

DAY PATIENT HEALTH ASSESSMENT & PRE-ADMISSION QUESTIONNAIRE

| PERSONAL DETAILS | | | | | | | |
|--|-----------------------------|--|-----------------------------|--|--|-------------------------------|---------------------------------|
| <input type="checkbox"/> Dr | <input type="checkbox"/> Mr | <input type="checkbox"/> Mrs | <input type="checkbox"/> Ms | <input type="checkbox"/> Miss | Other | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> De Facto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated | | | | | | | |
| Surname: | | | | | Given Names: | | |
| Previous Name: (if changed from last visit) | | | | | Preferred Name: | | |
| Address: | | | | | State: | Postcode: | |
| City/Town/Suburb: | | | | | | | |
| Date of Birth: / / | | | Email address: | | | | |
| Home phone: | | Work phone: | | | Mobile phone: | | |
| Country of Birth: | | | | Occupation: | | | |
| Are you of Aboriginal or Torres Strait Islander origin? | | | | | | | |
| <input type="checkbox"/> No | | <input type="checkbox"/> Yes, Aboriginal Descent | | | <input type="checkbox"/> Yes, Torres Strait Islander | | |
| Please provide below details: <input type="checkbox"/> Next of Kin <input type="checkbox"/> Responsible Person <input type="checkbox"/> Power of Attorney (as defined in the National Privacy Principles) | | | | | | | |
| Name: | | | | | Relationship: | | |
| Address: | | | | | | | |
| Home phone: | | Work phone: | | | Mobile phone: | | |
| Authority to contact the above named regarding: | | Emergency | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please initial | | |
| | | Outcome of treatment | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please initial | | |
| | | Account/Fund matters | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please initial | | |
| MEDICARE CARE CARD INFORMATION | | | | | | | |
| Medicare Card Number: | | | | | | | |
| Reference Number beside patient name: | | | | Expiry Date: | | | |
| To whom should the account be addressed to if the patient is under 18 years: | | | | | | | |
| Name.....DOB:..... | | | | | | | |
| Medicare Number.....Reference.....Expiry Date..... | | | | | | | |

If you have not provided a Medicare number in the space above, please indicate below if this is because you:

☐ Do not know the number or have not yet been issued a card OR ☐ Are not eligible to receive a Medicare card

If you are a visitor to Australia, have you been issued with a Medicare card stating "VISITOR RHCA" ☐ YES ☐ NO ☐ N/A

Have you applied for permanent resident status and your Medicare card states "INTERIM CARD" ☐ YES ☐ NO ☐ N/A

HEALTH CARE CARDS (Please enter details below and present relevant cards to reception)

| | | | |
|---|-----------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Pension Card/Health Care Card | Card Number: | Expiry Date: | |
| <input type="checkbox"/> Commonwealth Seniors Card | Card Number: | Expiry Date: | |
| <input type="checkbox"/> Pharmacy Card | Card Number: | Expiry Date: | |
| <input type="checkbox"/> Safety Net Entitlement Card | Card Number: | Expiry Date: | |
| <input type="checkbox"/> Dept of Veterans' Affairs (DVA) Card | Card Number: | Expiry Date: | |
| | DVA Card Colour | <input type="checkbox"/> Gold | <input type="checkbox"/> White |

HEALTH FUND INSURANCE DETAILS (Completion of this section will authorise use of particulars for eligibility checking and invoicing purposes).

| | | |
|--|---|---|
| Do you have private health insurance? | Hospital: <input type="checkbox"/> YES <input type="checkbox"/> NO | Excess amount if applicable \$..... |
| Name of Health Fund: | | Membership Number: |
| Restrictions: <input type="checkbox"/> YES <input type="checkbox"/> NO | Exclusion for eye surgery: <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you have ultimate or ultra cover? <input type="checkbox"/> YES <input type="checkbox"/> NO (Bupa/Medibank Private Members only) |

OTHER INFORMATION

The main reason I am considering refractive/cataract surgery is:

Please list the most important tasks that you require good vision (eg: for work, at home or recreation):

Please indicate if you have received a copy of the "Useful Information" leaflet: ☐ YES ☐ NO

You may obtain details of our Privacy Policy from the Reception area.

Do you require to speak with our staff regarding any information you have received? ☐ YES ☐ NO

DAY PATIENT HEALTH ASSESSMENT & PRE ADMISSION QUESTIONNAIRE cont...

Please indicate below how you heard about us:

| | | | | | |
|---|--|--------------------------------------|---|---|---|
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Radio Nova | <input type="checkbox"/> Hayley Pearson/Adelady | <input type="checkbox"/> White Pages | <input type="checkbox"/> Google |
| <input type="checkbox"/> Radio – Hit 107 | <input type="checkbox"/> PodCast | <input type="checkbox"/> Health Fund | <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Yellow Pages online | <input type="checkbox"/> Yellow Pages - book |
| <input type="checkbox"/> Facebook/Social Media | <input type="checkbox"/> Doctor/Specialist | <input type="checkbox"/> Website | <input type="checkbox"/> Athlete-Jess Trengove | <input type="checkbox"/> Other..... | |

Consumer Participation

Adelaide Eye & Laser Centre encourages consumer participation to assist in the ongoing quality process including the safety of all consumers (which may include patients and their carers). This may be achieved through various means which include, but are not limited to, survey information post surgery, social media updates or following up on complaints or suggestions. In some instances, patients or carers may also be asked to participate in a brief interview or consultation on quality issues or their overall experience at AE&LC. If you would like to be further involved or have any suggestions or comments, please don't hesitate to speak with our staff.

DECLARATION

Payment for consultations are payable at the time of your visit. Our account terms require that any outstanding amounts are settled in full within 30 days. Accounts outstanding after this time may be subject to further costs that are incurred as a result of debt collection.

I certify that the information contained within this form is true and correct.

| | | |
|-----------|--------------------|-------|
| | | |
| Signature | Print Name in full | Date |

Office Use Only:

Checked By: _____

Entered By: _____

OPV: ☐

PRE-ADMISSION QUESTIONNAIRE

DAY PATIENT HEALTH QUESTIONNAIRE

Surname:

First Names:

DOB:

Address:

PATIENT TO COMPLETE - Please fill in this form pending potential surgery.

| PLEASE TICK BOX | | If YES, please provide details | Staff Use Initial actions |
|--|--|---|---------------------------------|
| Do you know your weight? | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, please specify. | |
| Do you know your height? | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, please specify. | |
| | | Office Use Only Your BMI (kg/m ²) | |
| Have you had previous Refractive Surgery? | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Have you had anaesthetics in the past? | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Have you had any side effects with any anaesthetics? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please specify: | |
| Have any blood relatives had any side effects with anaesthetics? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please specify: | |
| Allergies: Are you sensitive or allergic to any medications / latex / rubber / other? (Please provide a separate list if not enough room). | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please specify allergy and reaction: | |
| Are you taking any medications or tablets, including any vitamins and supplements? (Please provide a separate list if not enough room). | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please list: | |
| Do you have heart or high blood pressure problems? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please specify: | |
| Do you have a pacemaker? | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Do you get shortness of breath or chest pain after exercise or climbing stairs? | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Do you have breathing problems or take medicine for breathing problems? | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Do you have diabetes? Type: | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Past Medical / Surgical history. Do you have any other medical conditions? Please list previous illness, operations and the year you had them. (Please provide a separate list if not enough room). | <input type="checkbox"/> No <input type="checkbox"/> Yes | Please list: | |

| | | |
|-------|----------|------|
| Name: | Address: | DOB: |
|-------|----------|------|

| | PLEASE TICK BOX | | If YES, please provide details below | Staff Use Initial Actions |
|--|-----------------------------|------------------------------|--|---------------------------------|
| Is it possible that you may have HIV, AIDS or Hepatitis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Do you or have you had any bacterial infections, eg: MRSA, VRE or CRE/CPE? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please specify: status, location, duration, treatment. | |
| Do you have any skin integrity concerns or skin sensitivities? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please specify: | |
| Do you have any skin pressure sores or skin ulcers? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please provide details: | |
| Are you currently experiencing any type of infection or have you been exposed to a person that is suffering an infectious disease in the past two weeks, ie : chicken pox, measles, etc. | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please specify: | |
| Have you had a fall in the last 12 months? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Do you have any physical disabilities or mobility problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please specify: | |
| Are you currently receiving treatment for a mental health illness? Please provide details. | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please provide details: | |
| Do you suffer from memory loss or confusion? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Have you previously suffered an episode of delirium? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Do you smoke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Amount per day: Amount per week: | |
| Do you drink alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Amount per day: Amount per week: | |
| Do you have any dietary requirements? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please specify: | |
| Have you been overseas in the last 4-6 weeks and had an overnight stay in an overseas hospital? Have you travelled to China recently or been in contact with anyone who has? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Please provide details: | |
| Do you have an Advanced Care Plan? If yes, please provide copy of ACP. | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Creutzfeldt-Jakob Disease (CJD) | | | | |
| Have you had a dura mater graft (prior to 1989? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Do you have a family history of two or more first degree relative with Creutzfeldt-Jakob Disease or other unspecified progressive neurological disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Have you suffered from a recent progressive dementia (physical or mental) the cause of which has not been diagnosed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Have you received human pituitary hormones prior to 1985? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Have you been involved in “Look Back” for CJD or do you have a “Medical Confidence letter” regarding your risk of CJD? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |

Name:

Address:

DOB:

PATIENT TO COMPLETE - Please fill in this form pending potential surgery.

Discharge Planning

| | | |
|---|---|---|
| Where do you live? | <input type="checkbox"/> Own home <input type="checkbox"/> Retirement Village <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Family member's home <input type="checkbox"/> Hostel <input type="checkbox"/> Other: _____ |
| Who do you live with? | <input type="checkbox"/> Alone <input type="checkbox"/> With a friend <input type="checkbox"/> Other: _____ | <input type="checkbox"/> With family <input type="checkbox"/> De facto |
| Where will you stay after your surgery? | <input type="checkbox"/> Alone <input type="checkbox"/> With a friend <input type="checkbox"/> Other: _____ | <input type="checkbox"/> With family <input type="checkbox"/> De facto |
| If you are alone, who will assist? | Please specify: | |
| RDNS / HOME NURSES REQUIRED? | <input type="checkbox"/> No | <input type="checkbox"/> Yes Notified? |
| Nursing Home providing care? | <input type="checkbox"/> No | <input type="checkbox"/> Yes Notified? |

If you find there is not enough space on this form for you to provide all the details, please provide details below and overleaf.

PATIENT COMPLIANCE STATEMENT

I understand that I need to organise a responsible adult to both accompany me home and stay with me for 12-24 hours.
 I understand that surgery may be cancelled if I do not have a responsible adult to accompany me home and stay with me for 12-24 hours.

Patient Signature:

Print Name:

Date:

Office Use Only

Registered Nurse Signature:

Print Name:

Date: