

Clinical staff use only: If PA Assessment by RN was required tick sign _____ Director of Nursing sign _____

M.R. No. _____

RANDWICK DAY SURGERY

Prov. No. 0999901X

This centre is owned and operated by Dr. G. Tier, Dr M. Stergoulis, Dr J. Cannon & Dr A. Theodore
2 Eurimbla Avenue Tel. 9398 8190
RANDWICK 2031 Fax 9314 5331

PRE-ADMISSION FORM

Please answer ALL questions, printing clearly, and **RETURN THE FORM TO THE DAY SURGERY AT LEAST ONE WEEK PRIOR TO YOUR ADMISSION.** All information given is treated as strictly confidential.

Surname _____ Given Names _____

Home Address _____

P/code _____

Postal Address (if different from above) _____ P/code _____

Telephone-Home _____ Business _____ Mobile _____

Please be advised all patients over the age of 55yrs will require pre-anaesthetic testing, this includes Full Blood Count, BSL & ECG (speak to your dentist/RDS for further information)

*Age _____ Date of Birth _____ Sex: M F Occupation: _____

Medicare No: _____ Valid to: _____ Ref: _____

Veterans Affairs No: _____ Pensioner Pharmaceutical Benefits No. _____

Do you have private health insurance - hospital cover? Yes No

Name of fund _____ Membership No. _____ Table _____

Name of member _____ Date joined _____ Date paid to _____

Family Single Date your cover was last updated (if applicable) _____

Next of Kin: Name _____ Tel. No. _____

Address: _____

Relationship to patient: _____

Date of Admission: _____

Proposed treatment: _____ (check with your dentist if unsure)

Time of Admission: _____ am/pm

Name of admitting Dr/Dentist _____

Is this your first admission to Randwick Day Surgery? Yes No

Do you require an interpreter service ? Yes No

Surname: _____ Given Names: _____ dob: _____

The following information is required by the NSW Health Department for statistical purposes:

*Country of birth: _____ Language spoken at home _____

*Are you of Aboriginal or Torres Strait Islander origin: Y, Aboriginal Y, TSI Y, both A&TSI No

*Marital status: Married/defacto Never married (single) Widowed Divorced Permanently separated Not known

*Have you been admitted to hospital within the last 28 days: No Yes, this hospital Yes, other hospital

MEDICAL HISTORY: *To be completed by the patient before admission.*

1. Have you had any previous operations or serious illnesses? No Yes

If yes please detail _____

2. Have you had any reactions or problems with previous anaesthetics? No Yes

If yes please detail: _____

3. Do you carry a Medic Alert Card? No Yes

4. Are you allergic to any foods, drugs, complimentary medicines or dressings? No Yes

If yes please detail _____

Previous Anaphylaxis? _____ No Yes

5. Are you being treated for any other medical condition? No Yes

If yes please detail _____

6. Please list **all medications** you are currently taking, including herbal medications such as Fish Oil, Echinacea, Gingko, St. Johns Wart, Ginger or Garlic tablets. _____

7. Do you smoke? Yes No Are you pregnant? Yes No

8. Height.....cm Weight.....

9. Do you suffer from any of the following? *Please circle your answer*

Cough	Yes No	Heart disease/murmur	Yes No	HEP A/B/C	Yes No
Asthma	Yes No	Chest Pain	Yes No	HIV	Yes No
Breathlessness	Yes No	High Blood Pressure	Yes No	Glaucoma	Yes No
Blood Disorders	Yes No	Palpitations	Yes No	Prostate problems	Yes No N/A
Anaemia	Yes No	Fits	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	Gastric Reflux	Yes No	Acid indigestion	Yes No
Dental/Needle Phobia	Yes No				

10. Name of General Practitioner: _____

Address: _____ Tel No: _____

* **If you do not have a GP or details unknown please tick**