Sight Foundation Theatre Pre-Admission Form

To be completed by patient or carer

Level 3, Sydney Eye Hospital, 8 Macquarie Street, Sydney NSW 2000 GPO Box 2684, Sydney NSW 2001
Phone: 02 9234 1999 Fax: 02 9223 8299 Email: info@sightfoundationtheatre.org.au

Admission Details

Surgeon _____ Admission date _____

Previous admission ☐ Yes ☐ No Prev admit date _____

Personal Details

Title _____ Surname _____ Given names _____

Address _____

Suburb _____ Postcode _____

Mobile phone _____ Other phone _____

Sex _____ Date of Birth _____

Email address _____

The following information is required to be collected by the Department of Health

Marital status ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Country of birth _____ Language spoken _____

Occupation _____ Pension number _____

Medicare # _____ Medicare reference _____ Expiry _____

Are you of Aboriginal/Torres Strait Islander descent ☐ Aboriginal ☐ TSI ☐ Both

Private health insurance / Department of Veterans' Affairs / Workcover

Fund name _____ Membership no. _____

Date joined _____ Level of cover _____

Has your level of cover changed in the past 12 months ☐ Yes ☐ No

Is there an excess ☐ Yes ☐ No If yes, how much $ _____

DVA number _____ ☐ Gold card ☐ White card

Is DVA transport required on the day of surgery ☐ Yes ☐ No

Contact person (next of kin)

Name _____ Relationship _____

Mobile _____ Other phone _____

Declaration: The above information is accurate and correct and I 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 to relevant bodies as detailed in the Patient Information Brochure. I understand that the Centre is not liable for any valuables. 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 _____ Print Name _____ Date _____

Sight Foundation Theatre Patient History

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Medical History

Please tick any boxes below that apply to you

☐ Heart trouble	☐ Kidney problems	☐ Blood clots/embolus	☐ Asthma
☐ Pacemaker	☐ Sleep apnoea	☐ Bleeding or bruising	☐ Arthritis
☐ Other prosthesis	☐ Falls risk	☐ Growth hormone	☐ Diabetes Type I
☐ Contact dermatitis	☐ Glaucoma	☐ Organ transplant	☐ Diabetes Type II
☐ Latex/rubber allergy	☐ Current smoker	☐ Recent dental work	☐ Infectious viral illness
☐ Pregnant	☐ Former smoker	☐ Weight > 120kg	☐ Fits or fainting
☐ Dura mater graft	☐ High blood pressure	☐ Pressure injury	☐ Tuberculosis
☐ Spina bifida	☐ Stroke	☐ Persistent cough	☐ Leg ulcers

☐ Advance care plan or other treatment limiting order ☐ Other, specify: .....

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 any current or recent illnesses .....

List recent operations and dates .....

Medications

Please provide details of any medications, allergies or adverse reactions

Are you currently taking Warfarin? ☐ Yes ☐ No If yes, latest INR result & date .....

List allergies or adverse reactions .....

List all medications and complementary medications you are currently taking

Drug	Dosage	Frequency

Attach a further list of medication details if the above space is insufficient

Signature ..... Print Name ..... Date .....

Sight Foundation Theatre Treatment Request

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 of the nature, likely results and material risks of the recommended procedure or treatment, as detailed below.

Reason for procedure .....

.....

Recommended site/procedure/treatment .....

.....

Practitioner Signature ..... Date .....

SECTION B – To be completed by PATIENT

Patient informed consent

Dr ..... and I have discussed my present condition and the various ways in which it may be treated. I understand or confirm that:

- The procedure or treatment carries some risks and 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 or treatment may not give the expected results, even though the procedure or treatment is carried out with due professional care.
- I understand the nature of the procedure and that undergoing the procedure or treatment carries risks.
- I have had the opportunity to ask questions and I am satisfied with the explanations and answers in response to my questions.
- My consent to this treatment includes consent for anaesthetics, blocks, medicines or other treatments that could be related to this procedure or treatment.
- Patients / next of kin / carers or other nominated substitute decision makers / legal guardians should confirm the following with their health fund prior to admission or as soon as practicable after admission: reimbursement rates for each of the expected charges in relation to the policy; if the planned admission or treatment is within a waiting or exclusion period for the policy; and if there is a gap payment for the treatment.
- I may withdraw my consent.

(optional)
I authorise disclosure of information to .....
name and contact phone number of authorised person

Signature ..... Print Name ..... Date .....

DOCTOR'S STICKER IF AVAILABLE

Sight Foundation Theatre Recommendation for Admission

To be completed by doctor

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Patient Details

Title ..... Surname ..... Given names .....

Address .....

Suburb ..... Postcode .....

Phone ..... Mobile .....

Sex ..... Date of Birth dd/mm/yyyy .....

Clinical Details

Provisional diagnosis .....

.....

Other conditions .....

Skin integrity .....

Allergies .....

Medications .....

Operation / Surgical Procedure

Proposed operation .....

Date of operation dd/mm/yyyy ..... Implant model .....

Item numbers ..... Anaesthetic ☐ Topical ☐ Regional ☐ LA ☐ GA

Allergies .....

Medications .....

Specific surgical requirements .....

.....

Doctor signature

Signature ..... Date .....

Referring practitioner ..... Referrer ☐ GP ☐ Optometrist ☐ Other

Address .....

Phone .....