Diabetes ______	☐	☐
Bleeding disorder ______	☐	☐
Anaemia ______	☐	☐
Angina / Chest pain ______	☐	☐
Heart Attack / Cardiac history ______	☐	☐
Stroke ______	☐	☐
Rheumatic Fever ______	☐	☐
Epilepsy / Fits ______	☐	☐
Blood Clots: Legs or Lungs ______	☐	☐
Kidney disorder ______	☐	☐
An infectious disease or risk of exposure to an Infectious Disease (ie. Hepatitis B or C, HIV) ______	☐	☐

	Yes	No
Family history of CJD ______	☐	☐
History of receiving pituitary growth hormone ______	☐	☐
History of receiving dura mata graft ______	☐	☐
Previous Surgery / Procedure ______	☐	☐
Please specify ______		
Any Disabilities / Mobility problems ______	☐	☐
Please specify requirements ______		
______		
Interpreter Services required? ______	☐	☐
Are you:	**Yes**	**No**
A Smoker: Currently / Previous ______	☐	☐
Pregnant ______	☐	☐
Being treated for any Medical Condition ______	☐	☐
Please specify ______		
Taking any other regular Medication ______	☐	☐
Please specify ______		
Taking any Herbal Remedies ______	☐	☐
Please specify ______		
Taking Blood Thinning Medication ______	☐	☐
(ie. Aspirin / Warfarin). When ceased ______		

If you are taking any regular medication, please bring them with you on the day of admission.

Consent to Operative Treatment and administration of Anaesthetic or Procedure

Before giving your consent for the procedure, make sure you have received as much information as you require to make this decision.

I, (full name) ______ **, hereby**

consent to the specified Operation(s) / Procedure ______

being performed upon (Given Name) ______ **(Surname)** ______

The nature and effect of the above Operation(s) / Procedure have been explained to me by my Surgeon.

By consenting to the procedure, I am also:

- Consenting to blood collection and testing for infectious agents should an exposure injury occur to a staff member.
- Consenting to intervention should Emergency Care be required in the opinion of the Doctor.
- Consenting to the use of medical information, to enable optimal care be given.
- Consenting to the provision of medical records to any specialist at this facility that is involved in your health care.
- Certifying that I have a responsible adult to escort and remain with me overnight, following general anaesthetic or sedation.
- Certifying that I understand my rights and responsibilities.

Signed (Patient / Parent / Guardian) ______ **Dated this** ______ **day of** ______ **20** ______

Doctor's Confirmation:

I confirm that I explained the nature, purpose and material risks of this procedure / treatment to the person who signed the above Form of Consent.

Provisional diagnosis (To be completed by Medical / Dental Practitioner)

______

Signed (Medical / Dental Practitioner) ______ Date ______

Name (please print) ______

Southbank Clinical Risk Assessment Signed ______ Name ______ Date ______

Risk ☐ Yes Risk ☐ No Comments ______

______

______