Madison Day Surgery
Suite 3, 25-29 Hunter Street, Hornsby NSW 2077
Telephone: (02) 8445 0633 Fax: (02) 8445 0646
Email: reception@madisonds.com.au

Place ID Label Here

TEAR ON PERFORATION

PRE-ADMISSION FORM

MR2

TO BE COMPLETED BY PATIENT

PRE-ADMISSION FORM

Please indicate responses by crossing the appropriate box [X]

Surgeon:	**Date of Admission** / /
Procedure:	

PATIENT DETAILS

Title	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Prof ☐ Dr ☐ Sr ☐ Fr ☐ Gender M ☐ F ☐
Given Name	Family Name
Street Address	
Suburb	State Post Code Date of Birth / /
Phone	Home Work Mobile
Email	
First admission to the hospital:	Please complete **both sides of this form** and return to the day hospital with **the Consent Form** as soon as possible prior to your admission. Your responses are valuable to us in planning your admission and care. This form can also be completed online at www.madisonds.com.au
Subsequent admissions:	If your last admission was within the past three (3) months and there have been no changes to your personal details or medical condition since your last admission please cross here ☐ and sign at the bottom of this page
Marital Status	Married / De Facto ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐
Ethinicity	Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐
Language Spoken	Country of Birth

PRIVATE HEALTH INSURANCE / MEDICARE / DVA / WORKCOVER DETAILS

Medicare, DVA, Pensioner	Medicare No. Ref No: Expiry Date / /
	Dept of Veterans' Affairs File No. Gold ☐ White ☐
	Pension No.
Private Health Fund	Are you in a Health Fund? Yes ☐ No ☐
	Health Fund Name Membership No.
Worker's Compensation MVA Third Party	Admission covered by WC Claim Yes ☐ No ☐ Date of Injury / /
	Name of Employer Employer Phone No.
	Admission covered by MVA Claim Yes ☐ No ☐ Claim No.
	Insurance Co. Contact No.

NEXT OF KIN / CARER DETAILS

Next of Kin	Relationship Given Name Surname	
	Address Post Code	
	Telephone No.	Home: Work: Mobile:

Do we have permission to speak to this person regarding your admission and care? Yes ☐ No ☐ **or Carer?** Yes ☐ No ☐
Will this person be your carer on the day of surgery (ie taking you home)? Yes ☐ No ☐

Carer's Details (if not Next of Kin above)	Name Relationship	
	Telephone No.	Home: Work: Mobile:

PATIENT PRIVACY INFORMATION FOR PERSONAL HEALTH INFORMATION

Madison Day Surgery (MDS) ensures that your information is collected, stored and used in compliance to the Australian Privacy Principles (APP) (Privacy Act 1988 & Privacy Amendment Act 2012). Madison Day Surgery is committed to ensuring that the individual's information is used only for the purposes consented to by the individual. We may communicate with you or your referrer electronically using the highest standards of information security and privacy e.g. online registration, discharge information, patient satisfaction surveys & eNewsletters. You may opt out of this at any time.

I have carefully read all details on this form and confirm that all information given on the Admission forms is correct and true to the best of my ability. I have read the Patient's Rights and Responsibilities and Privacy information in the Patient Booklet, online at the website or on display in the hospital. I am aware that it is a requirement of my admission to have an escort home and a carer overnight following surgery.

Patient / Guardian Signature	Patient / Guardian Name	Date ....../....../......

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MEDICAL ASSESSMENT FORM

TO BE COMPLETED BY PATIENT

MEDICAL ASSESSMENT FORM

Patient's Name.. Date of Birth....../....../......

GP's Name.. Phone ....

Referred to Surgeon by: GP ☐ Optometrist ☐ or Other Specialist ☐

Name .... Suburb...

MEDICAL HISTORY Please indicate responses by crossing the appropriate box. ☐
if yes, further information to be provided below.

	Yes	No		Yes	No		Yes	No
Heart Conditions	☐	☐	High Blood Pressure	☐	☐	Recent Falls	☐	☐
Atrial Fibrillation	☐	☐	Stroke &/or TIA's	☐	☐	Skin Ulcers or Open Wounds	☐	☐
Pacemaker or Defibrillator	☐	☐	Epilepsy / Fits or Faints	☐	☐	Cold Sores /Herpes Simplex	☐	☐
Persistent Cough /Breathlessness	☐	☐	Mental Health Illness	☐	☐	Contact Dermatitis	☐	☐
COPD / CAL / Emphysema	☐	☐	Dementia or Alzheimer's	☐	☐	Kidney Disease	☐	☐
Tuberculosis	☐	☐	Neurological Condition	☐	☐	Gastrointestinal Ulcers/ Bowel	☐	☐
Asthma or Wheezing	☐	☐	Blood Clots	☐	☐	Glaucoma / Cataracts	☐	☐
Current Chest Infection /	☐	☐	Bleeding or Bruising	☐	☐	Retinopathy	☐	☐
Cancer	☐	☐	Anaemia	☐	☐	Latex / Rubber Allergy	☐	☐
Diabetes	☐	☐	Hepatitis or HIV	☐	☐	Are you pregnant?	☐	☐
Growth Hormone (pre 1985)	☐	☐	Arthritis or/ Limited Joint Movement	☐	☐	Do you Smoke?	☐	☐
Dura Mater Graft between 1972 - 1989	☐	☐	Paraplegia / Muscle Weakness	☐	☐	Overseas travel in last 3 months	☐	☐
Do you or your family have a history of Cruetzfeldt Jacob Disease (CJD)	☐	☐	Amputee	☐	☐	Do you drink Alcohol or take Recreational Drugs? Amount .... per week	☐	☐

Have you, or your family, ever experienced any problems with anaesthetics? **Yes** ☐ **No** ☐

LIST OF CURRENT MEDICATIONS - INCLUDING VITAMINS, SUPPLEMENTS OR HERBAL PREPARATIONS
Please attach a GP Management Plan or list on a separate sheet if insufficient space.

I am not currently taking any medications ☐ | Is your surgeon aware that you are on all the medications listed? Yes ☐ No ☐

Warfarin Therapy Yes ☐ No ☐ If presently taking Warfarin, please provide below the details of the most recent INR test.

Date ....../....../...... INR..................... Date ceased ....../....../...... Plavix ☐ Isocover ☐

Drug	Dosage	Frequency

ALLERGIES & ADVERSE DRUG REACTIONS Nil Known ☐ Please Use Extra Sheet If Insufficient Space.

Drug or Other	Reaction Type	Date

ILLNESSES AND CONDITIONS Please Use Extra Sheet If Insufficient Space.

OPERATIONS AND APPROXIMATE DATES Please Use Extra Sheet If Insufficient Space.

Height .... cm Weight .... kg | Is there anything else you feel we should know?

Patient / Guardian Signature | Patient / Guardian Name | Date ....../....../......

* F A D M I T P R E 2 *

MR2A

TEAR ON PERFORATION

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TEAR ON PERFORATION

TO BE COMPLETED BY SURGEON

RECOMMENDATION FOR ADMISSION

Please indicate responses by crossing the appropriate box ☒

This confirms the arrangements for ....
(Patient Name)

to be admitted to the hospital on .... /......... /.........

Provisional diagnosis	
Proposed operation	
Proposed anaesthetic	Topical ☐ Regional ☐ LA ☐ GA ☐
Specific medical history	
Bariatric status	Height .... cm Weight .... Kg Weight > 120 kg ☐

MEDICAL HISTORY

I am aware of the patient's medical history, current medications and allergies	☐ Yes	☐ No
Has the patient been seen by their GP in the last 12 months?	☐ Yes	☐ No
If no, do they need to be seen preoperatively?	☐ Yes	☐ No

SURGERY

Procedure item numbers	
Specific requirements	

Transfer to overnight care Yes ☐ No ☐

Reason for admission ....

....

Observation and ongoing care Yes ☐ No ☐

Doctor's Signature...

Doctor's Name... Date .... /......... /.........

RECOMMENDATION FOR ADMISSION

MR3

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For MDS use only

CONSENT TO SURGICAL TREATMENT

MR3A

TO BE COMPLETED BY SURGEON

CONSENT TO SURGICAL TREATMENT

I, Dr (Doctor's Name) .... have discussed with

(Patient's Name) .... whose date of birth is .... /......... /.........

the need for him / her to have the following procedure...

....

We have discussed what alternatives are available, the nature of the risks of the procedure, the risk that it may not give the expected result and the possibility of altered or additional procedures being required. We have also discussed the fact that the procedure may involve anaesthetics, medications and / or blood transfusions and that these all carry risks. On the basis of this understanding, we agree that I perform, and that he /she consent to this procedure.

Doctor's Signature...

Doctor's Name.. Date .... /......... /.........

Patient's Signature...

Patient's Name.. Date .... /......... /.........

Interpreter's Signature...

Interpreter's Name.. Date .... /......... /.........

CONSENT BY A RELATIVE OR LEGAL GUARDIAN TO SURGICAL TREATMENT

I, Dr (Doctor's Name) ....have discussed with

(Legal Guardian / Relative's Name)...the **Legal Guardian / Relative** of

(Patient's Name) .... whose date of birth is .... /......... /.........

need for him / her to have the following procedure...

....

We have discussed what alternatives are available, the nature of the risks of the procedure, the risk that it may not give the expected result and the possibility of altered or additional procedures being required. We have also discussed the fact that the procedure may involve anaesthetics, medications and / or blood transfusions and that these all carry risks. On the basis of this understanding, we agree that I perform, and that he /she consent to this procedure.

Doctor's Signature...

Doctor's Name .... Date .... /......... /.........

Relative/Legal Guardian's Signature...

Relative/Legal Guardian's Name ....Date .... /......... /.........

Interpreter's Signature...

Interpreter's Name.. Date .... /......... /.........

FRECCONGEN2

TEAR ON PERFORATION