STONNINGTON day surgery
Level 1, 253 Wattletree Road, Malvern 3144
Phone: 9508 9509 Fax: 9508 9599

Affix Patients Identification Label

PATIENT REGISTRATION CONSENT

PLEASE PRINT, RETURN TO THE DAY SURGERY PRIOR TO ADMISSION (at least 3 working days).

Admitting Doctor _____ Admission Date: _____ /_____ /_____ Time: _____AM / PM

Surname: _____ Given Names:_____ Title:

Address: _____ Postcode: _____

Tel: Home _____ Tel: Work _____ Mobile:_____

Sex: Male ☐ Female ☐ Age: _____ Date Of Birth: _____ /_____ /_____ Country Of Birth: _____

Aboriginal/Torres Strait Island Descent: Yes ☐ No ☐ Religion:_____ Language Spoken at Home _____

Marital Status: Currently Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other _____

Health Insurance Fund: _____ **Membership No.:** ☐☐☐☐☐☐☐☐☐☐☐☐

Medicare No.: ☐☐☐☐ ☐☐☐☐☐ ☐ **Individual Reference No.:** ☐

Vet Affairs No.: ☐☐☐☐ ☐☐☐☐ **Work Cover: / Tac Details:** _____

Uninsured Theatre Fee: _____

Have you ever been a patient at Stonnington Day Surgery? **Yes** ☐ When _____

Have you been hospitalised in the last 7 days? **Yes** ☐ **No** ☐ If Yes, _____ /_____ /_____

If Yes, Hospital:_____ Date of Admission: _____ /_____ /_____ Date of Discharge: _____ /_____ /_____

PERSON TO CONTACT IN AN EMERGENCY:

❶ **Name:**_____ Relationship to patient: _____

Tel: H: _____ Tel W: _____Mobile _____

❷ **Name:** _____ Relationship to patient: _____

Tel: H: _____ Tel W: _____Mobile _____

CONSENT for surgical operation / procedure and anaesthesia **(including minors)**

I _____hereby consent to **(Details of procedure - no abbreviations)**

_____

being performed on **(myself/my child - name)**_____by _____

(Doctor's name - print)

who has explained the nature, effect and risks of the proposed treatment to me.
I also request and consent to the administration of anaesthetics, medicines, blood transfusion or other forms of treatment normally associated with this operation/procedure.
I understand that other unexpected operations/procedures may be necessary and that I request that these be carried out if required.
I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this procedure.
I understand that should I require admission to a hospital for further care, I will be responsible for the cost incurred.
Following surgery I will be escorted home by a responsible adult, and have made arrangements for this. I understand that impairment of mental alertness may persist for up to 24 hours after anaesthesia and I will avoid making decisions or taking part in activities which depend upon full concentration or judgement during that period.
I understand that the sample of blood may need to be tested for infectious agents such as Hepatitus B, Hepatitus C and HIV in the event of its exposure to another person: for example my doctors or a hospital staff member.
I have read and understand the Privacy policy and patients Rights and Responsibilities documents available at reception.

Dated this _____ day of _____201 _____

Signed _____ *Relationship to Patient_____

Signature of Doctor_____ Date: _____ /_____ /_____

PATIENT REGISTRATION / CONSENT FORM MR31

STONNINGTON day surgery
Level 1, 253 Wattletree Road, Malvern 3144
Phone: 9508 9509 Fax: 9508 9599

Affix Patients Identification Label

PATIENT REGISTRATION CONSENT

PLEASE PRINT, RETURN TO THE DAY SURGERY PRIOR TO ADMISSION (at least 3 working days).

Admitting Doctor _____ Admission Date: _____ /_____ /_____ Time: _____AM / PM

Surname: _____ Given Names:_____ Title:

Address: _____ Postcode: _____

Tel: Home _____ Tel: Work _____ Mobile:_____

Sex: Male ☐ Female ☐ Age: _____ Date Of Birth: _____ /_____ /_____ Country Of Birth: _____

Aboriginal/Torres Strait Island Descent: Yes ☐ No ☐ Religion:_____ Language Spoken at Home _____

Marital Status: Currently Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other _____

Health Insurance Fund: _____ Membership No.: ☐☐☐☐☐☐☐☐☐☐☐☐

Medicare No.: ☐☐☐☐ ☐☐☐☐☐ ☐ Individual Reference No.: ☐

Vet Affairs No.: ☐☐☐☐ ☐☐☐☐ Work Cover: / Tac Details: _____

Uninsured Theatre Fee: _____

Have you ever been a patient at Stonnington Day Surgery? Yes ☐ When _____

Have you been hospitalised in the last 7 days? Yes ☐ No ☐ If Yes, _____ /_____ /_____

If Yes, Hospital:_____ Date of Admission: _____ /_____ /_____ Date of Discharge: _____ /_____ /_____

PERSON TO CONTACT IN AN EMERGENCY:

❶ Name:_____ Relationship to patient: _____

Tel: H: _____ Tel W: _____Mobile _____

❷ Name: _____ Relationship to patient: _____

Tel: H: _____ Tel W: _____Mobile _____

CONSENT for surgical operation / procedure and anaesthesia (including minors)

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_____

being performed on (myself/my child - name)_____by _____

(Doctor's name - print)

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Dated this _____ day of _____201 _____

Signed _____ *Relationship to Patient_____

Signature of Doctor_____ Date: _____ /_____ /_____

PATIENT REGISTRATION / CONSENT FORM MR31

Stonnington - Patient Registration / Consent Form MR31v2