hobson healthcare
endoscopy & day surgery

Altona: Cnr Queen & Sargood St, Altona VIC 3018
Werribee: 179 Princes Hwy, Werribee VIC 3030
Sydenham: 566 Melton Hwy, Sydenham VIC 3037

Please complete pages 1 and 2 and return entire document to us at least 5 days prior to your procedure

Admissions Form

Procedure: _____

Date of Procedure: ____ / ____ / ____ **Appointment Time:** _____

Title: _____ Given Name: _____ Surname: _____

Address: _____

Suburb: _____ Postcode: _____ State: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Country of Birth: _____ Marital Status: _____

MEDICARE CARD NO: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref No ☐ Valid to ☐☐ ☐☐☐☐

How will this admission be claimed?

Private Health Insurance: Name of Fund: _____ Membership Number: _____

Pension / Health Care Card Type of Pension: _____ Pension/ HCC Number: _____

Veterans Affairs: File Number: 2 _____

Workcover: Claim Number: _____ Insurance Company: _____

Uninsured:

Did you receive a Patient Information Brochure containing your rights and responsibilities: Yes ☐ No ☐ Any Questions?

_____

Referring Doctor: _____ Address: _____

Current GP (if not your referring Doctor): _____

Have you attended Hobson Healthcare before? Yes ☐ No ☐ **If YES** Werribee ☐ Altona ☐ Sydenham ☐

Have you been admitted to any other hospital within the past 7 days? Yes ☐ No ☐

Aboriginal or TS Island descent: Yes ☐ No ☐ Language Spoken: English: ☐ Other: ☐ _____

Do you live alone? Yes ☐ No ☐

Do you require a carer for physical/ intellectual disability? Yes ☐ No ☐

Do you wish to be contacted regarding your experience? Yes ☐ No ☐

Would you like to be involved and/or contacted with regards to our publications and Quality Standards? Yes ☐ No ☐

PATIENT COMPLIANCE STATEMENT

Following the procedure, **I WILL** have a responsible adult drive me home and have made arrangements for this to occur.
I realise the impairment of full mental alertness may persist for several hours following the administration of anaesthesia and I will avoid making serious decisions or taking part in activities which depend on full concentration or judgement during this period.
I WILL NOT DRIVE A CAR FOR THE REMAINDER OF TODAY. I agree to follow the recommendations provided by HHC on my discharge including making any follow up appointments with my Doctor.
Who will take you home after discharge from Hobson Healthcare (as per recommendation)?

Name: _____ Relationship: _____ Telephone: _____

Waiting ☐ Please call ☐ Where do you plan to go after discharge? _____

How will you get there? _____ Signed: _____

Next of Kin: Name: _____ Relationship: _____ Telephone: _____

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HEALTH INFORMATION

Admission Time:

GENERAL MEDICAL HISTORY (PLEASE TICK):

	Yes	No		Yes	No
High Blood Pressure	☐	☐	History of Blood clots (ie DVT, pulmonary embolism)	☐	☐
Chest Pain/Heart Attack/ Heart Surgery/Stents	☐	☐	MRSA	☐	☐
Other Heart Problems (e.g Pacemaker/Murmurs)	☐	☐	VRE	☐	☐
Asthma or breathing problems/sleep apnoea	☐	☐	TB	☐	☐
Epilepsy or fits/stroke	☐	☐	Psychiatric treatment	☐	☐
Bleeding problems	☐	☐	Diabetes	☐	☐
Liver problems	☐	☐	If yes - insulin	☐	☐
Kidney problems	☐	☐			
History of pressure ulcers	☐	☐	Nursing staff to complete - BSL		

List any other illness or diseases:

What previous operations have you had?

List your regular medications (including complimentary medicines)

ALLERGIES: (e.g. Drugs, Dressings, Food or Latex)

Have you had any complications from an anaesthetic in the past?

Do you take any blood thinning agents eg Warfarin, Plavix, Pradaxa, Asasantin? Yes ☐ No ☐

Have you had cortisone or steroids in the last 12 months? Yes ☐ No ☐

Have you or a relative had any complications due to previous anaesthetic? Yes ☐ No ☐

Have you experienced fainting, or had a fall over the last 12 months? Yes ☐ No ☐

Have you had a sore throat, a respiratory tract or other infection in the last 2 weeks? Yes ☐ No ☐

Do you use an aid of any sort e.g. walker, hearing, walking stick? Yes ☐ No ☐

Do you suffer from dementia/alzheimers/confusion? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ How many per day? _____ Do you drink alcohol 3 or more days per week? Yes ☐ No ☐

Do you have: Dental caps/crowns Yes ☐ No ☐ Dentures/False teeth Yes ☐ No ☐

Weight _____ kgs Height _____ cms

FEMALE PATIENTS ONLY: Are you or could you be pregnant? Yes ☐ No ☐ Are you breastfeeding? Yes ☐ No ☐

Have you been diagnosed with or do you have risk factors for HIV? Yes ☐ No ☐ Hep B ☐ Hep C ☐

Acquired Immune Deficiency Syndrome (AIDS) Yes ☐ No ☐

Did you receive a pituitary growth hormone therapy between 1980 and 1995? Yes ☐ No ☐

Have you had a dura mater graft? (brain surgery between 1972-1987) Yes ☐ No ☐

Do you or your family have Creutzfeldt Jakob Disease (CJD)? Yes ☐ No ☐

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ACKNOWLEDGEMENT & CONSENT FOR PROCEDURE

PATIENT DECLARATION

I acknowledge that the Doctor has explained the scheduled procedure and the potential risks and understand risks that are specific to me.

I understand my option to not have the procedure.

I understand the nature of, and consent to, the administration of anaethetic as considered by the anaesthetist to be relevant to this procedure.

I have been encouraged to ask questions and raise any concerns with the Doctor about my condition, the procedure and its risks as well as treatment options. Any questions have been answered to my satisfaction.

I understand that if biopsies (tissue samples) are removed during my procedure, these may be tested for disease and then disposed of appropriately by the pathology provider.

I understand that no guarantee has been given that the procedure will improve my condition, and that the procedure, though rare, may make my condition worse. I understand that there may be additional tests requested by the Doctor.

I understand that should I require admission into hospital for further care, I will be transferred to the closest public hospital.

On the basis of the previous statements;

I _____ CONSENT
(patients name in full)

to _____
(procedure/operation in full including LEFT/RIGHT)

Signature: _____ Date: _____

SURGEON CONFIRMATION

I _____ have explained to the patient, the nature of the above operation/procedure.

Signature: _____ Date: _____

DOCTORS NOTES:

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ADMISSION (office use only)

PATIENT DECLARATION

Weight:				
BP	PR	RR	T	
O_2Sat	BSL (If applicable)			
Late ate:		Late drank:		Bowel prep:
Comments:				

PRE PROCEDURE CHECKLIST (NURSING)
(Admission Nurse to complete)

	Yes	No	N/A	Comments
ID Band (ask Pt/Carer to state full name, address & DOB)				
Allergies				
Discharge arrangements (confirmed and documented)				
Prostheses (limb, eye/ contact lenses/hearing aid/glasses)				
Falls risk assessed?				
Falls tool required?				
Pressure Injury assessed				
Pressure injury tool required?				
Skin Integrity confirmed (if sore, cut, abrasion present, list in comments)				
Alert Form				
Dentures: Upper – IN OUT Lower – IN OUT Loose Teeth				
Jewellery? taped/removed				
Valuables? (if yes, specify)				
Medical Certificate Req'd				
Operative Site (prepared & inspected by)				

Do you understand your rights and responsibilities?

Admission Nurse Signature: _____ Print: _____

Designation: _____

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