PRE-ADMISSION INFORMATION AND PATIENT REGISTRATION FORM
This form should be returned as soon as possible and no later than a week prior to your admission date.

YOUR ADMISSION INFORMATION:

ADMISSION DATE: _____ / _____ / _____

ADMISSION TIME: ____________________________________

FAST FROM: ________________________________________
PLEASE READ AND KEEP FOR YOUR INFORMATION

Before your admission:
The date and time of your surgery is arranged through your Surgeon’s Rooms. Please contact Surgeon’s rooms directly if you are unsure.

Plan to have someone drive you to Townsville Day Surgery on the day of admission. It is likely that your concentration will be impaired for a few days after the anaesthetic. As a result, you are legally not allowed to drive a vehicle for 24 hours after an anaesthetic. You will need someone who we are able to contact to pick you up and discharge you into their care. If you are unable to provide adequate information regarding this, your procedure may be cancelled and re-scheduled.

Please be aware that it is necessary for you to have a responsible adult accompany you home and stay with you for the first 24 hours following your surgery. It is also advised that you stay within 1 hour’s journey of a Hospital following some procedures. If either of these is not possible, please discuss alternatives with your surgeon and notify nursing staff of your arrangements on the day of admission.

Please understand that cancellation of your procedure may result if you do not have the appropriate measures in place.

Fasting Instructions:
YOUR SURGEON WILL ADVISE YOU WHEN TO COMMENCE FASTING.

DO NOT eat or drink on the day of your surgery after the advised time of fasting given by your surgeon. Take your normal prescribed medications on the morning of the procedure with a sip of water (unless you have been advised otherwise by your GP or Surgeon). You may brush your teeth but DO NOT swallow any water. DO NOT chew gum on the day of your surgery.

Smoking:
DO NOT smoke on the day of your surgery. Smoking is not permitted on Townsville Day Surgery premises.

Doctors’ Fees:
Please note that you will also receive an account direct from the Doctors involved in your procedure (Surgeon, Anaesthetist and Assistant where required). Please contact your Surgeon and Anaesthetist Rooms directly regarding these fees.

Fees and Health Fund Information
Before your visit to Townsville Day Surgery, we strongly advise that you contact your health fund to verify your level of cover and whether you will be covered for your surgery in a private hospital setting.

Please be aware that all health funds place their new members in waiting periods, regardless of whether you are joining private health insurance for the first time or you have changed over from another health insurer.

Most health fund policies have excesses, co-payments, exclusions and restrictions.

Exclusions: you agree not to be covered at all for certain services. No benefits are payable for the excluded service by your health fund at all.

Restrictions: you agree to receive only limited benefits for certain services. This is usually enough to cover you as a private patient in a public hospital, but will leave you with large expenses if you are treated in a private hospital.

Most exclusions are complex and it is important that you understand how they may impact upon your cover. If the procedure is an excluded item on the level of cover you hold, your health insurer will not cover any costs associated with the hospital.

If you have joined your health insurance fund less than 12 months ago or you have recently changed levels of cover:

Any time you join a health fund for the first time, you are subject to waiting periods on hospital benefits for the first 12 months and pre-existing ailment conditions may apply.

What is a waiting period? A waiting period is an initial period of health fund membership during which no benefit is payable for certain procedures or services.

What does “Pre-Existing Ailment” mean? A pre-existing condition is defined as any ailment, illness, or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. The pre-existing condition waiting period applies to new members and members upgrading their policy to any higher level benefits under the new policy.

Please be aware if you have changed/upgrade your level of cover, your health insurance provider will often place you in a 2 month waiting period.

Questions we recommend you ask your health insurer prior to your admission:

• What level of cover do I hold?
• Have I been a member for more than 12 months?
• Does my policy cover me for this procedure?
• You may require ‘item numbers’ which can be given by your Surgeon
• Do I have an excess or co-payment for Day Surgery admissions?

Uninsured, Work Cover and Third Party Patients:
If your hospital stay is not covered by your health insurance or if it is a Workcover claim and has not been approved for payment prior to the admission date, you are fully responsible for the costs associated with the hospital.

If you are a self funded patient, we advise you contact Townsville Day Surgery on (07) 4725 4500 to obtain an estimate of fees and charges. You will require an item number for your procedure which will be provided by your Surgeon’s rooms. The quote we give you is an estimate only. If there are variations from the proposed treatment or unforeseen complications, the costs may vary.

Plastic and Reconstructive Surgery
Health Insurance fund will not pay any benefits towards the hospital account if the procedure is not deemed medically necessary.

If you are admitting for a Plastic or Reconstructive procedure and your health insurance will not pay any benefits, please contact Reception at Townsville Day Surgery for an estimate of hospital fees.

Payment of Day Surgery Fees:
Self-insured patients are required to pay full fees on admission.

Any excess payable under your Private Health Insurance Fund is payable on admission.

Townsville Day Surgery has EFTPOS and Credit Card facilities (Bankcard, Visa, Mastercard, Amex, Diners Club). Cash and Cheque are also accepted.

What you need to bring:
Please bring your Medicare card, Health Insurance membership card and any Pension/Concession cards you may hold.

Bring any current X-Rays (if applicable) and any medications or a list of your current medications.

What not to bring:
Please DO NOT bring large sums of money, jewellery or other valuables, as we cannot accept responsibility for their security.

We recommend that you wear loose, comfortable clothing with an open neck or button top.

Please remove all make-up and nail polish prior to your admission. If you have acrylic or gel nails, please ensure a toenail is free of nail polish.

Please do not wear strong smelling perfume or deodorant.

Parking:
A drop off / pickup zone is available at the front of the building for arrival and departure. There are a number of parking spaces for longer stays.

Due to the possibility of unpredictable delays, it is difficult for our staff to provide you with time frame for your stay with us.

Our nursing staff will endeavours to contact Escort/Carer prior to your discharge time, to advise them of when you will be ready to leave our care.
THIS COMPLETED FORM IS URGENTLY REQUIRED ONE WEEK PRIOR TO YOUR DATE OF ADMISSION
If there is insufficient time for us to receive this form please fax or phone the hospital between the hours of 7am to 6pm. Thank you.

ADMISSION DETAILS
Admission date:_____ / _____ / _____ Time:______________am/pm Admitting doctor:________________________

PATIENT DETAILS (please print)
Title: □ Mr □ Mrs □ Ms □ Miss □ Master □ Other (e.g. Rank)________________________
Surname: __________________________ First name: __________________________ Middle name: __________________________
Residential address:________________________________________ Postcode:_____
Postal address:________________________________________ Postcode:_____
Phone (home):________________________ Phone (work):________________________ Mobile:________________________
Date of birth:_____ / _____ / _____ Sex: □ Male □ Female Religion:________________________
Martial status: □ Married/defacto □ Never married □ Divorced □ Separated □ Widowed
Indigenous Status: □ Non-indigenous/Torres Strait Islander □ Indigenous □ Torres Strait Islander
Country of birth:________________________
Occupation:________________________ If Retired previous occupation:________________________

NEXT OF KIN DETAILS (please print)
Title: □ Mr □ Mrs □ Ms □ Miss □ Master □ Other (e.g. Rank)________________________
Surname: __________________________ First name: __________________________ Middle name: __________________________
Relationship to patient:________________________
Address:________________________________________ Postcode:_____
Phone (home):________________________ Phone (work):________________________ Mobile:________________________

CONCESSION CARDS
Pension: □ Yes □ No Number: __________ __________ __________ __________ Valid to:_______ / ____ / ____
Veterans’ Affairs file number:________________________ Card colour: □ Gold □ White

MEDICARE
Medicare card no.: _______ _______ _______ _______ _______ Number beside ‘Patient on card’: ___ Valid to:___ / ___ / ___

HEALTH INSURANCE DETAILS
We recommend you contact your Health Fund prior to your admission date. Please refer to Health Fund section for further information. If self-insured, please contact Townsville Day Surgery (07 4725 4500) for an estimate of hospital fees.
Name of fund:________________________ Membership no.:________________________
□ Workcover / Third Party Liability - Have you lodged a claim yet? □ Yes □ No Claim no.: __________________________
□ Defence Force - □ Army □ RAAF □ Navy
Rank:________________________ Unit:________________________ EP ID:________________________ Defence Approval no.:________________________

DECLARATION (REQUIRED FOR ALL PATIENTS)
I certify that the above information is true to the best of my knowledge and agree to its release in support of my insurance claim.
Signature: ______________________________________ Date:________________________
(Patient or parent/guardian)
PATIENT COMPLIANCE STATEMENT

• I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify I have had nothing to eat or drink from the fasting time instructed.
• I certify that I have a responsible adult to accompany me home and to stay with me 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 and others and will not drive a motor vehicle for 24 hours following anaesthetic.

Name of escort/carer: ________________________________________________
Phone: __________________________
Signature: ____________________________ Date: ____________________________
(Patient or parent/guardian)

CURRENT MEDICATIONS

<table>
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<tr>
<th>Medication Name</th>
<th>Dosage</th>
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</tbody>
</table>

Please read each question below and tick the appropriate answer. Use space provided for any further information.

Have you had any Aspirin in the last week? ☐ Yes ☐ No
How many and when: ____________________________

Are you currently on Warfarin or anti-platelet drugs? ☐ Yes ☐ No

Have you had any Cortisone / Steroids in the past 3 months? ☐ Yes ☐ No
If yes, state whether tablets, injection or cream: ____________________________

Do you take any un-prescribed drugs or other substances? ☐ Yes ☐ No
Details: __________________________________________
________________________________________
________________________________________
**DEMOGRAPHIC LABEL**

**PHYSICAL**

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>Waist Measurement (cm)</th>
</tr>
</thead>
</table>

Do you have an Advanced Health Care Directive?  

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Please provide copy</th>
</tr>
</thead>
</table>

Do you have an Enduring Power of Attorney?  

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Please provide copy</th>
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</thead>
</table>

Name of Attorney: ____________________________________________

Phone: ________________________________________________________

Do you have a Guardian?  

<table>
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<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>If yes, Guardian must be present during pre-procedure checks</th>
</tr>
</thead>
</table>

**ALLERGIES AND REACTIONS**

Do you have any allergies or reactions?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

Please document any known allergies or reactions eg. Medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit.

Have you been allergic to latex?  

| Yes | No | Reaction |

Drug Allergy?  

| Yes | No | Reaction |

**PAST SURGICAL/MEDICAL HISTORY:** Surgery and medical conditions to be listed below

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgery/Medical Condition</th>
</tr>
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</table>

Have you or a member of your family ever had any problems with either local or general anaesthetic? Details:  

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
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</table>

**CARDIAC (circle answer)**

Hypertension / High blood pressure  

| Y | N | Rheumatic Fever | Y | N |

High Cholesterol  

| Y | N | Blood clot on lungs / legs (DVT) | Y | N |

Heart Attack  

| Y | N | Anaemia | Y | N |

Irregular heart beat / palpitations / heart murmur  

| Y | N | Chest pain / Angina | Y | N |

Do you have a joint or heart valve replacement, angioplasty / stent, pacemaker / defibrillator or eye implant?  

| Y | N |

**RESPIRATORY (circle answer)**

Bronchitis / Asthma / Emphysema / COPD / Shortness of breath / Bronchiectasis / Asbestosis / Tuberculosis / None  

| Y | N |

Have you recently had a cough, cold or sore throat?  

| Y | N |
### VASCULAR (circle answer)

- Peripheral Vascular Disease: Y / N
- Pressure ulcer / injury: Where:

### ENDOCRINE (tick answer)

- **Diabetes:**
  - Yes [ ]
  - No [ ]
  - If yes, year diagnosed: [ ]
- Controlled by:
  - Insulin [ ]
  - Diet [ ]
  - Tablet [ ]
- Thyroid problems?
  - Yes [ ]
  - No [ ]

### GIT / GUT (circle answer)

- Indigestion or Reflux: Y / N
- Hepatitis or Jaundice: Y / N
- Kidney Disease: Y / N
- Liver Disease: Y / N

### NEURO (circle answer)

- Stroke / TIA: Y / N
- Back or neck problems: Y / N
- Epilepsy or other fits: Y / N
- Stress - related conditions: Y / N
- Fainting / Dizziness: Y / N
- Sleep disorders eg. Sleep Apnoea: Y / N
- A fall or falls within the last 6 months: Y / N
- Difficulty walking / unsteady on feet: Y / N

### INFECTION CONTROL (circle answer)

- Do you have a wound / infection?: Y / N
- Have you ever had an infection with any multi resistant bacteria eg. ‘Golden Staph’?: Y / N
- Do you have a family history of 2 or more first-degree relatives with Creutzfeldt-Jakob disease or other undiagnosed neurological illness?: Y / N
- Do you have Hepatitis or HIV (AIDS virus?)?: Y / N
- To your knowledge, did you receive pituitary hormone injections before 1986?: Y / N
- Have you any reason to believe that you are in a high-risk group for hepatitis or HIV (AIDS virus?)?: Y / N

### PSYCHOSOCIAL (circle answer)

- Depression / Anxiety?: Y / N
- Diagnosed Mental Illness?: Y / N
- PTSD - Post-Traumatic Stress Disorder: Y / N

### SPECIAL NEEDS (circle answer)

- Primary Language:__________________________
- Cultural consideration:__________________________
- Interpreter required Y / N
- Specify:__________________________

### OTHER (circle answer)

- Hay fever Y / N
- FEMALES: Are you pregnant?: Y / N
- Have you ever had a blood transfusion?: Y / N
  - If yes, have you had a reaction?: Y / N
- Do you have a: Dental Appliance / Cap / Plate / Crown / Bridge Y / N
- Do you drink alcohol? Daily intake:__________________________ Y / N
- Do you smoke? How many per day?:____________ If stopped, how long ago?__________ Y / N
- Do you use, or have you used in the past year, recreational drugs?: Y / N
- Details:__________________________
### OTHER (tick or circle answer)

Do you have or have you had cancer? Year of diagnosis: ________________

Type: ___________________________  Y / N

Site(s): ___________________________  Y / N

Treatment:  
- □ Surgery
- □ Radium
- □ Last chemo: _____ / _____ / _____

Arthritis  Y / N  Skin conditions?  Y / N

Specify: ___________________________

Do you tend to bleed or bruise easily?  Y / N

Details: ___________________________

Any other medical disease or illness?  Y / N

Details: ___________________________

### PATIENT SIGNATURE

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature: ___________________________

Print name: ___________________________

Date: _____ / _____ / _____

### NURSE REVIEW

Reviewed by Admitting Nurse  Date: _____ / _____ / _____

Nurse: ___________________________

Signature: ___________________________