



PATIENT ADMISSION FORM AND QUESTIONNAIRE

Patient's name:

Admission date:

Admission time:

Fast from:



57 GREENHILL ROAD
WAYVILLE SA 5034

T 08 8373 1300
F 08 8373 1277

admin@vistadaysurgery.com.au
www.vistadaysurgery.com.au

SAFETY AND QUALITY

INFECTION PREVENTION AND CONTROL

Vista Day Surgery has a comprehensive infection prevention and control program in place. Our facility and staff are regularly audited for compliance with national infection prevention and control guidelines, Australian Standards for reprocessing of reusable instruments (AS 4187) and the Australian Commission of Safety and Quality in Healthcare [ACSQHC] National Safety and Quality Health Service Standards.

HAND HYGIENE AUSTRALIA PROGRAM

Vista Day Surgery is committed to the Hand Hygiene Australia program and conducts regular audits to ensure compliance.

CLINICAL INDICATORS

Clinical indicators are measures of elements of clinical care which may, when assessed over time, provide a method of assessing the quality and safety of care. Vista Day Surgery collect a number of clinical indicators that can be benchmarked against published data. These include:

- Failure to arrive
- Unplanned overnight admission
- Unplanned delay in discharge
- Cancellation after arrival due to pre-existing medical condition, acute medical condition/administration or organisation reason
- Medication error/Adverse drug reaction
- Unplanned return to operating room
- Hospital acquired infection
- Patient fall

DISCHARGE INFORMATION

Vista Day Surgery provides comprehensive information both before and after your surgery to assist patients to be fully informed, prepared and in control of your planning for discharge and post discharge follow up.

PATIENT FEEDBACK

All patients are given the opportunity to provide feedback, formally and informally. This feedback is treated with the utmost confidentiality and may be provided anonymously. Your opinion is important to us so when you receive a survey, we encourage you to take the time to fill it in.

All feedback is de-identified and tabled at our Day Surgery meetings as well as our Medical Advisory Committee.

HOW CAN YOU HELP US MANAGE SAFETY AND QUALITY?

We value our patients and their carers. Please feel free to let one of the staff know if you would like to assist with reviewing any of our Safety and Quality initiatives.

WOULD YOU LIKE FURTHER INFORMATION?

Our Director of Clinical Services, Carina Mathiasen, will be very happy to discuss any questions or concerns you may have with our Safety and Quality. She can be contacted by phone 8373 1300 or email cmathiasen@vistadaysurgery.com.au

RIGHTS AND RESPONSIBILITIES

My Rights:

- I can access services to address my healthcare needs.
- I receive safe and high quality health services, provided with professional care, skill and competence.
- The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
- I receive open, timely and appropriate communication about my health care in a way I can understand.
- I may join in making decisions and choices about my care and about health service planning.
- My personal privacy is maintained and proper handling of my personal health and other information is assured.
- I can comment on or complain about my care and have my concerns dealt with properly and promptly.

My Responsibilities:

- Answer questions about my health honestly and completely.
- Comply with discharge instructions or inform Medical and/or Nursing staff if you do not intend to do so.
- Be courteous, considerate and respectful towards others.
- Respect the privacy of others.
- Fulfil your financial obligations.
- Raise concerns if you are unhappy with services.

PRIVACY INFORMATION

The privacy of your personal information is important to us at Vista Day Surgery and we are committed to ensuring it is protected. Vista Day Surgery complies with the Australian Privacy Principles in relation to the management of personal information.

The health information collected by Vista Day Surgery assists in providing a health service to you. Typically, it includes information relating to your symptoms, examination, test results, diagnosis, treatment, and care information as well as admission and registration information. Vista Day Surgery proposes to collect health information from you for the following purposes:

- To process your registration, admission and discharge,
- To ensure that each health care professional involved in your care has all the facts relating to your consultation and/or procedure.

The intended recipients of your health information are:

- Staff involved in your care at Vista Day Surgery,
- Data service providers engaged by Vista Day Surgery from time to time,
- Department of Human Services, other governmental departments or legal entities, where disclosure is obliged by law, and
- Staff at selected pathology and/or radiology services if required.

The supply of the information by you is voluntary, except where required by law. However, should you not supply the information, or supply only part of it, this may compromise your future care or treatment, particularly where the information is necessary for your required care or treatment. If you have already provided information and consent for its use and disclosure, but you have changed your mind, you can make written application to revoke your earlier consent.

You have the right to request access to, and request correction of, your health information in accordance with the relevant legislation.

Further information about these procedures, patients' rights, responsibilities and our complaints process is available in our reception area at Vista Day Surgery.

Alternatively, they can be obtained from our Director of Clinical Services upon request:

57 Greenhill Road, Wayville South Australia 5034

P 08 8373 1300 **F** 8373 1277 **E** admin@vistadaysurgery.com.au

PATIENT INFORMATION

PRE-ADMISSION INFORMATION

Pre-admission is an important part of your Day Surgery care. To ensure we can confirm your admission, financial and other arrangements we ask that:

- You complete ALL the questions on the tear out forms on page 5 to 8.
- Your doctor completes the Consent forms.

Forward the completed forms no less than 7 days prior to your admission to Vista Day Surgery in one of the following ways:

- In person or post:

Vista Day Surgery
Level 2, 57 Greenhill Road
Wayville, SA, 5034

- Fax: (08) 8373 1277
- Email: admin@vistadaysurgery.com.au

If you require any assistance, please contact staff at Vista Day Surgery who will be happy to help you.

PRE-ADMISSION TELEPHONE CALL - NURSE

Once we receive your completed admission forms, an Admissions Nurse will contact you to confirm your admission details and discuss the information you have provided and any special requirements.

PRE-ADMISSION TELEPHONE CALL - ADMINISTRATION

An Administration staff member will contact you to confirm your Health fund cover and discuss any relevant out of pocket expenses. All excesses attached to your hospital fund are paid on the day of surgery and are an out of pocket fee (not rebatable).

ON DAY OF ADMISSION

Please ensure you have the following with you on admission:

- Health Fund card
- Medicare card
- Pension / Concession card
- Medications in original packaging
- Wear comfortable clothing.
- Please wear non-slip footwear.

On arrival you should go directly to the Reception counter on Level 2.

We plan to admit you as close as possible to your procedure time. However to enable staff to prepare you adequately for your procedure there may be a waiting time between your admission and procedure time.

On admission, the nursing staff will interview you to complete your admission and administer any medication if required.

You will then be shown to the admissions area where the Anaesthetist will see you prior to your procedure.

Do not...

- Bring valuables as Vista Day Surgery does not accept liability for any items brought into the facility.
- Wear jewellery (wedding ring is permitted but will be taped during procedure)
- Wear make-up.

SPECIAL NEEDS

Please ensure you advise the Admission Nurse when they contact you if you have any special needs such as specific dietary requirements, any Treatment Limiting Orders or Advanced Care Directives.

CHILDREN HAVING SURGERY

Our staff will ensure the special needs of your child are met. A favourite toy or teddy bear may help your child to feel more comfortable.

A parent or guardian must remain with the child in the waiting room and will then be invited to rejoin their child after surgery in the recovery room, once they are settled.

We cannot allow you to have other children with you during these times. If available, a second adult is a good idea for the journey home, as your child may still require your comfort.

A pre-operative visit to Vista Day Surgery can be arranged so that your child may feel more familiar with the surroundings.

INSTRUCTIONS FOR PATIENTS HAVING GENERAL OR IV SEDATION ANAESTHESIA

Fasting

You must have nothing to eat and drink six (6) hours before your admission time. This includes gum, lollies, milk, coffee etc. You can have a glass of water (200mls) up to four (4) hours before your admission time unless otherwise directed by your doctor or nurse during your pre-admission telephone call.

Time in hospital

You will be required to stay in hospital until you are clinically fit for discharge. This time varies from person to person, though on average you will be in Recovery for 1-2 hours after your operation.

Transport home

You must have a responsible adult drive you home and stay with you overnight. This is for your own safety as you may be lightheaded after your surgery.

Taking care at home

Following surgery, a small degree of anaesthetic may still circulate in your body for up to 24 hours. This means:

- Do not drive a vehicle or operate machinery.
- Do not take sedatives unless prescribed by your doctor.
- Do not drink alcohol for 24 hours post discharge.
- Do not sign any legal documents for at least 24 hours post discharge.

On discharge, you will be given written instructions which you can refer to during your convalescence.

INSTRUCTIONS FOR PATIENTS HAVING LOCAL ANAESTHESIA

Fasting

You do not need to fast before a local anaesthetic. Have a light breakfast or lunch before you come to hospital.

Time in hospital

Following your procedure you will stay in the Recovery area of the day surgery until you are able to go home. The average stay is about 30 minutes following a local anaesthetic.

Transport home

Because of the nature of the surgery, it is strongly advised that you have someone available to collect you from the hospital and drive you home.

ACCOUNTING FEES

You may choose to contact your health fund although Vista Day Surgery will also be contacting your health fund to confirm your details prior to your admission.

Details which will be confirmed include:

- Your level of health cover adequately covers the cost of the accommodation, procedure and prostheses if required.
- If an excess / co-payment is payable for your admission.

If you have been a member of your health fund for less than twelve months your fund may not accept liability for the costs of your admission, e.g. in the case of pre-existing conditions prior to your joining.

Your health fund has the option to obtain details from your GP or specialist.

Please note that the surgeon fee, surgical assistance (if relevant), pathology (if relevant) and anaesthetic fees will be billed separately by the practitioner/service.

PAYMENT PROCEDURE

- Private patients: a claim will be made directly to your health fund. Any excess or co-payment must be paid on admission.
- On the completion of a Health Fund check with your insurance company and it is found that you have not served your 12 months waiting period you will be required to pay all expenses associated with your procedure prior to admission – please advise your health fund of your upcoming admission to Day Surgery.
- Veterans' Affairs patients: the Day Surgery will lodge a claim on your behalf.
- Workcover / Third Party patients: total payment must be made on admission unless written approval for admission has been received from the insurer.
- Uninsured patients: total estimated payment must be paid on admission.

PAYMENT MAY BE MADE BY:

Bank Cheque (we do not accept Personal Cheques), Credit Card or EFTPOS.

If you intend to pay your account using EFTPOS, please check your daily limit as most banks have a daily limit of \$1,000.

If you have any questions about the admission procedures, completion of forms, costs or health insurance status, our staff will be happy to assist you. Phone (08) 8373 1300.

AFFIX PATIENT LABEL HERE

ADMISSION FORM

Admitting Doctor:

Admission Date: / / Time:

PREVIOUS ADMISSIONS

Have you previously been admitted to Vista Day Surgery? No Yes If yes, year:

PERSONAL DETAILS

Title: Mr Mrs Ms Miss Other:

Surname:

Given Name(s):

Residential Address:

Suburb:

State: Postcode:

Postal Address (if different):

Suburb:

State: Postcode:

Email address:

Telephone: Home:

Business:

Mobile:

Preferred contact number for pre-operative phone call:

Preferred time:

Sex: M F Date of Birth: / / Age:

Occupation:

Marital Status: Single Married De facto
 Separated Divorced Widowed

Nationality:

Language spoken at home:

Are you of Aboriginal or Torres Strait Islander descent?

No Yes If yes, Aboriginal Torres Strait Islander
 both Aboriginal and Torres Strait Islander

Religion:

PERSON COLLECTING YOU FROM VISTA DAY SURGERY

Name:

Relationship to patient:

Address:

Suburb:

State: Postcode:

Telephone: Home:

Business:

Mobile:

SECOND CONTACT PERSON

Name:

Relationship to patient:

Address:

Suburb:

State: Postcode:

Telephone: Home:

Business:

Mobile:

PERSON RESPONSIBLE FOR ACCOUNT

Is the Patient responsible for this account?
 No (complete this section) Yes (go to next question)

Name:

Relationship to patient:

Telephone: Home:

Mobile:

Other:

PTO

PLEASE FOLD THEN TEAR ALONG PERFORATION

AFFIX PATIENT LABEL HERE

ENTITLEMENTS

Medicare Card Number:

Reference No:

Expiry Date: / /

Pension/Health Care Card Number:

Safety Net No:

Expiry Date: / /

Veteran Affairs Number:

Card Colour: White Gold

HOW WILL YOU CLAIM FOR THIS ADMISSION?

(Please tick one box only)

- Private Health Insurance (complete **Section A** and **C**)
- Workcover/Third Party (complete **Section B** and **C**)
- Repat/Veterans' Affairs (complete **Entitlements** – above, and **Section C**)
- Uninsured (complete **Section C** only)

SECTION A: PRIVATE HEALTH INSURANCE

Name of fund:

Membership Number:

Table:

Excess (if applicable): \$

Co-Payment (if applicable): \$

Are you aware of the excess: Yes No

All excesses attached to your health fund are to be paid on the day of surgery and are an out of pocket expense (not rebatable)

Length of membership on this table: Over 12 months
 Less than 12 months

SECTION B: WORKCOVER OR THIRD PARTY (IF APPLICABLE)

Workcover Third Party Claim

Insurance company:

Date of Injury/Accident: / /

Address of Insurance Company:

Claim number:

Claim Manager:

Employer (Workcover only):

Expiry date: / /

SECTION C: PAYMENT OF ACCOUNT

All patients to complete.

By signing this form I acknowledge that:

- I certify that the information contained on this form is true and correct to the best of my knowledge.
- I understand that Vista Day Surgery will not accept any responsibility for loss or damage to patients' valuables.
- I have read and understood the information, and accept the conditions, set out in this form, and have no further questions.
- I agree to sign a patient Estimate of Expenses form on admission.
- I understand the costs are estimates only and subject to change as a result of variations in the actual treatment received.
- I understand that other service providers may be involved in my care and this estimate does not include those fees.
- I acknowledge that it is my ultimate responsibility to confirm with my health insurer the level of cover held.
- I accept responsibility for full payment of all amounts for hospital fees and charges not funded by my insurer, and will finalise payment at time of admission.

Signature of patient/parent/guardian:

Name of patient/parent/guardian:

Date: / /

Address:

PLEASE FOLD THEN TEAR ALONG PERFORATION

HEALTH QUESTIONNAIRE

PLEASE PRINT CLEARLY AND ENSURE ALL QUESTIONS ARE COMPLETED

Patient's Name:

Address:

Postcode:

Date of Birth: / /

Have you ever had a reaction to:

DRUGS: Yes No Details:

FOOD: Yes No Details:

LATEX: Yes No Details:

OTHER: Yes No Details:

PHYSICAL DETAILS

What is your weight?: kilograms

What is your height?: centimetres

ANAESTHETICS

Have you had an anaesthetic before? Yes No

Have you, or any blood relatives, had problems with anaesthetics in the past? Yes No

PREVIOUS OPERATIONS

Have you had any previous operations? Yes No

Details:

CARDIAC:

Have you ever had a heart attack? Yes No If yes, year:

Have you ever had heart surgery? Yes No If yes, year:

Do you have a pacemaker/internal defibrillator? Yes No

Make: Model: Last checked:

Do you have a prosthetic heart valve? Yes No

Do you have cardiac stents? Yes No

Type: Bare Metal or Drug Eluting Date implanted:

Do you have angina? Yes No

Do you use: Glycerol Trinitrate Patches? Yes No

Do you use: Sublingual Spray? (If yes, please bring it with you) Yes No

Do you have any other heart problems? Yes No

If yes, specify:

Do you have palpitations? Yes No

Do you have an irregular heart beat? Yes No

Do you have Rheumatic fever? Yes No

Do you have a tendency to bleed, clot or bruise easily? Yes No

Have you ever had high blood pressure? Yes No

RESPIRATORY:

Do you smoke? Yes No

Daily amount: Date ceased: / /

Do you have Asthma? Yes No

Do you have Bronchitis? Yes No

Do you have Hay Fever? Yes No

Do you have Emphysema? Yes No

Do you have Sleep apnoea? Yes No

Do you use a nebuliser, puffer or EPAP/CPAP machine or home Oxygen? (please bring puffers with you) Yes No

Have you ever had throat, nose or lung surgery? Yes No

DIABETES:

Do you have diabetes? Yes No

If yes: Type I Type II Unsure

Controlled by: Diet Tablet Insulin

If you take insulin has your Doctor given you instructions regarding your Diabetic Medication? Yes No

If no, please call them for advice.

GASTROINTESTINAL:

Have you ever suffered from reflux or heart burn? Yes No

Do you have hiatus hernia/gastrointestinal ulcers? Yes No

Do you have any special dietary requirements? Yes No

Do you have a gastric band in place? Yes No

If yes, is your admitting surgeon aware of this? Yes No

PTO

PLEASE FOLD THEN TEAR ALONG PERFORATION

SKELETAL / MOBILITY:

Do you have Back/Neck/Jaw problems? Yes No

Have you ever had Back/Neck/Jaw surgery? Yes No

Do you have arthritis? Yes No

Have you experienced fainting, dizziness or fallen in the last 12 months? Yes No

Do you use a walking stick? Yes No

Do you use crutches? Yes No

Do you use a walking frame? Yes No

Do you have problems weight bearing? Yes No

Do you use a wheel chair? Yes No

How many people need to help you transfer from your wheelchair? _____

PROSTHESIS / AIDS:

Do you wear glasses / contact lenses? Yes No

Hearing Aid or other hearing appliance? Yes No

Dentures/Caps/Crowns/Loose teeth? Yes No

Artificial joints or limbs? Yes No

Metal plates or pins? Yes No

Body piercing? Yes No

OTHER:

Have you ever tested positive to Hepatitis A, B or C, HIV, TB, MRSA, VRE or CRE? Yes No

Please specify: _____

Do you have an intellectual disability? Yes No

Do you have Alzheimer's/Dementia? Yes No

Female patients, could you be pregnant? Yes No

Number of weeks: _____

Do you drink alcohol? Yes No

Daily amount: _____

Have you ever had a stroke? Yes No

Date: / / Residual problems: _____

Do you suffer from migraines? Yes No

Have you had a recent cold, flu or unexplained temperature? Yes No

Do you have or have you been exposed to an infectious disease in the past 14 days? (e.g. Chickenpox, Measles) Yes No

Do you have any other medical or surgical problems? (e.g. Epilepsy, Liver, Kidney, Psychiatric) Yes No

Please specify: _____

Have you ever been diagnosed with cancer? Yes No

If yes, type of cancer: _____

Year diagnosed: _____

Do you currently have any skin wounds, pressure sores or skin ulcers? Yes No

Please specify: _____

Do you require an interpreter? Yes No

Language spoken at home: _____

Do you have someone to interpret for you? Yes No

Name of person: _____

ASSESSING RISK OF CJD:

Do you have a family history of two or more first-degree relatives with Creutzfeldt-Jakob disease or other unspecified progressive neurological disorder? Yes No

Have you had a dura mater graft prior to 1989? Yes No

Have you received human pituitary derived gonadotrophin or growth hormone prior to 1986? Yes No

Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed? Yes No

AFFIX PATIENT LABEL HERE

MEDICATIONS (A PRINT OUT FROM YOUR GP IS SUFFICIENT)

Do you take any blood thinning/arthritis medication? (e.g. Warfarin, Plavix, Asprin) Yes No

Name of medication: _____

Have you been instructed to cease this medication? Yes No

Date last taken: / / Or still taking: _____

If NO please call your Doctor for advice, as these medications may need to be stopped prior to admission.

Please list any medications you take (prescription, non-prescription including herbal - Krill Oil, Echinacea, Olive Leaf / vitamins / recreational):

FOR PATIENTS WHO WILL HAVE A GENERAL ANAESTHETIC OR IV SEDATION:

Following surgery I will have a responsible adult drive me/ accompany me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia.

I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.

Signed: _____

Date: / /

FOR ALL PATIENTS:

I have read and understood the information for my visit on pages 2-8. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information. I agree and consent to Vista Day Surgery collecting and using personal information about me for these purposes.

Signed: _____

Date: / /

If you require assistance or have any questions regarding the admission procedures, completion of forms, costs or health insurance status, our staff will be happy to assist you.

PLEASE FOLD THEN TEAR ALONG PERFORATION

CONSENT FORM

CONSENT TO MEDICAL PROCEDURE(S) AND/OR TREATMENT

1. PATIENT CONSENT TO MEDICAL PROCEDURE(S) AND/OR TREATMENT

I, (being the Authorised Person)
(print full name)

being the patient, or parent, or guardian of
(print the name of patient above if the Authorised Person is the patient's parent or guardian)

acknowledge that:
(name of medical practitioner)

- has:
1. explained to me the nature, consequences and risk of the proposed medical procedure(s) and/or treatment;
 2. explained to me the likely consequences of not undertaking the treatment;
 3. given me the opportunity to ask questions about the medical procedure(s) and/or treatment and I am satisfied with the explanation and the answers given to me;
 4. explained any alternative treatment or courses of action that might be reasonably considered in the circumstances;
 5. told me that the procedure(s) and/or treatment may not give the expected result even though the same is carried out with due care and skill; and
 6. told me of the nature, purpose and likely results of the following medical procedure(s) and/or treatment:

Name of procedure(s)/treatment:

Reason for procedure(s)/treatment:

- I also understand that other procedures, including blood transfusions, may be necessary or advisable to be performed during the course of the procedure(s) and/or treatment, whether expected or unexpected.
- I acknowledge that the nature, consequences and risks of those other procedures have been fully explained to me by the above named medical practitioner and I consent to the other procedures being performed at the same time, with the exception of:

.....
(insert other procedures not consented to e.g. blood transfusion, if applicable or Not Applicable)

- I also consent to a sample of blood being taken for infectious disease screening (including a HIV test) if a Vista Day Surgery staff member is exposed to my/the patients (as applicable) body fluids prior to, during, or following the procedure(s) and/or treatment. I understand that should blood test results confirm that I am/the patient is (as applicable) suffering from HIV or some other notifiable condition, the test results will be reported to SA Health in accordance with section 64 of the *South Australian Public Health Act 2011*.
- I consent to undergoing/the patient undergoing (as applicable) the above procedure(s) and/or treatment and continues in effect including for subsequent admissions until 12 months from date of consent. I understand that I may withdraw my consent at any time.

Authorised Person's Signature: Date: / /

Medical Practitioner's Signature: Date: / /

2. CONSENT TO ANAESTHETIC PROCEDURE (IF APPLICABLE)

I, being the Authorised Person, have had the nature, consequences and risk of an anaesthetic procedure explained to me by:

Name of medical practitioner:

I understood and am satisfied with the explanations that I have been given and I consent to undergoing/the patient undergoing (as applicable) the anaesthetic procedure.

Authorised Person's Signature: Date: / /

Medical Practitioner's Signature: Date: / /

3. CONSENT VIA INTERPRETER (IF APPLICABLE)

I, (Full name of interpreter)

have given a verbal translation of this form relating to consent to: Procedure(s)/treatment Anaesthetic procedure
in the language that the Authorised Person understands, which is:

Interpreter's Signature: Date: / /

