Spring Hill
SPECIALIST
DAY HOSPITAL
A MEMBER OF VIRTUS HEALTH

PATIENT LABEL

Online Admission (preferred)

1 Access the Hospital website:
- www.shsdh.com.au

2 Go to the Pre Admission section to complete the form and then click Submit

At least 7 days before Admission

OR Paper Admission

Complete and send to Reception at:
Spring Hill Specialist Day Hospital
Levels 1 & 4, St Andrew's Place
33 North Street, Spring Hill QLD 4000

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 ☐ INDETERMINATE ☐	PERMANENT RESIDENT YES ☐ NO ☐
MARITAL STATUS MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ DE FACTO ☐		
ARE YOU (IS THE PATIENT) OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN? NO ☐ YES ABORIGINAL ☐ YES TORRES STRAIT ISLANDER ☐ YES BOTH ABORIGINAL & TORRES STRAIT ISLANDER ☐ DECLINE TO ANSWER ☐		
LANGUAGE SPOKEN AT HOME	COUNTRY OF BIRTH	OCCUPATION

Emergency contacts

NEXT OF KIN		RELATIONSHIP	MOBILE
NAME OF GUARDIAN OR POWER OF ATTORNEY			MOBILE

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 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 30 DAYS? YES ☐ NO ☐

REFERRING LOCAL GP **SUBURB OF LOCAL GP**

Health care cards (if applicable)

PENSION NO.	TYPE OF PENSION	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, ATTACH CONFIRMATION LETTER)

WRITTEN APPROVAL FOR DAY SURGERY 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. ☐ (Box MUST be ticked)

I HAVE READ AND AGREE WITH THE DAY HOSPITAL'S PRIVACY STATEMENT ☐

PATIENT / GUARDIAN SIGNATURE **DATE**

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PLACE PATIENT LABEL HERE

Please complete all of the following requested information to assist our nursing team in undertaking a pre-admission assessment to ensure we are able to provide for you safely during your stay.

Do you require an interpreter for your admission? YES ☐ NO ☐

Do you have any cultural requirements? YES ☐ NO ☐

If yes please specify .....

Are you supported by aides? Hearing aids ☐ Glasses ☐ Walking aids ☐

other .....

Do you have an Advanced Care Directive? YES ☐ NO ☐

Do you have a decision maker or a carer who handles your affairs (including mental health carer) YES ☐ NO ☐

Name:

Mobile:

Email:

SURGICAL HISTORY (List previous operations)

GENERAL MEDICAL HISTORY (List serious/major illnesses)

BELOW MUST BE COMPLETED IN ORDER TO SUBMIT THE FORM ONLINE

Height: **Weight:** **Blood Group (if known):**

ANAESTHETIC RISKS

Have you had an adverse reaction during general or local anaesthesia? YES ☐ NO ☐

If yes, please specify: .....

Any history of airway complications or difficult intubation? YES ☐ NO ☐

If yes, please specify .....

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

Have you ever received blood/blood product (including anti D)? YES ☐ NO ☐

If yes, did you have a reaction? .....

Do you have: crowns ☐ bridges ☐ dentures ☐ caps ☐ braces ☐
retainers ☐ gum disease ☐ loose teeth ☐ cracked tooth ☐

ALLERGIES

Have you, or any of your family, experienced an adverse/allergic reaction to:

medication ☐ food ☐ sticky plaster ☐ latex ☐ rubber ☐ (balloons /gloves)

or other substances? Please specify below:

MEDICATION

Have you stopped taking regularly prescribed medication? If YES, please list — YES ☐ NO ☐

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

Have you taken any blood thinning medication this week?

Aspirin ☐ Warfarin ☐ Coumadin ☐ Clopidogrel ☐ Iscover ☐

Plavix ☐ Brufen ☐ Nurofen ☐ Indocid or Natural Thinners (eg Vitamin E, Chinese herbs, Ginkgo, Fish Oil, Garlic)? .....

Diabetics medication: Are you on a diabetic medication that contains Dapagliflozin, Empagliflozin or Ertugliflozin? YES ☐ NO ☐

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

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

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MEDICAL HISTORY (Please indicate if you have a history of any of the following)

Diabetes ☐ Type 1 ☐ Type 2 ☐ – insulin ☐ tablet ☐ or diet controlled ☐

Heart Attack ☐ Chest Pain ☐ Angina ☐ Palpitations ☐ Heart Murmur ☐
Irregular Heart Beat ☐ Enlarged heart ☐ Congestive Cardiac Failure ☐

Name of Cardiologist .....

Heart Valve ☐ Stent ☐
Pacemaker ☐ Defibrillator ☐ Please bring card with you

Make .....

Model ..... Last Checked .....

Blood Clots (DVT/PE) ☐ STROKE (TIA) ☐ Anaemia ☐ Bleeding disorder ☐

Hypertension ☐ High Cholesterol ☐

Epilepsy ☐ Fits ☐ Febrile convulsions ☐

Cancer ☐ Please specify .....

Limb odema ☐ Colostomy ☐ Illeostomy ☐ Recent fracture ☐
Back pain or injury ☐ Cervical conditions ☐ Arthritis ☐ Mobility problems ☐

Obstructive Airway Disease ☐ Bronchitis ☐ Asthma ☐ Hay Fever ☐
Sleep apnoea ☐ Shortness of breath ☐

Vision impairment ☐ Hearing impairment ☐ Speech Impairment ☐

Bladder problems ☐ Kidney problems ☐

Thyroid Disease ☐ Specify: .....

Liver Disease ☐ Specify: .....

Auto Immune Disease ☐ Specify: .....

Hiatus Hernia ☐ Gastrointestinal Ulcer ☐ Bowel disorder ☐ GORD ☐
Heartburn ☐ Dysphagia ☐

Any history of lapband when last checked? Inflated ☐ Deflated ☐

Mental health condition/illness ☐

Specify: .....

Disorientation ☐ dizziness ☐ confusion ☐ memory loss ☐
inability to follow instructions ☐ eating disorder ☐

History of falls? YES ☐ NO ☐ Number of falls in last 12 months? .....

Do you take regular medication that impairs your co-ordination/ mental function	YES ☐ NO ☐

Skin rash ☐ eczema ☐ skin tear ☐ history of pressure areas ☐

Needle Phobia: YES ☐ NO ☐

INFECTIOUS DISEASES please indicate if you have any of the following:

Recent Cold ☐ Flu ☐ Pneumonia ☐

Other .....

Had recent signs and symptoms of gastrointestinal infections?	YES ☐ NO ☐

Been diagnosed with or been in contact with, anyone with an infectious disease:
Chicken Pox ☐ German Measles ☐ Covid 19 ☐ influenza ☐

Other: .....

Had a recent respiratory infection (cold or flu) with signs or symptoms with a temperature over 37.5 degrees?	YES ☐ NO ☐
Have you been in a high-risk area / hot spot for COVID-19 (overseas, interstate or local areas) in the last 14 days?	YES ☐ NO ☐
Have you recently returned from travelling overseas/interstate (i.e. within the past 4-6 weeks)	YES ☐ NO ☐
Have you had an overnight stay in either an overseas hospital or in residential aged care in the last 12 months?	YES ☐ NO ☐

Have you been diagnosed with any of the following?
Hepatitis A ☐ B ☐ C ☐ TB ☐ MRSA ☐ VRE ☐ CRE ☐ CPE ☐ MRO's ☐

Do you or any of your family suffer from or had exposure to Creutzfeldt Jakob disease (CJD)?	YES ☐ NO ☐
Received human pituitary hormone or had a dura mater graft between 1972 and 1989?	YES ☐ NO ☐
Have you received pituitary growth hormones prior to 1985?	YES ☐ NO ☐
Do you have a family history of 2 or more relatives with CJD or Unspecified Neurological Disorder?	YES ☐ NO ☐

DIETARY REQUIREMENTS

Normal ☐ Diabetic ☐ Gluten Free ☐ Lactose Free ☐ Vegetarian ☐

Other .....

LIFESTYLE (Please indicate)

Alcohol YES ☐ NO ☐ If Yes, standard drinks per day: .....

Smoking YES ☐ NO ☐ If yes, how many each day? .....

IV or recreational drugs? YES ☐ NO ☐

DISCHARGE PLANNING

YOU RISK YOUR PROCEDURE BEING CANCELLED IF YOU DO NOT HAVE SOMEONE TO TAKE YOU HOME AND STAY WITH YOU OVERNIGHT

Name of Escort:
(Person driving you home)

Mobile:

Do you have a carer arranged to collect and care for you for first 24hours postoperatively? YES ☐ NO ☐

Do you receive community support? YES ☐ NO ☐

PATIENT/GUARDIAN SIGNATURE	**DATE**
NURSE SIGNATURE	**DATE**