St Vincent's Private Hospital
406 Victoria Street, Darlinghurst NSW 2010
Telephone (02) 8382 7111 Fax 8382 7220

PRE-ADMISSION INFORMATION

PLEASE COMPLETE THE PREADMISSION INFORMATION AND RETURN TO THE HOSPITAL AT THE ABOVE ADDRESS OR FAX ALL PAGES NO LATER THAN 72 HOURS PRIOR TO ADMISSION. WITHOUT THIS INFORMATION THE HOSPITAL CANNOT CONFIRM YOUR BOOKING

Have you been a patient at St Vincent's Private Hospital, Day Surgery or Cardiac Catheter Centre?

No ☐ **If yes, do you know the year of your previous admission** ____________________

Your Accommodation Preference : ☐ **Single** ☐ **Shared** (2 bed) (preference cannot always be guaranteed)

ADMISSION DETAILS

Date you are being admitted ______________ **Name of Admitting Doctor** ______________________

Your title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms Other ______________________

Surname______________________ **Given Name** ______________________

Surname last admission ☐ Unchanged **Previous Name** ______________________

Date of Birth ______________ **Religion** ______________________ **Sex** ☐ Male ☐ Female

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Defacto

Address ____

______________________________ **Post Code** __________

Contact Numbers
H
W
M

Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Country of Birth ______________________ Year of arrival in Australia [ ] ☐ N/A

Do you require an interpreter? ☐ No ☐ Yes **Language spoken at home**

PERSON TO NOTIFY / NEXT OF KIN ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

Person for notification ______________________**Relationship**______________

Address ______________________ **Post Code**______________

Contact numbers
H
W
M

Is the next of kin the same person? ☐ Yes ☐ No - if no please complete

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

Next of Kin ______________________ **Relationship** ______________

Address **Post Code**

Contact numbers
H
W
M

Please tick ☐ if you **DO NOT** want your GP contacted

Family Doctor (GP) **Suburb**

Contact Number

Are you entitled to Government Pharmaceutical Benefits ☐ **No** ☐ **Yes**

Type of Card **Pension Number** **Expiry Date**

HEALTH FUND DETAILS

Health Fund: ______________________ **Membership Number** ______________________

Medicare Number	First number					space						space		Expiry Date

Signed ______________________________ **Date** ______________________

*** ***ALL PATIENTS - Please turn the page, read & complete the sections overleaf*** ***

DAY SURGERY PATIENTS PLEASE NOTE – IF GOING HOME ON THE DAY OF SURGERY:

All Patients who have an anaesthetic (general or sedation) **MUST** have a responsible adult to collect them from Day Surgery and accompany them home. As a guide most patients are discharged 4 hours after their admission. Either you or the staff in DSU can contact your escort when you are ready to go home or they may like to wait for you.

IF YOU FAIL TO COMPLY WITH THESE SAFETY REQUIREMENTS, YOUR SURGERY WILL BE POSTPONED UNTIL ANOTHER DAY WHEN YOU ARE ABLE TO PROVIDE AN ESCORT TO TAKE YOU HOME

I HAVE ARRANGED FOR A RESPONSIBLE ADULT TO ACCOMPANY ME HOME ☐ **YES**

I AM AWARE THAT I SHOULD HAVE SOMEONE TO STAY WITH ME OVERNIGHT AFTER SURGERY ☐ **YES**

Signed .... Please print name ....

Name of person collecting me .... Phone ....Fax ....

Coming from outside Sydney: please provide details of accommodation in Sydney and all contact telephone numbers including facsimile number

ST.VINCENT'S PRIVATE HOSPITAL - CONSENT TO USE PERSONAL INFORMATION

St Vincent's Private Hospital is values based organisation and is committed to ensuring that it complies with the Health Records and Information Privacy Act 2002 (NSW) (HRIP Act) which protects the privacy of health information in New South Wales. We also respect and will uphold your right to privacy protection under the National Privacy Principles contained in the Privacy Act 1988. The National Privacy Principles prohibit the use of personal information in the event that you do not consent to the use of such information for those purposes. You are under no obligation to provide consent to the use of your personal information for any of the purposes described below. In the event that you do not consent, we will respect your wishes and will not use the information for that purpose in any identified format.

*If you **DO NOT CONSENT** to the use of your information for any of the following purposes, please indicate by TICKING the relevant box and signing the form.*

Any TICKED box indicates that consent is not given for that purpose:

☐ To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted the medical practitioner or institution about. This may include forwarding relevant prior information e.g. anaesthesia records.

☐ To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.

☐ To assist in the development of service delivery and planning in facilities owned and operated by St Vincent's Private Hospital.

☐ For research and development projects undertaken by St Vincent's Private Hospital in its own right or in conjunction with other organisations.

☐ To assist the Health Care Provider in providing practical training and education to medical, nursing and other allied health students.

☐ To assist the Health Care Provider in undertaking quality improvement activities.

☐ To enable the Health Care Provider to provide members of Returned Service Organisations and Ministers of Religion with sufficient details to enable them to visit me whilst I am a patient in this facility.

☐ To enable the Health Care Provider to provide access to my information to the Health Fund of which I am a member if requested by the Health Fund to do so.

☐ To receive educational materials on the condition I am being treated for at St Vincent's Private Hospital.

☐ To communicate promotional offers, special events or marketing initiatives to me.

☐ To contact me and invite me to make a contribution to or assist in fundraising activities.

☐ To clinical photographs and other images being taken for the purpose of clinical assessment and treatment of me/the patient. I also understand and agree that, unless I have indicated otherwise, the images may be used for teaching, training and research in a form that cannot identify me/the patient

** Irrespective of any request received, I direct you **NOT to provide my personal information to**:

specify name/details below

Name ....

I give consent to the use of my information as described, I understand I can withdraw my consent at anytime.

Signed (patient) ______________________________ Print name in full ____________________

Dated this Day of 20.....

St Vincent's Private Hospital

DAY SURGERY UNIT

PREADMISSION HEALTH QUESTIONNAIRE

Surname ______________________

Given name ______________________

DOB ____________ Doctor ______________

Date of Procedure ______________________

Please complete this form & mail it in the reply-paid envelope to the Hospital 72 hours prior to your admission or fax all pages to: 02 8382 6330

MEDICAL HISTORY (please answer all questions by ticking yes or no in the appropriate box)					
Have you ever had or now have:	**Yes**	**No**	***Have you ever had or now have:***	**Yes**	**No**
Heart trouble	☐	☐	Blood clots in: ☐ legs or ☐ lungs	☐	☐
Heart attack	☐	☐	Anaemia or other blood disorders	☐	☐
Chest pain or angina	☐	☐	Bruising or bleeding problems	☐	☐
High blood pressure	☐	☐	Indigestion or heartburn	☐	☐
Rheumatic fever	☐	☐	Acid reflux or hiatus hernia	☐	☐
Palpitations	☐	☐	Stomach or duodenal ulcer	☐	☐
Heart murmur or artificial valve	☐	☐	Gall bladder trouble	☐	☐
Shortness of breath	☐	☐	A stroke	☐	☐
Asthma	☐	☐	Fits or epilepsy	☐	☐
Collapsed lung	☐	☐	Funny turns or fainting	☐	☐
Have you had a cold or flu recently	☐	☐	Muscle weakness	☐	☐
Do you have a cough or bronchitis	☐	☐	Sleep apnoea	☐	☐
Do you have Arthritis Type : ☐ rheumatoid ☐ osteo ☐ gout ☐ neck or ☐ back problems	☐	☐	Are you or could you be HIV positive Ladies, are you or could you be pregnant	☐ ☐	☐ ☐
Kidney trouble: Type ☐ failure ☐ stones ☐ dialysis ☐ infection	☐	☐	Have you ever had a blood transfusion. If yes, year:	☐	☐
Diabetes, if yes, how is it controlled ☐ diet ☐ tablets ☐ insulin Year diagnosed:	☐	☐	Liver problems: ☐ cirrhosis ☐ jaundice Hepatitis: ☐ A ☐ B ☐ C ☐ D ☐ E Year diagnosed:	☐ ☐	☐ ☐
Cancer: type ______________ Year diagnosed:	☐	☐	Organ transplant: Type: Year:	☐	☐
Do you have any implanted medical devices e.g. ☐ pacemaker ☐ joint replacement Other please specify:	☐	☐	Any history of multi-resistant organism (e.g. MRSA Golden Staph) Location on body .... Hospital location Year:	☐	☐
Have you ever had a fall Were you injured, If yes, how	☐ ☐	☐ ☐	Do you fall often Are you unsteady on your feet	☐ ☐	☐ ☐
Do any serious medical problems run in your family (e.g. blood clots) Parkinson's disease?	☐ ☐	☐ ☐	*Do you have Creutzfeldt- Jacob Disease (CJD)* *Have you had Human Pituitary Growth Hormone prior to 1985* *Have you had neurosurgery prior to 1985*	☐ ☐ ☐	☐ ☐ ☐

Is there any other relevant medical history?

SURGICAL HISTORY			
Please list any previous operations and the year - start with the latest first	**Year**		**Year**

PTO

Operation	Year		Year

ANAESTHETIC HISTORY

	Yes	No
Have you or a member of your family had any problems with anaesthetics e.g. difficult intubation or malignant hyperpyrexia	☐	☐
Have you had problems with nausea or vomiting after anaesthetics	☐	☐
Do you suffer from travel sickness or motion sickness	☐	☐

DRUGS & MEDICATIONS

Have you ever taken	Yes	No	***Have you ever taken***	Yes	No
Drugs for diabetes	☐	☐	Drugs for asthma	☐	☐
Drugs for heart trouble	☐	☐	Drugs for arthritis / anti-inflammatories	☐	☐
Drugs for high blood pressure	☐	☐	Drugs for nerves or sleeplessness	☐	☐
Drugs to stop blood clotting	☐	☐	Drugs for depression	☐	☐
Any cortisone in the last 6 months	☐	☐	Drugs for any psychological condition	☐	☐

Current medications: please list tablets, capsules or injections you take. Include aspirin, oral contraceptives, naturopathic remedies, vitamins and products from the health food store or any "recreational drugs"

Medication	Strength	Route eg oral	Dose	Frequency Morning	Midday	Evening	Night	Date & time last taken

ALLERGIES & ADVERSE REACTIONS

☐ **I HAVE NO KNOWN ALLERGIES (please tick)**

☐ **I AM ALLERGIC TO :** **TYPE OF REACTION**

☐ **I HAVE A LATEX ALLERGY:** ***if yes, is the reaction:***

Immediate and severe (a reaction known as anaphylaxis)	☐ Yes	☐ No
A rash	☐ Yes	☐ No
Unsure of the type of reaction	☐ Yes	☐ No

GENERAL HEALTH AND LIFESTYLE

	Yes	No	
Do you smoke	☐	☐	If yes, how many cigarettes a day do you smoke:
Have you ever smoked	☐	☐	If yes when did you give up:
Do you drink alcohol	☐	☐	If yes, how much & how often:

DIET, WEIGHT & HEIGHT

Are you on a special diet	☐	☐	If yes, what type of diet
What do you weigh			kg *(or stones pounds)*
How tall are you			cm *(or feet inches)*

Signature ____________________ Please print name ____________________ Date _________

Reviewed and entered by: ______________________________ Date _________