Bendigo Day Surgery

Partner in Medical **Excellence**

ADMISSION FORM

DOCTORS INSTRUCTIONS:
Please complete the information on page 6
Please give the Admission Form to the patient for completion and delivery to the Bendigo Day Surgery **AT LEAST ONE WEEK PRIOR TO SURGERY**

IMPORTANT PLEASE READ:

PATIENTS INSTRUCTIONS:
Please complete the information on **pages 3 & 5**
Please read, complete and sign page 4
Please see page 2 for **important** financial information
(Keep pages 1 & 2)
Deliver or post all other pages to Bendigo Day Surgery AT LEAST ONE WEEK PRIOR TO YOUR PROCEDURE

A nurse will contact you the day prior to your procedure to confirm the time of your arrival and any other instructions

If you have any questions or problems relating to your admission please contact the Bendigo Day Surgery:

PO Box 2735, Bendigo Delivery Centre VIC 3554
1 Chum Street, Bendigo Vic
T: (03) 5444 3533 • F: (03) 5444 1743
enquiry@bendigodaysurgery.com.au
www.bendigodaysurgery.com.au

AF02 June 2016

IMPORTANT PAYMENT INFORMATION

IF YOU ARE PRIVATELY INSURED

The Bendigo Day Surgery advises that prior to your visit that you contact your Health Fund. You should make sure of the following:

- Am I fully covered for my day surgery?
  (This does not apply to public or basic cover where some payment will be required)
- Am I paid up and have I served all waiting periods?
- Do I have any excess or co-payment applicable with my fund?
- Are there any exclusions with my cover?
- Is my health fund contracted with Bendigo Day Surgery?
  If not, please advise Bendigo Day Surgery immediately

IF YOU ARE UNINSURED

- You will need to phone the Bendigo Day Surgery on (03) 5444 3533 with an item number (which should be obtained from your Specialist) to obtain a quote

ANY PAYMENT DUE IS REQUIRED ON THE DAY OF YOUR SURGERY INCLUDING EXCESS / CO-PAYMENTS

- We accept cash, cheque, EFTPOS, Mastercard and VISA
- Any payment due by you to your health fund is your responsibility
- If you have any questions we suggest that you contact your health fund or the Bendigo Day Surgery

PATIENT HEALTHCARE RIGHTS

You can access Patient Healthcare Rights on our website
www.bendigodaysurgery.com.au or www.health.vic.gov.au/patientcharter
Alternatively you can contact a staff member at Bendigo Day Surgery for further information.

TREATMENT WITH RESPECT AND DIGNITY

You can expect to be treated with courtesy and to have your ethical, cultural and religious practices and beliefs respected.
You can legally discharge yourself at any time even against the advice of your Doctor or hospital staff. However you must accept the risks and sign a form accepting responsibility.

WHEN SHOULD I ARRIVE

Our Nursing Staff will contact you on the day before your procedure to confirm your arrival time. If your procedure is on a Monday you will be called on the Friday before your procedure.

During this phone call you will be informed of your fasting requirements and a brief nursing history will be taken to help us co-ordinate your care at the Bendigo Day Surgery.

PLEASE RETAIN THIS PAGE

BOOKING FORM

OFFICE USE ONLY

MRN No							

TO BE COMPLETED BY THE PATIENT

PATIENT DETAILS

Procedure Date:..... **Surgeon:**..... **Referring Dr:**.....

Have you been admitted to the Bendigo Day Surgery previously? ☐ No ☐ Yes Year .....

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

Surname:..... **Given Names:**.....

Residential Address: .....

.....

Postal Address (if different)**:** .....

Date of Birth: ...../...../..... **Gender:** ☐ Female ☐ Male **Occupation:**.....

Tel.: (H) ..... (W) ..... (Mob) .....

Email Address: .....

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

Country of Birth: ☐ Australia ☐ Other.....

If Australia, which state: ☐ VIC ☐ NSW ☐ SA ☐ WA ☐ QLD ☐ NT ☐ TAS ☐ ACT

Language used at home: ☐ English ☐ Other ..... **Religion:**.....

Are you an Aboriginal or Torres Strait Islander: ☐ Yes ☐ No **Do you need an interpreter?** ☐ Yes ☐ No

NEXT OF KIN

Name:..... **Relationship to patient:**.....

Address (if different to above)**:** .....

Tel.: (H) ..... (W) ..... (Mob) .....

MEDICARE NO:..... Ref No:..... Exp. Date:.....

PAYMENT OF ACCOUNT (Please tick the appropriate box and complete details)

☐ **Ambulance VIC** ☐ YES ☐ NO Membership No.: ..... ☐ Single ☐ Family

☐ **Health Insurance** Fund Name:..... Table:.....

Member No:..... Excess:.....

Have you been in hospital within the last month? ☐ Yes ☐ No

☐ **Veteran's Affairs** Member Number:..... Card Colour: ☐ Gold ☐ White

☐ **Workcover** Employer:..... Tel:.....

Accident date...../...../..... Claim No.:.....

Insurance Co.: .....

☐ **Third Party (T.A.C.)** Insurance Co.: .....

Claim No.:.....

☐ **Self Pay** Quoted: $ .....

☐ **I DECLARE I AM AWARE OF MY HEALTHCARE RIGHTS.**

☐ **I DECLARE I AM LIABLE FOR COSTS INCURRED IN AMBULANCE TRANSFER WHERE NECESSARY.**

I agree to be personally liable for any costs at the Bendigo Day Surgery irrespective of any claim I may have against any Health Fund or any other third party. Also I understand that should I require admission for further care I will be responsible for all costs incurred

Signature - Patient / Responsible Person:.....

OFFICE USE ONLY

Excess		Waiting Period	Y/N	Financial	Y/N	Time & Date	

INFORMATION HANDLING - PROTECTING YOUR PRIVACY

The Bendigo Day Surgery is committed to providing quality health care for its patients. As a fundamental part of this commitment, management and staff of the Bendigo Day Surgery understand the importance of ensuring that patients are fully informed and involved in their healthcare.

The Bendigo Day Surgery is a health provider in the private sector, bound by the Australian Privacy Principles as contained within the Privacy Act 1988 (as amended). These principles set the standards by which personal information is collected and handled. A copy of these principles is available for inspection at the reception desk at Bendigo Day Surgery.

In order to provide quality healthcare it is necessary for Bendigo Day Surgery to maintain files pertaining to your health and background. These files are updated and added to each time you are admitted to Bendigo Day Surgery to ensure they remain accurate, up to date and relevant.

These files may contain the following types of information:

- Personal details (e.g. name, address, date of birth, Medicare number, language spoken, next of kin)
- Medical history
- Notes made during the course of medical consultations and procedures
- Referrals to or from other health service providers
- Results and reports received from other health service providers

The information held is provided by you (unless it is unreasonable or impracticable to do so) or arises as a consequence of information you have provided to us. Sometimes information about you is collected from other sources if it is necessary to do so, for example results or reports from other treating doctors or health funds.

You have the right to refuse to provide certain information, however this may impact on our ability to provide the best care for you during your stay. Failing to disclose information pertaining to your medical history and/or treatment may have a detrimental effect on your health.

Your medical file is handled with the utmost respect for your privacy. Your file may be accessed by medical practitioners, nursing staff and administrative staff involved in your care.

We store information in different ways, including in paper and electronic form. The security of your personal information is important to us and we take reasonable steps to protect it from misuse, interference and loss, and from unauthorised access, modification or disclosure. Staff are bound by strict confidentiality requirements and legal obligations as a condition of employment. Our building and electronic data is protected by secure storage policies, passwords and/or security systems.

Information regarding your treatment may be sent to your local doctor, another community or health care facility or provided to health care funds, TAC or WorkCover as appropriate. If you do not want this to happen, please let a staff member know as soon as possible. Ordinarily we will not release the contents of your medical file without your consent. However, there may be occasions where we will be required to release the details of your file irrespective of your consent, including where the law requires disclosure (such as pursuant to a court subpoena).

You have the right to access any information we hold concerning you. Should you wish to access this information, please ask for a copy of the form ACCESSING YOUR MEDICAL RECORD. A copy is available at reception or via our website.

Should you have a question or complaint in relation to the privacy policies in place at Bendigo Day Surgery, please contact the Director of Nursing. Any complaint is required to be made in writing and addressed to the DON and marked private and confidential. Complaints will be addressed within 30 days of receipt.

The full version of the Bendigo Day Surgery Privacy Policy is available at reception or on our website should you wish to access it.

CONSENT TO USE INFORMATION

To be completed and signed by the patient

I.....

hereby acknowledge that I have received and read a summary of the Bendigo Day Surgery Privacy Policy (above) prior to my admission. I consent to personal information obtained by Bendigo Day Surgery to be handled in the manner outlined above.

Signed .....

Date .....

MEDICAL HISTORY

TO BE COMPLETED BY THE PATIENT

Do you have or have you ever had any of the following? Please tick and provide details below:

Diabetes		Epilepsy		Hiatus Hernia	
Malignant Hyperthermia		Stroke		Indigestion / Heartburn / Reflux	
Heart Attack		Rheumatic Fever		Cancer	
Angina / Chest Pain		Arthritis		Kidney Problems	
Palpitations		Bleeding or Clotting Problems		Nervous System Disorders	
High Blood Pressure		Hepatitis B / Hepatitis C / HIV		Anxiety or Depression	
Breathlessness		Jaundice		Neck or Spinal Problems	
Asthma or Wheezing		Other Liver Problems		Skin Tears or Pressure Injury	
Persistant Cough		Tuberculosis		Ulcers or open wounds	

Details of major or chronic health problems ticked above:.....

.....

Height ..... cms **Weight**.....kg *Please note: We are not equipped to perform G/A Procedures on patients over 150kg. If you are please notify your surgeon.*

			Details
Do you have a cardiac pacemaker or any other artificial medical device? If yes, who is your cardiologist?	Yes	No	
Do you have diabetes? Type I / Type II / Insipidus (circle) Controlled by: Insulin / tablets / diet (circle)	Yes	No	
Do you have any drug or food allergies? Details:	Yes	No	
Do you have any special dietary requirements? Details:	Yes	No	
Do you have any treatment limiting orders or an advanced care plan?	Yes	No	
Do you smoke?	Yes	No	
How many cigarettes per day?			
Have you ever smoked?	Yes	No	
When did you stop?			
Do you have more than 3 alcoholic drinks per day?	Yes	No	
Have you ever used drugs not prescribed by a doctor?	Yes	No	
Do you use an aid to walk?	Yes	No	
Do you have a recent history of falling or are you afraid of falling?	Yes	No	
Are you a resident of an aged care facility? If yes, where:	Yes	No	
Have you or any family member ever had any problems with anaesthetics? If yes, details	Yes	No	
Have you had any previous surgery? If yes, details:	Yes	No	
Could you be or are you pregnant?	Yes	No	
Have you ever had an infection or colonisation of MRSA, VRE or CRE?	Yes	No	
Do you have a family history of 2 or more relatives with Crutzfeldt Jakob Disease (CJD) or other unspecified progressive neurological disorders?	Yes	No	
Have you ever received human pituitary hormones between the years of 1960-1985?	Yes	No	
Have you had a dura mater graft? (Prior to 1989)?	Yes	No	
Have you returned from travelling overseas in the last 4-6 weeks?	Yes	No	
If yes, did you have an overnight stay in an overseas hospital or residential care facility?	Yes	No	

Please list any medications you are taking below. Include any over the counter medications, herbal remedies or supplements. Attach a separate sheet if neccessary.

Medication	Dose	When Taken

CLINICAL PATHWAY

Bendigo
Day Surgery

OFFICE USE ONLY

ALLERGIES/SENSITIVITY

OFFICE USE ONLY

Title	Family Name	MRN	
Given Names		VMO	
Address	Street	DOB / /	Gender M / F
Town	State	Postcode	

CLINICAL DETAILS

TO BE COMPLETED BY ADMITTING DOCTOR

Proposed operation: ..... Proposed Date: .....

Provisional diagnosis: ..... Anaesthetic (Please circle) G/A or L/A

Estimated duration: ..... Provisional Item Numbers: .....

Pre operative orders: .....

.....

.....

.....

CLINICAL PATHWAY

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 any post procedure treatment required.

However 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 by the anaesthetist to be necessary or advisable.

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 until the day after my operation and that I should not undertake any of these tasks until then.

Date .....

Signed: ..... Relationship of Patient .....

Signature of Doctor: ..... Dated .....