BRISBANE
DAY HOSPITAL

PRE-ADMISSION FORM

Family Name		Given Names			
Date of Birth		Age		Title	
Sex	Male ☐ Female ☐ Indeterminate ☐ Transgender ☐ Transsexual ☐ Pangender ☐				
Address					
Contact Details	Mobile:	Home:	Work:		
Medicare number		Medicare Expiry			
Email Address					
Country of Birth		Language spoken			
Marital Status	Never married ☐ De Facto ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐				
Religion	Catholic ☐ Hindu ☐ Muslim ☐ Jewish ☐ Buddhist ☐ None ☐ Other ☐ _____				
Indigeneity	Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ South Sea Island ☐ Non-Indigenous ☐				
Occupation		Impairments			
Escort Name		Escort Number			
Next of Kin		Next of Kin's phone number			
GP's Name		GP's phone number			
GP Practice Name and Address					

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MEDICAL HISTORY

Name: _____ / **Height**: _____ cm / **Weight**: _____ kg

Topic	No / Yes	Details
Have you had any **previous surgeries or procedures**?	N ☐ Y ☐	
Have you or your family members ever had any problems with **anaesthetics**?	N ☐ Y ☐	
Are you taking any **medications**? If yes, what are you taking, and how often do you take it?	N ☐ Y ☐	
Do you **smoke**? If yes, how many?	N ☐ Y ☐	
Do you use any **recreational drugs**? If yes, please specify which drug/s you use and how often you use.	N ☐ Y ☐	
Do you drink alcohol? If yes, please specify how much and how often you drink.	N ☐ Y ☐	
Do you have any **allergies to medications**? If yes, please provide details.	N ☐ Y ☐	
Do you have any other allergies or sensitivities?	N ☐ Y ☐	
Are you currently breastfeeding?	N ☐ Y ☐	
Do you have any respiratory conditions? (e.g. asthma)	N ☐ Y ☐	
Do you have any heart conditions? (e.g. high or low blood pressure, heart murmurs from rheumatic fever, palpitations)	N ☐ Y ☐	
Do you have any bleeding/clotting conditions?	N ☐ Y ☐	
Do you have diabetes? If yes, what type and what treatment are you on?	N ☐ Y ☐	
Do you suffer from heartburn / acid reflux / indigestion?	N ☐ Y ☐	
Do you have any neurological, psychiatric, or psychological conditions? (e.g. epilepsy, depression, bipolar)	N ☐ Y ☐	
Do you have any of the following? Hepatitis A, Hepatitis B, Hepatitis C, HIV, sexually transmitted disease, TB, MRSA, VRE	N ☐ Y ☐	
Do you have any other medical condition(s)?	N ☐ Y ☐	

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CONSENT TO CARE AND PERSONAL INFORMATION

Please read the below very carefully and initial after each. Failure to consent may result in your procedure being cancelled or postponed.

I have read and accept the risks and complications that are associated with having this procedure_____.

I understand that there may be occasions when the expected outcomes of the procedure are not always achieved _____.

I can confirm that I have been given adequate discharge instructions for my post-operative care and I will adhere to them _____.

I have provided Brisbane Day Hospital will an honest medical history and understand that I am responsible for any undesirable outcomes that may arise due to me not disclosing specific medical history _____.

I have been made aware of the alternatives to my requested procedure _____.

I understand that Brisbane Day Hospital will not be responsible for any injuries and/or damages that I may cause or sustain in the event that I ignore, overlook, or not accept the advice, cautions, or warnings that have been given to me _____.

I understand that my blood may be taken for pathology in the event of a sharps injury by nursing staff or the anaesthetist _____.

I understand that Brisbane Day Hospital may send off tissue samples for histological examination _____.

I am aware that Brisbane Day Hospital is not responsible for any valuables, including cash, that I bring to the facility _____.

I agree to the administering of medications, anaesthetic, and other forms of treatment associated with having my procedure as is deemed necessary by the operating doctor, anaesthetist, and nursing staff _____.

I understand that for my own, and other people's safety, it is illegal to drive for 24 hours following anaesthetic. I have arranged for a responsible person over the age of 18 to pick me up from this facility after my procedure _____.

I am aware that if my escort fails to pick me up on time, I will be charged an hourly fee of $100 until they arrive _____.

I have a responsible person over the age of 18 who will be supervising me for the first 24 hours following my procedure (if having anaesthetic) _____.

I understand that I cannot catch a taxi after my procedure unless I have a responsible person over the age of 18 accompanying me. I understand that I cannot catch public transport home at all (if having anaesthetic) _____.

I am aware that if I fail to produce an escort after my procedure, I will be transferred to a public hospital for the next 24 hours or until I can be picked up, and will be responsible for the transfer fee _____.

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CONSENT TO CARE AND PERSONAL INFORMATION CONTINUED

I will stay at Brisbane Day Hospital until the nurses and/or doctors deem me medically able to leave. I understand the failing to comply with the facility's instructions may result in undesirable outcomes _____.

If I brought a referral, I understand that Brisbane Day Hospital will send a letter to my GP/Specialist which will outline the details of my procedure and any pathology results _____.

I am aware that the pathology provider used during my course of treatment may send billing information to my home address _____.

I understand that I am responsible to contact Brisbane Day Hospital for any pathology results _____.

I give permission for any **abnormal** pathology result where the nursing staff are unable to contact me, to be referred to my nominated GP/specialist/surgeon, and a registered letter sent to my address with the result _____.

I will contact my surgeon's rooms, an after-hours GP, or the nurses hotline for my afterhours care/advice as Brisbane Day Hospital is only open between 8am and 4pm, Monday to Friday _____.

I am aware that my personal details and procedure information are given to Queensland Health in an unidentified format for government data collection, and that this is a legal requirement _____.

I understand that if using my private health, Brisbane Day Hospital will disclose the nature of my procedure to the health fund, and that the procedure details will appear on my health fund account _____.

I understand that if using Medicare, Brisbane Day Hospital will disclose the nature of my procedure to Medicare, and that the procedure details will appear on my MyGov account _____.

I understand that my next of kin will be notified of my procedure and any subsequent outcomes when I am **not** able to provide such consent _____.

If I have a notifiable disease (Chlamydia, HIV, Hepatitis A, etc.), or discover that I have a notifiable disease upon my treatment here at the facility, I understand that Brisbane Day Hospital must notify the National Notifiable Diseases Surveillance System of your details, as is the required by the law _____.

I understand that in the case of an emergency, I may need to be transferred to another medical facility for medical treatment _____.

I consent to Brisbane Day Hospital providing my operation notes to my surgeon and their rooms for aftercare purposes _____.

I have read and understand the above statements:

Name		Initials	
Signature		Date	