Sight Foundation Theatre

RECOMMENDATION FOR ADMISSION
TO BE COMPLETED BY DOCTOR

Doctor's sticker if available

Sight Foundation Theatre
Level 3, Sydney Eye Hospital, 8 Macquarie St, Sydney 2000
GPO Box 2684, Sydney NSW 2001. Phone (02) 9234 1999 Fax (02) 9223 8299

Patient Details

Title .... Surname .... Given Names ....

Address ....

Suburb.. Postcode ....

Telephone (Home)....................................... (Business)....................................... (Mobile)..

Sex: ❑ Male ❑ Female Date of Birth .... /.......... /..........
DAY MONTH YEAR

Clinical Details

Provisional Diagnosis ....

....

Other Conditions Present ....

Skin Integrity ....

Allergies ....

Medications ....

....

Operation / Surgical Procedure

Proposed Operation...

....

Date of Operation ..../.............../............... Implant Model ....

Item Numbers ....

Type of Anaesthetic ❑ Topical ❑ Regional ❑ LA ❑ GA

Specific Surgical Requirements ....

....

Signature ....

Referring Practitioner

GP.. Optometrist ....

Address ....Telephone ....

Sight Foundation Theatre
REQUEST FOR SURGICAL TREATMENT

ADDRESSOGRAPH FOR SFT USE ONLY

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SECTION A - TO BE COMPLETED BY MEDICAL PRACTITIONER

PROVISION OF INFORMATION TO PATIENT

I, Dr.. have informed this patient as detailed below, the nature, likely results, and material risks of the recommended procedure or treatment.

Reason for Procedure ....

....

Recommended Site / Procedure / Treatment ....

....

Signature of Medical Practitioner .... Date............ /............ / 201.......

SECTION B - TO BE COMPLETED BY PATIENT

PATIENT CONSENT

Dr.. and I have discussed my present condition and the various ways in which it may be treated.

The doctor has told me that:

- The procedure / treatment carries some risks and that complications may occur;
- An anaesthetic, eye block, sedation or medicines may be needed, and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure / treatment may not give the expected results even though the procedure / treatment is carried out with due professional care.
- I understand the nature of the procedure and that undergoing the procedure / treatment carries risks.
- I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
- I understand that I may withdraw my consent.

I, ... request and consent to the procedure / treatment described above for me ....

I also consent to anaesthetics, blocks, medicines or other treatments which could be related to this procedure / treatment.

I specify disclosure of information to the following nominated person

Name .... Phone Number ....

....

Signature of Patient Print name of Patient

Date .... /............ /............

Pre-Admission Form

To be completed by Patient or Carer for each admission and returned to the Centre.

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Please PRINT clearly. Your responses are valuable to us in planning for your admission and care.

Admission Details Previous Admission ❑ Date ....

Surgeon .... Date of Admission..

Personal Details

Title .... Surname .... Given Name ....

Address ....

Suburb .... State .... Postcode ....

Telephone (Home) .... (Business) .... (Mobile) ....

Email ....

Sex: ❑ Male ❑ Female Date of Birth .... /............ /............
DAY MONTH YEAR

The following information is required for Department of Health purposes:

Marital Status: ❑ Single ❑ Married ❑ De facto ❑ Separated ❑ Divorced ❑ Widowed

Country of Birth.. Language Spoken ....

Are you of Aboriginal/Torres Strait Islander (TSI) descent? ❑ Aboriginal ❑ TSI ❑ Both

Occupation .... Pension Number ....

Medicare Number .... Reference.. Expiry Date..../..../.....

Private Health Insurance / Department of Veterans' Arfairs / Workcover

Fund Name .... Membership No. ....

Date Joined...Level of cover ....

Has this level of cover changed in the last 12 months? ❑ YES ❑ NO

Is there an Excess? ❑ YES ❑ NO If yes, amount? $......................................

Have you paid an excess this year? ❑ YES ❑ NO If yes, amount? $......................................

DVA Number .... ❑ Gold card ❑ White card

DVA transport required on day of surgery? ❑ YES ❑ NO

Person to Contact (Next of Kin)

Name .... Relationship ....

Address .... Suburb .... Postcode ....

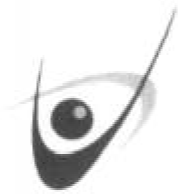
Telephone (Home)..................................... (Business) .... (Mobile)..

Second Contact: (Home).............................. (Business).. (Mobile)..

Privacy, Informed Financial Consent and Rights and Responsibilites
The above information is accurate and correct and I understand and agree to disclose health fund details and to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason. I agree to the disclosure of my personal details for the relevant bodies as previously detailed on pages 6 and 14. I also understand that the Centre will not be liable for any valuables that I bring to the Centre. I also confirm that I will be accompanied home by a responsible adult, have someone with me the night of surgery and will not travel on public transport.

Signature of person responsible for the account / patient ....

Name .... Date ....



Patient History Form

To be completed by Patient, Carer or Doctor for each admission to the Centre.

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Please PRINT clearly. Your responses are valuable to us in planning for your admission and care.

Medical History

Please tick any of the boxes that apply to you:

❑ Heart Trouble
❑ Pacemaker
❑ Other Prosthesis
❑ Contact Dermatitis
❑ Latex/Rubber Allergy
❑ Are you pregnant?
❑ Dura Mater Graft
❑ Spina Bifida
❑ Kidney
❑ Sleep Apnoea
❑ Falls Risk
❑ Glaucoma
❑ Smoker
❑ High Blood Pressure
❑ Stroke
❑ Blood Clots / Embolus
❑ Bleeding or Bruising
❑ Growth Hormone (Pre 1985)
❑ Organ Transplant
❑ Recent Dental Work
❑ Weight (greater than 120Kgs)
❑ Pressure Injury
❑ Persistent Cough
❑ History of Smoking
❑ Asthma
❑ Arthritis
❑ Diabetes ❑ Type 1 ❑ Type 2
❑ Infectious Viral Illness
❑ Fits or Faints
❑ Tuberculosis
❑ Leg Ulcers
❑ Height
❑ Advance Care Plan / Other Treatment - Limiting Order
❑ Other..

Do you or your family have a history of Creutzfeldt Jakob Disease (CJD)? ❑ YES ❑ NO

Do you or your family have a history of rapid onset dementia or memory loss? ❑ YES ❑ NO

Have you or your family ever experienced problems with anaesthetics? ❑ YES ❑ NO

List Recent and Current Illnesses ....

....

List Most Recent Operation/s and Approximate Date/s ....

....

Medications

Warfarin ❑ If presently taking Warfarin please supply most recent INR Blood Test

Date .... Result ....

List Allergies / Adverse Reactions ....

....

Current Medications and Complementary Medicine

Drug	Dosage	Frequency

Please attach a list of any further medications.

Signature ....

Name .... Date ....