Virtus SPECIALIST DAY HOSPITALS
MEMBERS OF VIRTUS HEALTH

☐ SPRING HILL
☐ MACKAY

At least 7 days before Admission

Online Admission (preferred)
1 Access the website of your nominated hospital:
- Spring Hill shsdh.com.au admin@shsdh.com.au
- Mackay msdh.com.au admin@msdh.com.au

2 Go to the Pre Admission section to complete
3 Submit

OR Paper Admission
Complete and send to Reception at your nominated Hospital.

patient label

Planned admission date

Treating doctor

Patient details

TITLE	GIVEN NAMES	FAMILY NAME
ADDRESS		POSTCODE
POSTAL ADDRESS (IF DIFFERENT TO ABOVE)		POSTCODE
TEL HOME	TEL WORK	MOBILE
EMAIL ADDRESS *please print clearly*		
DATE OF BIRTH / /	SEX FEMALE ☐ MALE ☐	PERMANENT RESIDENT YES ☐ NO ☐
MARITAL STATUS M ☐ S ☐ D ☐ W ☐ SEP ☐ DE FACTO ☐		
INDIGENEOUS ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ BOTH ☐ NEITHER ☐		
LANGUAGE SPOKEN AT HOME	COUNTRY OF BIRTH	OCCUPATION

Emergency contacts

NEXT OF KIN		RELATIONSHIP	TEL MOBILE
NAME OF ESCORT	(PERSON DRIVING YOU HOME)		TEL MOBILE

You risk your procedure being cancelled if you do not have someone to take you home and stay with you overnight

Your Medicare Details, Health Fund and Referring GP

MEDICARE NO. | | | | | | | | | | REFERENCE NO. | | (LOCATED BESIDE YOUR NAME ON YOUR CARD)	**EXPIRY DATE**
NAME OF FUND	**MEMBERSHIP NO.**

I HAVE NO HEALTH FUND COVER ☐

I HAVE OVERSEAS INSURANCE ☐ **WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSION OR FULL PAYMENT WILL BE REQUIRED ON ADMISSION.**

HAVE YOU BEEN ADMITTED TO HOSPITAL IN THE LAST 28 DAYS? YES ☐ NO ☐

REFERRING LOCAL GP	**SUBURB OF LOCAL GP**

Health care cards (if applicable)

PENSION NO.	EXPIRY DATE
DEPT VETERANS AFFAIRS NO. | | | | | | | | | |	DVA CARD COLOUR | | | |

If claiming workers compensation/third party accident insurance

EMPLOYER		
ADDRESS		POSTCODE
TEL	CONTACT	DATE OF ACCIDENT / /
INSURANCE COMPANY	CONTACT	CLAIM NO.
ADDRESS	POSTCODE	TEL

APPROVAL GIVEN YES ☐ NO ☐ (IF YES, PLEASE ATTACH CONFIRMATION LETTER)

WRITTEN APPROVAL FOR DAY SURGERY PROCEDURE MUST BE RECEIVED BY THE FACILITY PRIOR TO ADMISSION OR FULL PAYMENT WILL BE REQUIRED ON ADMISSION.

Payment agreement

To the best of my knowledge, the above information is true and correct. I agree to pay any shortfall in reimbursement by my Health Fund; or, in the case of unfunded procedures, where the procedure takes longer than quoted or anticipated. I also agree to cover the costs of any prosthesis or consumable items not routinely included in the estimate or this admission. ☐

PATIENT SIGNATURE	DATE

SDH-FM-001A
QFG
PAD 1
VERSION 1
IST ISSUE
26SEPT18
REVISED -

PLACE BARCODE LABEL HERE

Risk assessment

MEDICAL HISTORY

List previous operations, hospital admissions or any major/serious illness

Have you, or any of your family, experienced an adverse reaction during anaesthesia general or local? YES ☐ NO ☐ If yes, please specify.

Have you, or any of your family, had a history of malignant hyperthermia? YES ☐ NO ☐

MEDICATIONS / ALLERGIES

Please list current medications including any non-prescribed medications such as vitamins, herbs, natural or traditional therapies

MEDICATION/DRUG OR VITAMIN NAME	STRENGTH	NO. TAKEN	HOW OFTEN

Have you used steroid/cortisone medication in the past 6 months? YES ☐ NO ☐

BLOOD THINNERS Have you taken any blood thinning medication this week? eg Aspirin, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix, Brufen, Nurofen, Indocid) or **Natural Thinners** (eg Vitamin E, Chinese herbs, Ginkgo, Fish Oil, Garlic)? YES ☐ NO ☐

DIABETES Do you use insulin YES ☐ NO ☐
Are you tablet controlled ? YES ☐ NO ☐
Are you diet controlled? YES ☐ NO ☐
Please bring ALL diabetic tablet medications AS WELL as your INSULIN on day of admission.

ALLERGIES Do you have any known allergies to any medications, dressings, latex or food? If yes, please list

HEIGHT in cms _____ WEIGHT in kgs _____

If 150kgs or over please contact day hospital reception. A pre admit anaesthetic assessment will be conducted over the phone to ensure your utmost safety.

DO YOU HAVE, NOW OR IN THE PAST, ANY OF THE FOLLOWING?	YES	NO
CIRCULATION		
SEVERE HEART PROBLEMS Heart attack, heart failure, acute myocardial infarction. Any recent hospitalisation for heart disease. If YES, please contact the Day Hospital		
A PACEMAKER OR DEFIBRILLATOR Please bring your Pacemaker/Defibrillator card with you		
BLOOD CLOTS (DVT/PE)		
Have you ever received blood/blood product (eg anti D). If YES, did you have a reaction?		
STROKE (TIA)		
Malignancy or recent fracture		
Blood pressure NORMAL ☐ HIGH ☐ LOW ☐		
Anaemia		
RESPIRATORY		
SEVERE LUNG DISEASE		
Asthma. If YES, please bring your medication		
Recent respiratory infection (cold or flu) or signs or symptoms with a temperature over 38 degrees? If YES, please contact the Clinical Services Manager at your nominated hospital.		
Sleep apnoea		
SYSTEMS		
Vision impairment		
Hearing impairment		
Cochlear implant		
Bladder / kidney problems		
Anxiety / depression / panic attack		
Epilepsy / seizures / fits / dizzy spells		
INFECTION		
Tick if any apply to you Hepatitis A ☐ B ☐ C ☐ D ☐ E ☐		
Tick if any apply to you TB ☐ MRSA ☐ VRE ☐ CRE ☐		
In the last 2 weeks, have you had, or been in contact with, anyone with Chicken Pox or German Measles?		
Do you or any of your family suffer from or had exposure to Creutzfeldt jakob disease (CJD)?		
Received human pituitary hormone or had a dura mater graft between 1972 and 1989?		
DENTAL		
Crowns, bridges, dentures, caps		
Dental problems (eg gum disease, loose teeth, cracks)		
MOBILITY		
Fallen in the past 12 months		
Medication in the past 24 hours that impairs your co-ordination/ mental function		
Cognitive impairment (eg disorientation, dizziness, confusion, memory loss, inability to follow instructions)		
Back pain or injury / mobility problems Bed or wheel chair bound		
SKIN		
Skin rash, eczema, skin tear		
History of pressure areas		
LIFESTYLE		
Alcohol: How much each day? _____ Standard drinks		
Tobacco: How many each day? _____		
OTHER		
Have you ever used IV or recreational drugs?		
If female, are you pregnant? If no, date of last period __/__/__		
Needle phobia: If YES, please inform reception staff upon arrival		
Do you have an Advanced Care Plan/Health Care Directive?		
Any medical conditions/physical disability that may affect your procedure with us? If YES, please list		
I have read and agree with the Day Hospital's Privacy statement.		

PATIENT/GUARDIAN SIGNATURE | DATE

ADMISSION NURSE If YES to any of the above, record in COMMENTS section of Theatre Checklist

NURSE SIGNATURE | DATE