Sight Foundation Theatre Pre-Admission Form

To be completed by patient or carer

Level 3, Sydney Eye Hospital, 8 Macquarie Street, Sydney NSW 2000
Email: info@sightfoundationtheatre.org.au
Phone: 02 9234 1999

Admission Details

Surgeon Dr _____ Admission date _____

Previous admission ☐ Yes ☐ No Previous admission date _____

Personal Details

Title _____ Given names _____

Surname _____

Street address _____

Suburb _____ Postcode _____

Mobile phone _____ Other phone _____

Sex _____ Date of birth _____

Email address _____

NSW Health Required Information

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

Country of birth _____ Languages spoken _____

Occupation _____ Pension number _____

Medicare # _____ Medicare reference _____ Expiry _____

Are you ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Private Health Insurance / Department of Veterans' Affairs / Workcover

Fund name _____ Membership no. _____

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

DVA number _____ Card type ☐ 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 have been advised that I should be accompanied home by a responsible adult, have someone with me the night of surgery and I will not travel home on public transport.

Signature _____ Print Name _____ Date _____

Sight Foundation Theatre Patient History
To be completed by patient or carer

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Medical History

Please tick any boxes below that apply to you

☐ Leg ulcers	☐ Kidney problems	☐ Blood clots/embolus	☐ Asthma
☐ Pacemaker	☐ Sleep apnoea	☐ Bleeding or bruising	☐ Arthritis
☐ Other prosthesis	☐ Creutzfeldt Jakob Disease	☐ Growth hormone	☐ Mental health disorder
☐ Contact dermatitis	☐ Glaucoma	☐ Organ transplant	☐ Persistent cough
☐ Latex/rubber allergy	☐ Tobacco user	☐ Recent dental work	☐ Infectious viral illness
☐ Pregnant	☐ Stroke	☐ Tuberculosis	☐ Seizures
☐ Dura mater graft	☐ Neurological disorder	☐ Pressure injury	☐ Spina bifida
☐ Dementia/ Brain Injury	☐ High blood pressure	☐ Other, please specify: _____	

How much do you weigh? _____ kg

Are you at risk of falling or fainting? ☐ Yes ☐ No

Do you have diabetes? ☐ Type I ☐ Type II ☐ No

Do you have vision in both eyes? ☐ Yes ☐ No

Do you have any issues with your heart? ☐ Yes ☐ No

Do you have an advance care plan or other treatment limiting order? ☐ Yes ☐ No

Do you or your family have a history of rapid onset dementia or memory loss? ☐ Yes ☐ No

Do you have an enduring guardian/ substitute decision maker ? ☐ Yes ☐ No

Do you have any allergies, or have you ever had an adverse reaction to medication? ☐ Yes ☐ No

Allergy details _____

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

List any current or recent illnesses _____

_____

List recent operations and dates _____

_____

Medications

Please list all medications and complementary medications you are currently taking

Drug	Dosage	Frequency

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

Signature _____ Print Name _____ Date _____

Sight Foundation Theatre Treatment Request

INTERAL USE ONLY

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SECTION A Provision of information to patient – To be completed by MEDICAL PRACTITIONER

I, Dr _____ have informed my 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 Patient informed consent – To be completed by PATIENT

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 surgeon 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 am aware that the final account will represent the actual procedures performed and the actual length of stay, and may not be confirmed until after discharge, when an additional amount may be payable as a result of any variations. I understand that benefits from my health insurance fund or other compensation arrangements may not fully cover the charges made by the Centre, and I hereby acknowledge my responsibility for any difference.
- I may withdraw my consent.

I authorise disclosure of information to (optional) _____
Name and contact phone number of authorised person

Signature _____ Print Name _____ Date _____

SURGEON'S STICKER IF AVAILABLE

Sight Foundation Theatre Recommendation for Admission

To be completed by Surgeon

Level 3, Sydney Eye Hospital, 8 Macquarie Street, Sydney NSW 2000
Phone: 02 9234 1999 Email: info@sightfoundationtheatre.org.au

Patient Details

Title _____ Given names _____

Surname _____

Street address _____

Suburb _____ Postcode _____

Mobile phone _____ Other phone _____

Sex _____ Date of birth _____

Clinical Details

Provisional diagnosis _____

_____

Other conditions _____

Skin integrity _____

Allergies _____

Medications _____

Operation / Surgical Procedure

Proposed operation _____

Date of operation _____ Anaesthetic ☐ Topical ☐ Regional ☐ LA ☐ GA

Implant model _____

Item numbers _____

Medications request _____

Surgical requirements _____

Surgeon Details

Signature _____ Date _____

Name _____ Practice Name _____