castlemaine
HEALTH

Your surgery has been scheduled for / / with ....
It is anticipated that your stay in hospital **may be:**
☐ Day Stay
☐ Overnight or longer

To assist us to prepare for your stay we need to collect information about you.
You can provide this information to us either by:

- **Going online** to this secure link **http://tinyurl.com/CHSurgery** and following the instruction on that page. You will need to enter the password **CHSurgery$** which includes the dollar sign at the end, and we strongly advise that you use the Chrome browser

  OR

- **Filling in the enclosed form** and returning it in the pre-paid envelope supplied as soon as possible. The forms to complete and return are: Surgical Preadmission Checklist, Pre-Admission Surgical Patient Registration form. (write date of surgery if not already filled out)

IF YOU ARE PRIVATELY INSURED
It is your responsibility to contact your Health Fund prior to surgery:
Are you covered for the procedure?
Are you paid up and served all waiting periods?
Do you have an excess or co-payment?
Are there any exclusions with your cover?
An amount payable letter will be sent to you if an excess applies. All payable amounts **must be paid 3 days prior to surgery**. In the event that your level of cover excludes the service provided you may be billed for that service post discharge. Your surgeon and anaesthetist will bill you separately.

IF YOU ARE SELF FUNDING
An amount payable letter will be sent to you. All payable amounts **must be paid 3 days prior to surgery**. This may not be the final cost. There may be variations from the proposed treatment or unforeseen circumstances which will alter the payment amount. You may receive an additional invoice post discharge. Your surgeon and anaesthetist will bill you separately.

Our Pre Admission Nurse will also contact you **within** the week prior to:
- Confirm your clinical information &
- Give you a time to arrive and fasting instructions. *(The time given is not your surgery start time)*

If you need to **cancel or postpone your procedure for any reason or have any other enquiry** you will need to:

(a) Contact your Surgeon's Secretary, and
(b) Contact the Pre-admissions Nurse on **(03) 5471 3621**

We will endeavour to ensure that your stay with Castlemaine Health will be as comfortable as possible.

SURGICAL PREADMISSION
Patient Information

Welcome to Castlemaine Health.

We look forward to caring for you and to ensure that your stay will be as pleasant as possible. Our aim is to provide a comfortable environment, of the highest possible standard. We offer dedicated and professional staff to ensure that you receive the best possible care at Castlemaine Health.

The following information will answer most of your questions so please READ CAREFULLY.

What should you bring?

- Health care card, pension card, other benefit cards or safety net details.
- All your **tablets** in their ORIGINAL container including **inhalers** and **insulin**.
- X-rays or scans if applicable to your surgery. E.g. nose, ear, shoulder, knee surgery
- A book or magazine (or favourite quiet toy for child).
- One support person/driver only is allowed to stay with you.
- If staying overnight, please bring night attire and toiletries
- Patients may require a small amount of money for prescriptions if required post surgery.

What should you do?

- Organize your driver escort home. Driver must have a full license. If you are having a same day stay procedure, it is essential that you have a support person to stay with you after discharge and over night.
- **Refrain from smoking and using recreational substances** for at least 24 hours before your procedure if you are having a general anaesthetic. You will not be able to smoke until after discharge from the Hospital.
- Have a **shower** the morning of your surgery. No powder, deodorant or perfume.
- Leave all jewellery and valuables at home. Do NOT wear makeup or nail polish.
- Buy Panadol to have at home for post operative pain management.

If you are having a COLONOSCOPY

Refer to the specific instructions received from your Surgeon. The instructions detail what you may or may not eat and drink and how to take the bowel preparation medication you have purchased.

What about medication, food and drink?

BRING all medications, in their packets, with you to hospital.

If you are having a **LOCAL ANAESTHETIC** there is no restriction on food and drink

If you are having a **GENERAL ANAESTHETIC or SEDATION** there are restrictions on food and drink

Morning Surgery

- DO take your regular medication with a little sip of water at the normal time. *(refer below for diabetic medication instruction)*
- Do NOT eat after midnight
- Drink restricted fluids as per instructions provided during your preadmission phone call
- Do NOT chew gum or consume sweets

Afternoon Surgery

- DO take your regular medication with a little sip of water at the normal time. (refer below for diabetic medication instruction)
- DO have a LIGHT breakfast (e.g. tea and toast) but, do NOT eat after 7.00 am
- Drink restricted fluids as per instructions provided during your preadmission phone call
- Do NOT chew gum or consume sweets

Other Medications and Conditions?

Diabetes Do NOT take your morning diabetic TABLETS on the day of your surgery.
If you are on INSULIN, your anaesthetist will contact you prior to your surgery. They will then be able to provide instructions, prior to your surgery, about your INSULIN dose(s).

Asthma DO take your inhalers and medication as usual and bring them to hospital with you.

Castlemaine Health

SURGICAL PRE ADMISSION CHECKLIST

UR No ....

Surname ....

Given Names ....

DOB ....

AFFIX PATIENT LABEL HERE

PLEASE COMPLETE AND RETURN FORMS AS SOON AS POSSIBLE TO FACILITATE YOUR ADMISSION

Last Name:.............................. **Given Name:**.............................. **D.O.B:**..............................

Prior to surgery the Pre-Admission nurse will contact you via phone with an admission time and fasting instructions

Please provide the following to enable this: ☐ Home Phone:.............................. ☐ Work Phone:..............................

☐ Mobile:.............................. ☐ Email Address:..............................

On day of procedure, bring in :

1. Medications in packets
2. Scans/x-rays – orthopaedic surgery
   – sinus surgery
3. Mirena – gynaecological surgery
4. Crutches – arthroscopy/foot surgery

Office Use Only

Call Date:............ Hour: ☐AM ☐PM ☐N/A ☐Msg left Initials:.......

Call Date:............ Hour: ☐AM ☐PM ☐N/A ☐Msg left Initials:.......

Call Date:............ Hour: ☐AM ☐PM ☐N/A ☐Msg left Initials:.......

Date:.............................. ☐ Day ☐ LDS ☐ Overnight Surgeon:..............................

Procedure:.............................. Fasting From:..............................

Admission Details (Patient Name, UR, DOB) → Initials:.............................. Admit Time:..............................

List below all medications you are currently taking (ie. puffers, patches, injections, tablets, herbal supplements, laxatives)

Name of Medication	Dose	Frequency	Reason for taking *eg;diabetes, blood pressure*	Check at Phone Call	Check on Admission (Last Taken)

Are you allergic to any medications, adhesive tapes, foods or latex If yes, describe	☐ No ☐ Yes		
Have you recently taken any steroid medications *(If yes, tick appropriate box & include details in the medication list above)* ☐ Cortisone ☐ Prednisolone	☐ No ☐ Yes		
Do you take a blood thinning medication INR level:.............. ☐ Aspirin ☐ Warfarin ☐ Plavix ☐ Iscover ☐ Cartia ☐ Eliquis ☐ Pradaxa ☐ Xarelto ☐ Other:..............................	☐ No ☐ Yes		
<u>Do you have a pacemaker</u> Date last checked:.............. Type:.............................. Cardiologist:	☐ No ☐ Yes		

How tall are you:.............................. **How much do you weigh:** .... **BMI**

23 ☐ | If BMI over 35 → ☐ Report to CVAS | If weight over 110 → ☐ Confirm with a third person

SURGICAL PRE-ADMISSION CHECKLIST MR/103

Please tick boxes and record relevant details		Check at Phone Call	Check on Admission
Are there any legal directives in place for providing consent? Eg: guardianship, court order, medical treatment decision maker If yes, give details:... *If you have an Advanced Care Directive, please bring a copy with you to hospital.*	☐ No ☐ Yes		
Have you had any of the following ☐ Heart surgery .... ☐ Lung surgery .... ☐ Spinal surgery .... ☐ Head, Neck surgery .... ☐ Other major surgery	☐ No ☐ Yes		
Have you or a relative had problems with a previous anaesthetic, operation or with malignant hyperthermia	☐ No ☐ Yes		
Are there any health conditions that run in the family If yes, describe:	☐ No ☐ Yes		
Have you been: ☐ put on a Special diet → Describe:.............................. **Or do you have:** ☐ Dietary restrictions	☐ No ☐ Yes		
Do you currently smoke: ☐ cigarettes ☐ e-cigarettes ☐ vaping ☐ marijuana Total number per day:................ If an ex-smoker, when ceased:	☐ No ☐ Yes		
Do you drink alcohol Approximate number per week:	☐ No ☐ Yes		
Do you use recreational substances Frequency:.................................. Describe:	☐ No ☐ Yes		
Do you use a mobility aid: If yes → ☐ Walking Stick ☐ Frame ☐ Scooter	☐ No ☐ Yes		
Are you able to walk 1 kilometre	☐ No ☐ Yes		
Do you do your own: ☐ Housework ☐ Shopping ☐ Wood Chopping ☐ Lawn Mowing	☐ No ☐ Yes		
Do you have care responsibilities for others	☐ No ☐ Yes		
Do you have any self care problems	☐ No ☐ Yes		
Do you receive any community services	☐ No ☐ Yes		
If you are a female patient: Are you currently breastfeeding Are you currently pregnant → How many weeks:	☐ No ☐ Yes ☐ No ☐ Yes		
For a same day stay, **it is essential for you to have an adult support person to stay with you after discharge and overnight** – Has this been organised:	☐ No ☐ Yes		
Who is your escort home: Must be a fully licensed driver Name: .... Phone Numbers:			
Extra Information:			

Patient Name: .... DOB: .... UR No: ....

	Do you currently have or have you ever had any of the following conditions *(tick the appropriate boxes)*	Check at Phone Call	Check on Admission
RESPIRATORY	Shortness of Breath.................. ☐ Bronchitis .... ☐ Emphysema .... ☐ COPD .... ☐ Sleep Apnoea .... ☐ Disturbed Sleep .... ☐ Chronic Respiratory Failure .... ☐ Asthma .... ☐ Pneumonia .... ☐ Tuberculosis .... ☐ Lung disease .... ☐ Snoring .... ☐ Bronchiectasis .... ☐		
ENDOCRINE / METABOLIC	Diabetes................ ☐ Type 1 → ☐ Insulin controlled ☐ Type 2 → ☐ Diet Only ☐ Tablets Only BSL Range:....................... ☐ Insulin Only ☐ Tablets & Insulin *(If tablets or insulin ticked, ensure they are included in the medication list)* Thyroid disease.......................... ☐ Cystic Fibrosis.......................... ☐		
CARDIOVASCULAR	Angina.................................. ☐ Irregular Heart Beat..................... ☐ Heart Murmurs.......................... ☐ Ischaemic Heart Disease .... ☐ Chest Pain....................... ☐ Rheumatic Fever............. ☐ Palpitations.................... ☐ Chronic Heart Failure...... ☐ Heart problems:		
CIRCULATORY	High Blood Pressure..................... ☐ Low Blood Pressure..................... ☐ Coronary Artery Disease .... ☐ Bleeding Tendency........... ☐ Anaemia.......................... ☐ Blood Disorders/diseases.. ☐ Blood Clots in: ☐ Lungs ☐ Legs Blood Transfusion: → Year:.......................................		
GENITO URINARY	☐ Chronic Kidney Disease: Stage:.. ☐ Bladder Problems:...		
MUSCULOSKELETAL	Arthritis: Rheumatoid.................. ☐ Osteo.............................. ☐ Hip problems.............................. ☐ Osteoporosis.............................. ☐ Muscular Dystrophy..................... ☐ Systemic Lupus Erythematosus.... ☐ MND.. ☐ Neck problems................ ☐ Back problems................ ☐ Jaw problems................. ☐ Muscle Disorder.............. ☐ Spina Bifida.................... ☐ Fibromyalgia.................. ☐		
NERVOUS SYSTEM	Blackouts.. ☐ Fits.. ☐ Parkinson's Disease..................... ☐ Multiple Sclerosis........................ ☐ Epilepsy.......................... ☐ Stroke............................ ☐ TIA................................. ☐ Cerebral Palsy................ ☐ Plegia (eg: Tetraplegia, Paraplegia, Diplegia, Monoplegia, Hemiplegia)...... ☐		

Patient Name: .... DOB: .... UR No: ....

	Do you currently have or have you ever had any of the following conditions *(tick the appropriate boxes)*		Check at Phone Call	Check on Admission
DIGESTIVE	Hepatitis What Type................ ☐	Jaundice...................................... ☐		
	Chronic Liver Disease............. ☐	Reflux.. ☐		
	Stomach Ulcers........................ ☐	Crohn's Disease.......................... ☐		
	GORD .... ☐ (Gastro-Oespohageal Reflux Disease)	Ulcerative Colitis.......................... ☐		
MENTAL/BEHAVIOURAL	Anxiety.. ☐	Mental Health Problem................ ☐		
	Depression.............................. ☐	Intellectual Development Disorder.. ☐		
	Dementia.................................. ☐	Autism.. ☐		
	Down's Syndrome .... ☐	ADHD.. ☐		
	Other: .... ☐	Schizophrenia.............................. ☐		
Any other medical conditions not previously listed? (eg cancer)				

INFECTION CONTROL RISK SCREEN	Please complete – (If yes to any question, staff refer to Infection Control Admission Risk Screen MR/126(m)			
1	**A recent admission to an Australian health care facility within the last 4 weeks**	☐ No ☐ Yes		
2	**Direct transfer, overnight stay in hospital or residential care facility overseas in the previous 12 months**	☐ No ☐ Yes		
3	**Any contact with an infectious patient**	☐ No ☐ Yes		
4	**Any current symptoms of an infectious illness** (underline) e.g. diarrhoea, vomiting, febrile illness, rash, persistent cough, flu like symptoms, ebola	☐ No ☐ Yes		
5	**Any discharging or infected wounds or exfoliating skin disorder**	☐ No ☐ Yes		
6	**A current indwelling invasive device** e.g. PICC, Portacath, IDC, IV, Cannula	☐ No ☐ Yes		
7	**Any current or recent symptoms of communicable infectious disease** e.g. measles, chicken pox, pertussis	☐ No ☐ Yes		
8	**A history of Creutzfeldt Jakob Disease (CJD)**	☐ No ☐ Yes		
9	**A multi-resistant organism infection or colonisation** e.g. MRSA, VRE, C Difficile, ESBL, CPE	☐ No ☐ Yes		
10	**Currently immunosuppressed** (Neutrophils <1.0 10g/L)	☐ No ☐ Yes		

Office Use Only:

☐ Anaesthetist → emailed ☐ NUM → emailed

Tests / Requirements

☐ ECG

☐ Pathology:..

☐ Scans / X-rays ☐ Crutches ☐ Mirena

☐ Over 110 kg (third party check) ☐ Cataracts (manage eye drops)

☐ Other: ....

☐ Infection Risk Plan

Pre-Admission Nurse's Name:.. **Signature:**........................... **Date:**.........................

Admission Nurse's Name:.. **Signature:**........................... **Date:**.........................

What if you have to stay overnight?

- You may telephone the Nurse Unit Manager on the Acute Unit (Telephone: 5471 3473) to talk about your stay.
- Please bring night attire and toiletries.

What about my support person?

- A parent can stay overnight in their child's room.
- Other than above, overnight accommodation is not available at the Hospital.
- Contact the local accommodation booking service phone 1800 171 888 or www.maldoncastlemaine.com for a wide range of motel and overnight stay options.
- Our cafeteria offers a selection of meals and snacks from 8.00 am
- Our cafeteria also has a comfortable lounge and waiting area.
- It is recommended that two adults accompany children to the age of 12 (if possible).

Is there anything else?

What if I get a cold or feel sick? Tell your local doctor and let the Pre Admission nurse know as soon as possible on 03 5471 3621.

If you have an **Advanced Care Directive p**lease bring a copy with you, along with the details of your **Medical Treatment Decision Maker** if you have one appointed.

Interpreter or Translation Service Should you require the hospital to access an interpreter or translation service, ensure you have completed the pre admission registration details.

Special Dietary requirements At your pre admission phone call please advise the nurse if you have any special dietary needs.

Ensuring Correct Procedures

It is a requirement for staff to recheck your information and to make sure they have everything right.

Before the procedure, a doctor or nurse will ask you to say your name, date of birth and the part of your body that will be treated or examined. Don't be alarmed by these questions; the staff know who you are. This is how they make sure they have everything right.

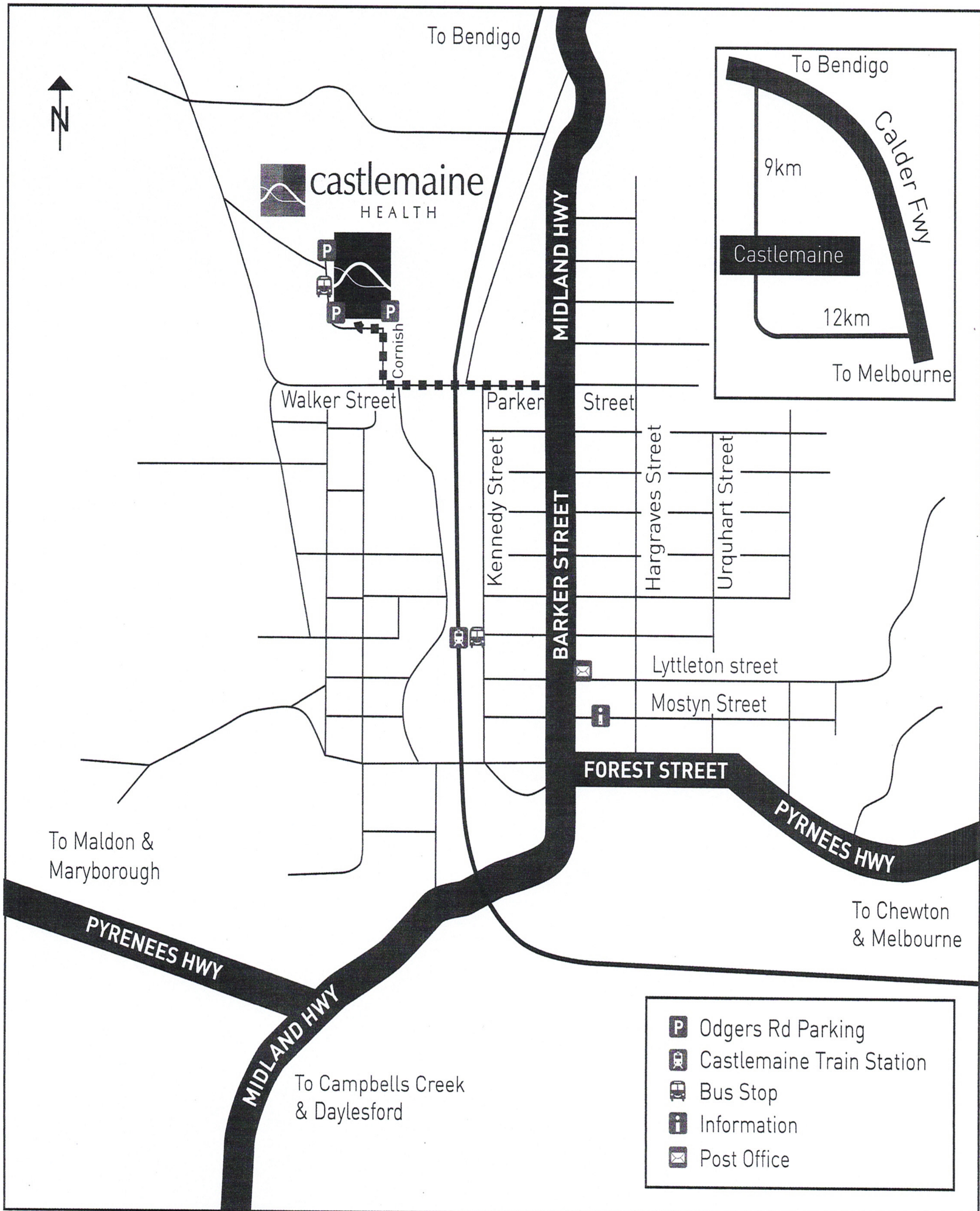
It is a requirement for the doctor to correctly identify the operative site.

Before your procedure, the doctor and nursing staff may need to mark with a pen on the part of your body where the procedure will happen. Some doctors will sign their name or initials; others may make an "X" or "Yes" mark on the correct body part.

Check that the mark does not rub off. It will be very important for the doctors and nurses to see the mark before the procedure commences. Tell your doctor or nurse if the mark rubs or washes off before the procedure.

Just before the procedure begins, everyone in the treatment room will take a short "time out" and check for the last time they have the right patient and are doing the right procedure on the right body part.

These important steps are taken to make sure that everything goes as planned for your care.


To Bendigo
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castlemaine
HEALTH
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Cornish
MIDLAND HWY
Walker Street
Parker
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Kennedy Street
BARKER STREET
Hargraves Street
Urquhart Street
Lyttleton street
Mostyn Street
FOREST STREET
PYRNEES HWY
To Maldon &
Maryborough
PYRENEES HWY
MIDLAND HWY
To Chewton
& Melbourne
To Campbells Creek
& Daylesford
To Bendigo
Calder Fwy
9km
Castlemaine
12km
To Melbourne
Odgers Rd Parking
Castlemaine Train Station
Bus Stop
Information
Post Office