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 ☐ Other ☐ Age: _____ Date Of Birth: _____ /_____ /______ Country Of Birth: ____________

Religion:__________ Language Spoken at Home __________ ____________________

Are you of Aboriginal or Torres Strait Islander Origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

☐ Yes, both Aboriginal & Torres Strait Islander ☐ Decline to Answer

Marital Status: Currently Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Defacto ☐

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** ☐

Have you been hospitalised in the last 14 days? **Yes** ☐ **No** ☐ If Yes, _____ /_____ /______

PERSON TO CONTACT IN AN EMERGENCY and BEFORE CONSENT:

❶ **Name:**______________________________ Relationship to patient: ______________

Tel: H: ________________ Tel W:________________Mobile ______________

❷ **Name:** ______________________________ Relationship to patient: ______________

Tel: H: ________________ Tel W:________________Mobile ______________

Do you have a substitute decision maker ☐ No ☐ Yes If yes, details ____________________

Do you have advanced care directives ☐ No ☐ Yes If yes, please provide a copy on admission

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 ____________________20________

Signed ________________ *Relationship to Patient____________________

Signature of Doctor______________________________ Date: _____ /_____ /______

PATIENT REGISTRATION / CONSENT FORM

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