

Pindara
Day Procedure Centre

**PRE-ANAESTHETIC/
ADMISSION QUESTIONS**

Surname: _____

First Name: _____

U.R. No.: _____

Ward: _____ Bed: _____

Please affix patient's identification label

QUESTIONS TO BE ANSWERED BEFORE ADMISSION:

Please circle the appropriate response e.g.

Y	N
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PATIENT HISTORY:

Heart Trouble	Y	N	Any problems with anaesthetics?	Y	N
Chest Pain	Y	N	If yes, what? _____ _____		
Asthma	Y	N			
Diabetes	Y	N			
High Blood Pressure	Y	N	Could you be pregnant?	Y	N
Epilepsy	Y	N	Do you smoke?	Y	N
Rheumatic Fever	Y	N	Do you drink alcohol?	Y	N
Bleeding Tendencies	Y	N	Do you have any allergies - food or drugs, etc?		
Stroke	Y	N		Y	N
Any infections we should be aware of?	Y	N	If yes, what? _____ _____ _____		
If yes, what? _____ _____					

Do you have any artificial joints, lens implants, dental appliances or contact lens? If so, what?

List Medications

List Operations

<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Who will drive you home on day of surgery? _____

Who will be home with you for the rest of the day? _____

Contact Phone No: _____ Locker No: _____

PRE-ANAESTHETIC/ADMISSION QUESTIONS

PATIENT'S DAY PROCEDURE CENTRE AGREEMENT

**I HAVE BEEN ADVISED OF THE SPECIAL NATURE OF DAY SURGERY
AND HAVE BEEN INSTRUCTED IN THE FOLLOWING TERMS WITH
REGARD TO MY UNDERGOING AN ANAESTHETIC**

- Client deemed suitable for day surgery by the surgeon and anaesthetist.
- My place of residence for post surgery is within one hour travelling time from medical attention.
- I have a responsible person 18 years or over to accompany me home and remain with me overnight post anaesthetic.
- I agree not to drive any type of vehicle, motorcycle, ride a bicycle or operate any type of machinery or electrical appliance which may be potentially harmful for 24 hours post anaesthetic.
- I agree not to consume alcohol for 24 hours post anaesthetic.
- I agree not to make any important decisions or sign a contract or any important documents within 24 hours of the anaesthetic.
- I agree to follow the written instructions provided by Pindara Day Procedure Centre.
- I agree to contact the hospital or private specialist in the event of any post operative complications.

Patient/Parent/Guardian* Signature

Date **Signature of Witness**

* Delete as necessary



**REQUEST / CONSENT FORM
FOR SURGICAL OPERATION PROCEDURE
AND/OR MEDICAL TREATMENT**

PATIENT STICKY LABEL

Name _____

U.R. No. _____

Ward _____ Bed _____

Part A: Provision of information to patient (To be completed by Medical Practitioner)

I, Doctor _____
(Insert name of medical practitioner)

have informed: _____
(Insert name of patient/parent/guardian)

of the nature, likely results, and material risks of the recommended operation/procedure and/or treatment. The agreed operation/procedure and treatment that the patient is to undergo is:

(Insert name of operation/procedure and/or treatment)

Interpreter required? Yes No

I, _____, an accredited interpreter have accurately interpreted the advice given by the medical practitioner named above to _____

Signature of Medical Practitioner

Date ____/____/____

Signature of Interpreter

Date ____/____/____

Part B: Patient Consent (To be completed by Patient)

The doctor whose name appears in Part A above and I have discussed my/my child's/my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of anaesthetic, medicines and/or a blood transfusion may be needed in association with this operation/procedure and/or treatment and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedure and/or treatments being carried out if required as long as they are related to the primary procedure set out in Part A.
- Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risk.

I have been advised of the material risks associated with this operation/procedure and/or treatment.

I have had the opportunity to ask questions about the operation/procedure and/or treatment and I am satisfied with the answers and information I have received.

I understand that I may withdraw my consent at any time prior to the operation/procedure and/or treatment.

I **consent/do not consent** to a blood transfusion if needed. (circle one)

I **request, understand and consent** to the operation/procedure and/or treatment as outlined above in Part A

Signature of patient/parent/guardian

Date ____/____/____

Signature of witness to patient's signature

Date ____/____/____

Print name of patient/parent/guardian

Address: _____

Print name of witness

Address: _____

CONSENT FORM