RESERVOIR PRIVATE HOSPITAL
DAY PROCEDURE CENTRE

#2

PLEASE RETURN 7 DAYS BEFORE YOUR ADMISSION.

UR NUMBER: PATIENT ADMISSION DETAILS

Admitting Doctor: please circle correct Doctor. **Dr Malki** **Dr Mariani** **Dr Rutherford**

General Practitioner (Name & Address): Phone:
Email: Fax:

Date of Admission:	Time:	Date of Procedure:

Operation/Procedure:
Iron Infusion:

Have you been hospitalized anywhere in the last seven day? Yes ☐ No ☐ If yes, where:
Have you been a patient at RPHDPC in the past 7 years? Please enter date ……………………………….

PATIENT DETAILS-*Please print as your name appears on Medicare Card*

Title:	Surname:	Previous Surname:

Given Names:

Address:	Postcode

Phone (H)	Phone (M)	Email address:
Sex: Male ☐ Female ☐	Date of Birth:	Marital Status:

Country of Birth (if Australia, which state)?

What language is spoken at home?

Do you require an interpreter? Yes ☐ No ☐

Are you an Australian Resident? Yes ☐ No ☐

Are you of Aboriginal/Torres Strait Island Descent? No ☐
Yes Aboriginal ☐ Yes, Torres Strait Islander ☐
Yes both Aboriginal & Torres Strait Islander ☐ Decline to answer ☐

Medicare Number:	Reference No:	Expiry Date:	Veteran's Affairs No:

Pension No: Full ☐ Part ☐
Health Care Card : Yes ☐ No ☐
Ambulance Victoria member no. ………………………………………….
Expiry Date:

HEALTH FUND INSURER OR SELF FUNDING Please circle the correct one

Fund:

Membership Number:…………………………………………

Is ambulance cover included? Yes or No please circle

ESCORT CONTACT DETAILS

Surname:	Given Name:	Relationship:

Contact Number:	Alternative contact number:

NEXT OF KIN

Surname:	Given Name:	Relationship:

Contact Number:	Alternative Contact Number:

Do you have a Legal Substitute Decision Maker? (Eg Power of Attorney) Yes ☐ No ☐ Same as Next of Kin ☐

Other ☐ Name: Relationship: Contact Number:

PLEASE TURN OVER THE PAGE

PATIENT PRE-ADMISSION HISTORY

ADMISSION DIAGNOSIS: Why are you having the procedure?

Did you have a consultation prior to your procedure? Yes or No

HEIGHT:	**WEIGHT:**	**BMI:**

MEDICAL HISTORY: Patient to complete. Please tick to indicate whether you have ever had any of the following:

	Y	N		Y	N		Y	N
Diabetes: Diet, Insulin or tablets?			Influenza			Pneumonia		
Epilepsy or Fits			Anaemia (low iron level)			Asthma/Bronchitis		
Pacemaker/Defibrillator			Bleeding disorder (clot)			Tuberculosis/TB		
CPAP machine / Sleep Apnoea			Rectal Bleeding			Rheumatic Fever		
Taking Blood Thinners			Stomach Ulcer			CVA (Stroke)		
Kidney Disease			Jaundice/hepatitis			High blood pressure		
Blood Transfusion			Gastro Oesophageal Reflux			Are you/ could you be pregnant?		

	Y	N
History of mental illness? Eg depression, Schizophrenia, self- harm, post- natal? Are you currently under any psychiatric treatment?		
Do you have cognitive impairment/dementia/memory problems?		
Have you suffered from delirium/post anaesthetic confusion?		
Have you ever been infected or colonised with a multi-resistant organism such as MRSA, VRE, CPE**?		
Have you recently returned from travelling overseas [i.e. within the past 4-6 weeks] and / or have had an overnight stay at an overseas hospital or residential care facility in the past 12 months?		
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 2 weeks, i.e. chickenpox, measles, influenza?		
Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B?		
Are you suffering from any pre-existing health care associated infection or communicable disease?		
1. Have you had a dura mater graft? (between 1972 and 1989)		
2. Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD)		
3. Have you received human pituitary hormones (growth hormones, gonadotropins) prior to 1985?		

Please give details:

Have you had a fall in the last 12 months? Yes ☐ No ☐ Do you use a mobility aid ? i.e. walking stick Yes ☐No ☐Details:

Do you have any mobility issues? Yes ☐ No ☐

History of pressure ulcer? Yes ☐ No ☐ Do you have delicate skin/ pressure sores/ cuts/ abrasions? Yes ☐ No ☐

Do you have an Advanced Care Plan/ Treatment Limiting Order? Yes ☐ No ☐

SURGICAL HISTORY

Have you ever had previous surgery? Yes ☐ No ☐

Please give details (state year)

ANAESTHETIC HISTORY		YES	NO
Have you ever had an anaesthetic ?			
Have you or any member of your family had problems with an anaesthetic?			
Do you smoke?	How many per day?		
Do you consume alcohol?	How much per week?		
Do you take any recreational drugs?			

****Carbapenem-producing Enterobacterales (CPE):** *Enterobacteriaceae* that are resistant to carbapenem antibiotics. May also be referred to as CRE or Carbapenem-resistant *Enterobacterales*. ***Methicillin-resistant Staphylococcus aureus (MRSA)****: strains of Staphylococcus aureus that are resistant to methicillin and all other beta lactam antibiotics including all the penicillins, cephalosporins and carbapenems.* ***Vancomycin Resistant Enterococcus (VRE):*** *Gram-positive bacteria that live in the gastrointestinal tract and are resistant to vancomycin. The vancomycin-resistant organisms commonly see are Enterococcus faecalis and Enterococcus faecium.*

Patient Label

#4

MEDICATION HISTORY

Please list all medications that you currently take including over the counter, herbal medicine and vitamins.

Name of Medication	Dose	Time taken

Do you have any allergies? (Medications, latex, tape, foods etc) ☐ Yes ☐ No

Please list: ____

____

NURSING PRE-ADMISSION

Patient Label

OFFICE USE ONLY

	Yes	No		Yes	No
Medical History checked by nurse			Suitable escort arrangements		
Medication History OK			Any social concerns		
BMI Checked			Procedure within Scope of Practice		

Has patient authorized a family member to provide further information? Yes ☐ No ☐
Details:

Any Variance from Admission Criteria? Yes ☐ No ☐ Patient Contacted? Yes ☐ No ☐ Date:

Is patient an OPEN ACCESS booking? Yes ☐ No ☐ Has the patient been consulted by Endoscopist? Yes ☐ No ☐

Dietary requirements: ………………………………………………

Discuss with Endoscopist/ Anaesthetist/Dermatologist? Yes ☐ No ☐ Details:

ALERTS: Yes ☐ No ☐ Please circle AND complete Alert Form Alert Form Created? Yes ☐ No ☐

Approved for Admission? Yes ☐ No ☐ Notes:

Print Name: **Signature:** **Date:**

NURSING ADMISSION

Observations on obs chart:	Y	N	Prep Completed	Y	N	Suitable escort arrangement	Y	N
ID Band on pt? BSL: Ketones :			Rights & Responsibilities Any questions about Rights/Responsibilities?			Dentures/implants/crowns. Glasses/contact lenses		
What matters to you today?			Last oral intake date and time: Diet/Food…………………………… Fluids…………………………………			Notes:		

Nurse name: **Signature:** **Date:**