Personal Details Pre-Admission Form

(Affix Patient Identification Label Here)

Please complete forms MR001, MR002 and MR004 and return to the Hospital as soon as possible. Forms can be returned in person, emailed: reception@hbsurgical.com or posted: PO Box 1125, HERVEY BAY QLD 4655.

Admission Details						
Date of Admission		Surgeon/Specialist				
Operation/Procedure						
Personal Details						
Title	☐ Mr ☐ Mrs ☐ Dr ☐ Master ☐ Miss ☐ Ms ☐ Child ☐ Other:					
First Name		Surname				
Date of Birth		Gender	Male ☐ Female ☐			
Indigenous Status	☐ Aboriginal ☐ Torres Strait Islander	☐ Aboriginal & Torres Strait Islander ☐ South Sea Islander				
Home Address						
	City		State		Postcode	
Postal Address (if different from above)						
	City		State		Postcode	
Phone Number	Home		Mobile			
Email						
Country of Birth		Religion				
Are you a permanent Australian Resident?	☐ Yes ☐ No					
Do you require an interpreter?	☐ Yes ☐ No	Language				
Enduring Power of Attorney	☐ Yes ☐ No If yes, have you supplied a complete copy ☐ Yes ☐ No					
Advanced Health Directive	☐ Yes ☐ No If yes, have you supplied a complete copy ☐ Yes ☐ No					
Next of Kin						
Name		Relationship				
Home Number		Mobile Number				
GP Details						
Name		Phone Number				
Practice Name						

Personal Details Pre-Admission Form MR001

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Entitlements				
☐ Medicare Card			Ref	Expiry /
☐ DVA Gold	File Number		Expiry	/
☐ DVA White	File Number		Expiry	/
☐ Health Care Card	Customer Reference Number		Expiry	/
☐ Pension Concession Card	Customer Reference Number		Expiry	/
☐ Safety Net Card	Card Number		Expiry	/

Payment Details (Please tick one)

You will be liable for all charges associated with the procedure performed and will be expected to pay all costs not reimbursed by the below funding source on or prior to your day of surgery.

☐ Private Health Fund	Fund Name:	
	Member Number:	
☐ DVA		
☐ Work Cover	Claim Number	
☐ Wide Bay Hospital and Health Service		
☐ Nil Insured		

Post Operative Care

During your admission you will receive medication that may interfere with your ability to drive and make decisions. It is hospital policy to discharge all day surgery patients into the care of a friend or relative for the first 24 hours post-surgery. This must be organised by you prior to admission to the hospital, failure to do so may lead to your procedure being postponed or cancelled. Children must have a driver as well as a carer for the journey home.

Who will be picking you up after your procedure?			
Name		Contact Number	
Who will be your postoperative carer?			
Name		Contact Number	

Declaration

☐ I certify that the Information provided by me is accurate to the best of my knowledge.

☐ I understand that the Hervey Bay Surgical Hospital is not responsible for the loss of any items that I bring into the hospital with me. (We recommend that you do not bring any items of value with you to hospital.)

☐ I certify that I have read and understood the information supplied to me including the Australian Charter of Health Care Rights.

Signature		Date	/ /

Personal Details Pre-Admission Form MR001

Patient Health Questionnaire

(Affix Patient Identification Label Here)

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Weight (kg)		Height (cm)	

Health and Risk Assessment - Do any of the following apply?

(Circle if more than one choice available)	YES	NO	*(Circle if more than one choice available)*	YES	NO
Do you consent to a blood transfusion if required?			Recurrent / active bladder infection		
Adverse reaction to a previous blood/ blood products transfusion			Prostate issues		
Heart attack /heart failure / angina			Liver disease/ disorder		
Irregular heart beat or murmur			Osteoarthritis/ Rheumatoid arthritis		
Artificial heart valve / implant / pacemaker / cardiac stent / defibrillator / heart surgery			Gastric reflux/ hiatus hernia		
High blood pressure			Problems with your bowels?		
Blood clots in lungs (PE) or legs (DVT)			Inflammatory bowel disease / Crohn's / Diverticulitis		
Do you take blood thinning medication?			Female patients could you be pregnant?		
Blood disorders/ disease			Any forms of cancer		
Anaesthetic difficulties			Do you smoke? If so, How many per day?		
Significant back / neck injury or surgery			Do you use recreational drugs? If so, what drug?		
Eating/swallowing difficulties			Do you drink alcohol? If so, How many per day?		
Sleep Apnoea (please bring CPAP if staying overnight)			Any rashes/bruising/ cuts/ ulcers/ pressure sores?		
Asthma/Bronchitis/COAD/Emphysema			Do you have any difficulty walking?		
Stroke/CVA/TIA's			Do you use a walking aide? (Please bring to hospital with you)		
Dizzy spells/blackouts			Do you have problems weight bearing?		
Recent fall (within 6 months)			Do you use a wheel chair?		
Epilepsy or other fits			Do you wear glasses / contact lenses?		
Neurological condition (eg Parkinson's)			Hearing Aid or other hearing appliance		
Diabetes Insulin / Tablet / Diet (please circle)			Dentures / Plate/ Caps/ Crowns/ implants / Loose / broken teeth		
Memory loss / Dementia / Alzheimer's			Do you live alone?		
History of post-surgery confusion / Delirium			Do you have support services in place?		
Anxiety / Depression / PTSD			Are you a carer for someone?		
Intellectual Disability			Other:		
Kidney / Bladder disease					

Patient Health Questionnaire MR002

HERVEY BAY surgical hospital

Patient Health Questionnaire

(Affix Patient Identification Label Here)

Infection control Risk Assessment - Do any of the following apply? ***(Circle if more than one choice available)***	YES	NO
Been exposed to a communicable disease in the past 14 days, such as Influenza, Chickenpox, Shingles or Measles.		
Ever been infected or colonised with a multi-resistant organism such as MRSA, VRE, CRE, CPE.		
Have / had Hepatitis A / B / C HIV or Tuberculosis?		
Do you live with a person who has had an infection with a multi-resistant organism?		
Live or work in a Nursing Home.		
Have any infected wounds. If so, where:		
Do you or 2 or more first-degree relatives have a family history of Creutzfeldt-Jakob Disease (CJD) or undiagnosed neurological illness?		
Received human pituitary hormone (growth hormone, gonadotrophin) prior 1986.		
Received a *dura mater graft* prior to 1990.		
Stayed overnight in another hospital in the past 3 months.		
Been in a hospital outside Australia in the past 12 months.		
Recently returned from travelling overseas or on a cruise ship within the past 6 weeks.		

Allergies – Medication/Food/Latex/Other (Attach list if extensive)

	Drug, food, other	**Reaction details**	**Drug, food, other**	**Reaction details**
☐ **None**				

Medications – please attach a current medication summary from your GP

	Current Medication	**Strength** e.g.10*mgs*	**Dose** *e.g. 1daily*	**Reason for taking?**	**Taking for how long or when ceased?**
☐ **None**					

Surgical History

☐ **None**	

Patient Health Questionnaire MR002

HERVEY BAY surgical hospital

CONSENT FOR THE COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Affix Patient Label Here

Surname:……

Given Names:……

Date of Birth: ……./……./…….

If you DO NOT want us to use or disclose your personal information in any of these ways, please tick the box in the column to show you do not give consent

NOTE: If there is no response by you against an item, it will be taken to mean that you agree with that use.

Use of Personal Information

	NO
1. To train and educate professional staff	☐
2. For health and medical research projects we undertake solely or in conjunction with related Research organisations and external research organisations with which we collaborate or partner ***You will not be identified in any research publication***	☐
3. To assist in the development of service delivery and planning facilities	☐

Disclosure of Personal Information

	NO
4. To or from other medical practitioners, hospitals or health service providers to assist in any current or future treatments that relate to the condition for which you are currently being treated including access to your medical information and records and provision of information following you discharge ***This is to allow those involved in your care to have access to your records and to be provided with relevant information about your medical condition. If you tick no, we may not be able to provide you with the service your require***	☐
5. To your local (or, where applicable, your referring) GP in a discharge summary	☐
6. To advise hospital affiliated associations of your presence in hospital, eg, RSL, Veterans Affairs Association, War Widows Association etc, if applicable	☐
7. To your family/carer to communicate your condition or discharge arrangements (where necessary)	☐
8. To or from medical practitioners, hospitals, health service providers, or external research organisations which we collaborate or partner with to assist in quality and research projects	☐

Declarations

- I have read and understood the information relating to the Collection and Use of my Personal Information.
- I understand that if I have **NOT** indicated 'NO' on this form that I consent to the use and disclosure of my personal information as set out above.
- I am authorised to sign this Form as, or on behalf of the patient named at the top of this page.

_____
Signature of patient / Date
(Unless patient is a minor or incompetent to sign)

_____
Signature of Parent / Guardian / Date
(If patient is a minor or incompetent to sign)

_____
Name of Patient

_____
Relationship to Patient

Consent for Personal Information

MR004