Patient Details / Consent Form

John Mooney Wing

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

Doctor's name

Operation date

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

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

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 (If required)

Name

Telephone (H) (Mobile)

Private Health Insurance details

☐ **Fund name**

Membership No.

☐ **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.

If covered by Private Health Insurance, the account will be forwarded directly to your Health Fund.

☐ 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

HR100

Patient details / Consent John Mooney Wing

General Health questions

PLEASE ANSWER **ALL** QUESTIONS. Answers to these questions will help us assess your fitness for your upcoming surgery.

	Yes	No
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 ______	☐	☐
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 and have received adequate information from my Surgeon and signed his personal Consent Form.

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 or a delegated member of my staff 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 ______

☐ Yes ☐ No Comments ______________________________

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