SAME DAY CONSULT/SURGERY FORM

THIS FORM MUST BE COMPLETED IN FULL

oro max clinic

INSTRUCTIONS:
To enable your surgeon to assess if you are a suitable candidate for Same Day Consult and Surgery you are required to complete this form (3 pages) and forwarded to our office with your Referral and X-ray. Please ensure you provide a home number and mobile number on this form and send to:

POST: Patient Liaison Officer
Level 2, 66 Rundle Street
Kent Town SA 5067

OR

EMAIL: reception@oromax.com.au

Once received, one of our surgeons will review your referral and x-ray and determine whether your surgery needs to be performed in a private hospital or under Intravenous Sedation in our Day Surgery. You will then be contacted by a Patient Liaison Officer to advise you of the preferred treatment plan and an estimate of fees.

FEES: ***Surgeon's fees*** are payable on the day of surgery.
Anaesthetist fees are payable a few days prior to your surgery.
Hospital fees are payable on the day of surgery.

CARER: You must attend with a carer as you will not be able to drive after your surgery.

FASTING: Our team will give you fasting instructions when your surgery is booked.

TREATMENT PLAN: A consultation appointment will be made for you at Level 2, 1 Hutt Street Adelaide. A surgery time will be booked in Adelaide and you will be advised of the location.

PATIENT INFORMATION	
TITLE	Mr / Mrs / Ms /Miss / Master / Dr
GIVEN NAMES	
(Preferred Name)	
SURNAME	
DATE OF BIRTH	
POSTAL ADDRESS	
SUBURB	
POST CODE	
OCCUPATION	
HOME PHONE	
WORK PHONE	
MOBILE	
EMAIL	

REFERRAL INFORMATION	
REFERRED BY	
USUAL MEDICAL GP	

CARD INFORMATION	
MEDICARE NO	_ _ _ _ / _ _ _ _ _ / _
No next to your name	
Expiry Date	_ _ / _ _ _ _
VETERAN NO	☐ White Card ☐ Gold Card

HEALTH INSURANCE INFORMATION	
NAME OF HEALTH FUND:	
HEALTH FUND MEMBERSHIP NO:	
Have you been with this Fund for more than 12 months?	**YES / NO**
DO YOU HAVE HOSPITAL INSURANCE?	**YES / NO**
DO YOU HAVE DENTAL EXTRAS?	**YES / NO**
If 'YES' are your Dental Extras with the same fund?	**YES / NO**

CONSENT

As I am seeking private treatment, I understand that the payment of the account is my sole responsibility. I undertake to pay any additional expenses incurred in recovery of overdue accounts. In the case of a minor this responsibility transfers to the person responsible for the account.
This Practice has a Privacy Policy on handling patient information. You are not obliged to provide any information requested of you, but that failure to do so might compromise the quality of your care. I consent to the handling of my information for the purposes required for my treatment subject to any limitations on access or disclosure, that I notify this Practice of in writing.

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MEDICAL HISTORY INFORMATION

NAME:	**DOB:**	**UR:** *To be completed by Oromax*
HEIGHT:	**WEIGHT:**	BMI: (office use only)

PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	**NO**	**YES**
Have you had an anaesthetic before?		
Have you or any relative ever experienced complications with an ANAESTHETIC?		
Have you had an operation in the last five years? If yes, please document reason below : ……		
Do you have any neck or jaw stiffness?		
Are you **ALLERGIC** to any drugs, food, tapes, latex or rubber? If yes, give details: ……		
Have you any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?		
Have you ever tested positive for Hepatitis B, Hepatitis C, HIV, MRSA or VRE? *(Please circle]*		
Is there a possibility that you may be pregnant?		
Do you have any special needs? (eg. needle phobia)		
Do you take ASPIRIN regularly, WARFARIN or 'blood thinning' medication?		
Have you had any treatment for excessive bleeding or bleeding disorder?		
Do you have or have had Anaemia?		
Do you have or have had High Blood Pressure?		
Have you had Rheumatic fever?		
Have you had a heart attack or heart problem (including chest pain, ANGINA, heart palpitations)?		
Have you had Heart Surgery? If yes, when? Do you have any of the following: ❒ Pacemaker ❒ Cardiac stents ❒ Heart valve replacement ❒ Other		
Do you have an arm shunt or suffer from Lymphedema of arms?		
Do you suffer from ASTHMA? If yes, do you use a puffer (eg. Ventolin)? YES / NO		
Do you have or have had troublesome shortness of breath, persistent cough or sleep apnoea?		
Have you ever had bronchitis or pneumonia? If yes, when?		
Do you or have you had any kidney disease?		
Are you a diabetic? If yes, Type 1 or Type 2?		
Have you ever had Hepatitis, jaundice or liver problems?		
Do you have stomach or peptic ulcers, Hiatus hernia, reflux, indigestion or heartburn?		
Do you or have you had any psychiatric conditions? (eg: Anxiety, Depression, Other)		
Do you suffer from Epilepsy, fits, blackouts or faints?		

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NAME: Please re-enter in case pages get separated.	**DOB:**	
PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	**NO**	**YES**
Do you suffer from eczema or any other skin condition?		
Have you or any member of your family had or been exposed to infectious/communicable disease in the last 2 weeks? (eg. Flu, shingles, measles)		
Do you require assistance with walking?		
Have you ever smoked? If yes, what is your daily amount? ……..		
Do you drink alcohol? If yes, what is your daily amount? ……..		
Do you use or have used in the past year any recreational drugs?		
Have you had any other serious illness?		
Any further comments?		
List names/doses of all TABLETS/MEDICINES you are currently taking (including un-prescribed drugs/herbal/ complimentary medicines):		
How do you plan to get home when you are discharged?		
Where will you be staying the night of your surgery?		

For patients who will have intravenous sedation at Oromax Day Surgery:

Following surgery, I will have a responsible adult drive me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia. I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.

For all patients:

I will follow discharge instructions and attend appointments as advised. The answers I have given to all questions are true to the best of my knowledge.

*Signed*_____ *Date*_____

PREADMISSION ASSESSMENT (Surgeon to complete)

Date……..

SURGEON: ❒ Dr Robinson ❒ Dr Doddridge ❒ Dr Sambrook ❒ Dr Jaunay ❒ Dr Collum ❒ Dr Carter ❒ Dr Candy

ALERT (Red Wrist Band): **YES / NO**

FURTHER FOLLOW UP REQUIRED: **YES / NO** **IF YES:**

❒ Refer for Pre-Anaesthetic Check

❒ Refer to General Practitioner

❒ Other:……

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