# Patient Details / Consent Form

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


southbank day surgery

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


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) (W)

## 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

## General Health questions

PLEASE ANSWER **ALL** QUESTIONS. Answers to these questions will help medical staff to 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 _____ | | |
| **Do you have:** | **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 _____ | ☐ | ☐ |
| 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) _____ Name _____ Date _____

Name (please print) _____

**Southbank Clinical Risk Assessment** Signed _____ Name _____ Date _____

☐ Yes ☐ No Comments _____

_____