

Peninsula Health



Request for Elective Admission

At Peninsula Health we are passionate about providing a health service that meets the needs of our community. For those patients who are to have elective surgery at either Frankston Hospital or Rosebud Hospital, this elective surgery pack will provide our clinical coordinators with the necessary information to place you on the waiting list to help identify any health or social issues that may need attention before and after your treatment.

Instruction for completion of forms:

Doctor to complete

- Request for elective admission form
- Consent with the patient or representative
- Progress Note page available if any clinical documentation is required.
- Please supply any relevant results, letters and reports for hospital records.

Patient or representative to complete

- Pre admission Service Questionnaire

When completed, please return this pack in the pre-paid envelope provided. If you have any difficulties completing the Pre Admission Service Questionnaire, please ring:

9784 7340

Please understand that failure to complete these forms (which we require to assist with active management of your fitness for surgery and discharge planning) may result in your treatment being unnecessarily delayed. Please notify the hospital if you change your name, address or phone number.

Patient's Nominated General Practitioner Surname: <i>Dr. Nisha Athapatta</i> Address: <i>3-7 Kingston Drive Carabourne East</i> Contact No.: <i>(03) 5495 0755 / 66</i> Fax: _____	
Category of Clinical Urgency: ☐ Category 1 (Urgent within 30 days) ☐ Category 2 (semi-urgent desirable within 90 days) ☐ Category 3 (Desirable within 365 days)	
Known Alerts: ☐ Latex, ☐ drug, ☐ VRE, ☐ MRSA?	Clinical Notes:
Special Requirements (equipment, prostheses, consumables, cell saver) ☐ Routine ☐ Extended ☐ Day Case ☐ Overnight ☐ Image Intensifier ☐ Part Case ☐ Whole case ☐ C-arm suitable Duration of Procedure _____	
Proposed Surgery / Procedure <i>Back pain and neck pain</i>	PPP Code: _____
Provisional Diagnosis <i>Reflexion infusion - Day care</i>	
Can the patient continue antiplatelet or anticoagulant therapy perioperatively? ☐ Yes ☐ No - please advise: _____	
Referring Consultant: <i>Dr. Mongle</i> Unit: <i>Pain Medicine</i>	
Surgery Details	
Medicare No. <i>342414053 51</i> Pension No. _____ DVA No & card colour _____	
Admission Type ☐ Private ☐ Public ☐ DVA ☐ TAC ☐ WC ☐ Other _____	
Private Health fund details Fund Name: _____ Membership No: _____	
Patient: Title _____ Surname _____ Given Name <i>SIVA</i> Date of Birth: _____ / _____ / _____ Male ☐ Female ☐ Address: _____ Postcode: _____ Phone: Home _____ Work _____ Mobile _____ Next of Kin: Name _____ Phone: _____ Mobile _____ Email: _____ Interpreter required ☐ No ☐ Yes - Language _____ Religion _____ Aboriginal / Torres Strait Island ☐ Yes ☐ No	

UR NUMBER	SURNAME	GIVEN NAMES	DATE OF BIRTH	Sex: M ☐ F ☐
Please fill in if no Patient Label available				
29/08/14 Print Code: 14369				

Peninsula Health
 Doctor to Complete
 REQUEST FOR
 ELECTIVE ADMISSION





**Doctor to Complete
CONSENT FORM
- OPERATION / PROCEDURE**
(Refer to PH Policy 6.1.3)

Peninsula Health

UR NUMBER.....
SURNAME.....
GIVEN NAMES.....
DATE OF BIRTH.....
Please fill in if no Patient Label available
Rev. 20/12/12 Print Code:13491

DOCTOR / PROCEDURALIST
Operations / Procedures proposed (to be documented by Doctor/Proceduralist):
Uterine Infusion

I, Doctor/Proceduralist..... have informed and explained to the ☐ Patient ☐ Responsible Person/Guardian
☐ The nature and effect of the proposed operation / procedure
☐ The material complications and risks as documented below:

I have also supplied the patient with relevant printed information from:
☐ EIDO Healthcare brochures (Peninsula Health Intranet), or
☐ Relevant Patient Information Brochure

Doctor / Proceduralist Signature.....
Print Name *Monique*
Date and Time.....

Waiting List Office has provided EIDO Health Care Brochure ☐ Yes
Signature Waiting List Staff Member:.....

PATIENT
Surname of Patient / Responsible Person / Guardian *Siva Reddy*
Given Names.....
confirm that the above information has been provided to me and I understand and give consent for:
 the proposed operation / procedure and other operations / procedures found urgently necessary during the operation,
 including the anaesthetic and/or blood product transfusion. I have also had the opportunity to ask questions and receive
 relevant information. I understand that no guarantee is given that the procedure will be performed by a particular surgeon/
 proceduralist. I understand I may withdraw consent, in writing at any time.

Signature of Patient / Responsible Person / Guardian *S. Siva Reddy*
Print Name.....
Relationship to Patient.....
Date and Time.....
 (* Please tick confirming Printed information supplied)

Confirmation of Consent on Admission
 Signature Patient.....
 Signature Doctor.....
 Date.....
 Date.....

HEIGHT/WEIGHT/AGE

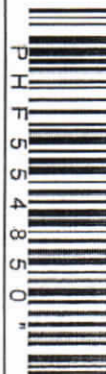
Patient to Complete

DATE OF BIRTH

15/10/13 Print Code:10562

.....ou a

- FOR COMPLETION BY PATIENT -



Peninsula Health
Pre Admission Service Questionnaire
(cont.)

Patient to Complete

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH.....

Please fill in if no Patient Label available

GENERAL HEALTH INFORMATION

Please ✓ boxes as appropriate

39. Do you require an Interpreter - if yes, what language? ☒ No ☐ Yes
40. Do you have a problem with your speech? - if yes, what ☒ No ☐ Yes
41. Do you have impaired eyesight? - Glasses / Contact Lens / Eye prosthesis / Legally blind (circle) ☒ No ☐ Yes
42. Do you have impaired hearing? - Deaf / Hearing aid (circle) ☒ No ☐ Yes
43. Has your bowel pattern changed recently? - Constipation / Diarrhoea / Blood / Incontinence (circle) ☒ No ☐ Yes *Bowel Issues*
44. Do you have any problems passing urine? - pain / odour / blood / incontinence, catheter (circle) ☒ No ☐ Yes
45. Do you have a stoma? - colostomy / ileostomy / ileal conduit, tracheostomy / laryngectomy (circle) ☒ No ☐ Yes
46. Have you had any falls in the past few months? ☒ No ☐ Yes
47. Do you use any mobility aids such as a stick, frame or wheelchair etc.? ☒ No ☐ Yes
48. Do you have any eating or swallowing difficulties or special eating/dietary needs? ☒ No ☐ Yes
49. In the last three months have you had a non-healing wound ☒ No ☐ Yes

DISCHARGE PLANNING

1. Do you live alone? ☒ No ☐ Yes
2. Do you live in a residential care facility? - nursing home / hostel / other supported accommodation (circle) ☒ No ☐ Yes *Children*
3. Do you have responsibility for the care of others at home? e.g. sole parent, care of disabled relative (circle) ☒ No ☐ Yes
4. Do you currently require assistance with toileting / showering / bathing / dressing / cooking / housework / shopping? (circle) ☒ No ☐ Yes
5. Will additional assistance be needed when you return home? ☒ No ☐ Yes
6. Do you currently receive any support services? e.g. home nursing / meals on wheels / home-help / personal care, respite care / Community Aged Care Packages - (circle) ☒ No ☐ Yes
7. We advise that you must have an adult escort you home and a carer overnight following discharge from day surgery.
- Who will stay with you? - Name: *Bharathi / Poja* Phone No. *0630 026678*
- Who will escort you home from hospital - Name: *Bharathi* Phone No. *0630 026678*
8. How long do you expect to be in hospital? *07/04/2015*
- Signature of Person Completing Form: *G. Siva Ganesan* Date Signed: *07/04/2015*
- Relationship to Patient (if not completed by the patient):