

**SIGHT FOUNDATION THEATRE  
PATIENT ADMISSION  
AND HEALTH HISTORY**

**Admission Details**

Surgeon: Dr \_\_\_\_\_ Admission Date: \_\_\_\_\_

Previous Admission: Yes / No Previous Admission Date: \_\_\_\_\_

**Personal Details**

Title: \_\_\_\_\_ Given Names: \_\_\_\_\_ Surname: \_\_\_\_\_

Sex: Male Female Other Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State \_\_\_\_\_ Postcode: \_\_\_\_\_

Mobile # \_\_\_\_\_ Alternative Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

**NSW Health Required Information (please circle correct response)**

Marital Status:

Single/ Never Married Married De facto Separated Divorced Widowed

Are you an Australian Resident? Yes / No

Country of Birth: \_\_\_\_\_ Languages Spoken at Home \_\_\_\_\_

Do you identify as: Aboriginal Torres Strait Islander Both Neither

Employment: Employed Home Duties Other Retired Student Unemployed

**Funding Details**

Do you have a valid Medicare Number: Yes No

Medicare Number \_\_\_\_\_ Reference No \_\_\_\_\_ Expiry date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Do you have Private Health Insurance: Yes, No Fund Name: \_\_\_\_\_

Membership No: \_\_\_\_\_ Is there an excess: Yes, No \$ \_\_\_\_\_

Do you have Department of Veterans' Affairs Entitlements

DVA Number: \_\_\_\_\_ Card Type: Gold Card White Card

Do you have a commonwealth concessional benefits card: Yes / No Number: \_\_\_\_\_

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**Next of Kin**

Title: \_\_\_\_\_ Given Names: \_\_\_\_\_ Surname \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

**Pick up person /overnight carer**

Title: \_\_\_\_\_ Given Names: \_\_\_\_\_ Surname \_\_\_\_\_

Same as next of kin? Yes No If no, Relationship to patient \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

I declare that the above information is accurate and correct. I agree to disclose health fund details and to pay all fees related to my hospital visit, including cases 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 understand that for safety purposes, non-recording closed-circuit cameras are in use in theatre and recovery areas, and I understand I will be monitored during my admission. I have been advised to be accompanied home by a responsible adult, have someone with me the night of surgery, and I will not travel home on public transport alone.

**Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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	Yes	No	If yes. please answer these questions. If no, please progress to the next question	Nursing notes
Have you had any recent surgeries or procedures? If so, please note.				
Operations				
CURRENT MEDICATIONS: including puffer, eye drop			CURRENT MEDICATIONS: including puffer, eye drops	
Do you take any of the following?				
-Anti-coagulant or blood thinning therapy e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaban, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor -Regularly take fish/cod oil, krill oil, garlic or ginkgo supplement -Semaglutide GLP-1RA's. e.g. Ozempic, Wegovy, Mounjaro, Victoza, Trulicity			Still take? Name: _____  Still take? No/Yes Day of weekly dose:	
Do you have a medical required or special diet e.g. diabetic, coeliac, disease, vegetarian, vegan, Kosher, Halal			Details:	
Do you have a history of smoking or vaping.?			Daily Amount: Ceased:	

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	Yes	No	If yes. please answer these questions. If no, please progress to the next question	Nursing notes
Do you drink alcohol			Daily Amount:  Ceased:	
What is your weight:        kgs  What is your height:        cm				Consult if BMI > 40
Do you use any prosthetics / aids e.g. aids for vision and hearing loss, walking sticks, other aids for daily living			Details:	Falls Risk Screen <input type="checkbox"/>
Do you live alone or are solely responsible for the care of another person at home			I have someone to look after me after discharge Y/N I receive community support/ aged care services. Y/N I have no carer after discharge Y/N	Discharge at risk <input type="checkbox"/>
Do you have someone to take you home from hospital home?				Discharge at risk <input type="checkbox"/>
Do you have a current Advance Health Directive  If yes, please supply a copy.				Copy provided <input type="checkbox"/>
Do you have an enduring power of attorney - health & medical guardian  If yes, please supply a copy.			Name:  Relationship:  Phone:	Copy provided <input type="checkbox"/>
<b>Do you have any known ALLERGIES/adverse reactions?</b>				
Are your Allergies to:  Medications			State:	Red File  Alert Sticker  <input type="checkbox"/>
Food	Yes	No		
Insect	Yes	No		

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Other	Yes	No		
You or a blood relative has had anaesthetic complications e.g. malignant hyperthermia or post-operative nausea and vomiting			Myself <input type="checkbox"/>  Family member <input type="checkbox"/>	
	<b>Yes</b>	<b>No</b>	<b>If yes. please answer these questions. If no, please progress to the next question</b>	<b>Nursing notes</b>
Blood pressure problems e.g. low, high, hypertension				
Cardiac conditions e.g. heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina				
Irregularities e.g. palpitations, irregular heartbeat, heart murmur, atrial fibrillation				
Cardiac surgery e.g. pacemaker, implants/devices, prosthetic heart valve, grafts, stents.			Year implanted	
Vascular disease e.g. carotid disease, aortic aneurysm, peripheral vascular disease.				
Elevated cholesterol, triglycerides				
<b>Do you have DIABETES?</b>				
Type 1 diabetes Type 2 diabetes			Controlled by: Diet    Insulin    Tablets	
History of cancer			Type:  Body Site:	
Hiatus hernia, gastrointestinal ulcers, reflux				
Liver disease, hepatitis (e.g. A, B, C), jaundice, cirrhosis				


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Stoma or bowel disease e.g. Crohn's, IBS				
Kidney disease, dialysis, renal impairment				
Bladder problems or habits, stoma, incontinence, urinary retention				
	<b>Yes</b>	<b>No</b>	<b>If yes. please answer these questions. If no, please progress to the next question</b>	<b>Nursing notes</b>
Blood clot in lung / legs (DVT / PE)			Year:	
Blood or bleeding disorders e.g. anaemia			Details:	
Neuromuscular diseases e.g. MS, myasthenia, dystrophies, Parkinson's. Stroke, mini stroke, TIA Limb paralysis or weakness			Impairments:	Falls risk screen <input type="checkbox"/>
Fear of falling, unsteady or fallen in last 6 months				
Epilepsy/fits, faints, blackouts, dizziness, seizures				
Speech or swallowing problems e.g. coughing when eating / drinking				
Have you been diagnosed with dementia, Alzheimer's, Brain injury short term memory loss				Cognitive risk screen/4at <input type="checkbox"/>
Difficulties with problem solving, attention span, understanding, post-surgery confusion  Other neurological problems e.g. meningitis, migraine, polio				
Do you have/had any BREATHING problems (see conditions below) Asthma, pneumonia, hay fever, asbestosis, bronchitis, emphysema,			Details:	

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Chronic Obstructive Pulmonary disease (COPD) Shortness of breath e.g. walking more than 50m, climbing stairs/inclines				
Sleep apnoea, disturbed sleep, snoring Other lung problems e.g. tuberculosis				
	<b>Yes</b>	<b>No</b>	<b>If yes. please answer these questions. If no, please progress to the next question</b>	<b>Nursing notes</b>
Prosthetics/Aids/Other hearing aids/appliance or implants Dentures other aids for daily living e.g. artificial limbs use of mobility aid e.g. walking stick, frame etc			Please bring with you on day of surgery.	
Diagnosed Mental Health condition e.g. Depression, Anxiety, Bipolar PTSD,				
Thyroid conditions				
Dental Surgery in the previous 4 weeks?			Date Type	
<b>Other Medical Conditions</b>				
Ever had MRSA, VRE, CRE or ESBL			Date:	Infection Policy Check
Do you currently have any open wounds or breaks on your skin			If so, where?	Skin Wound Form <input type="checkbox"/>
Do you have any other conditions or skin infections				
Had contact with anyone with an acute respiratory infection/illness in the past 7 days				
Had a fever or respiratory symptoms e.g. cough, sore throat, runny nose				
CJD screening				

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Can we make the day of surgery more stress-free for you?				
I confirm that the information completed in this form is correct			Signature:	Date:
HOSPITAL INFORMATION				
By ticking the following box I acknowledge that I have read and understood the information contained within the following:  Hospital Information (including admission, general information and about no responsibility accepted for patient valuables)			<b>Private Patient's Hospital Charter Your right to privacy under the Privacy Act</b>	

For readmission within 6 months of above date please complete on day of surgery

There has been nil change in my health history since my last admission

There following changes have occur:

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Signed

Date: