Epping Surgery Centre

Suite 3, Oxford Place
44-46 Oxford St, Epping NSW 2121
Tel: 02 9868 6555 Fax: 02 9868 6544
reception@eesc.com.au

Place ID Label Here

Admission Form

Admission Form

Please indicate responses by crossing the appropriate box ☒

Surgeon: Date of Admission / /

Procedure: Left ☐ Right ☐

Patient Details

Title	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Master ☐	Prof ☐	Dr ☐	Sr ☐	Fr ☐	Gender	M ☐ F ☐				
Given Names					Family Name										
Street Address															
Suburb			State		Post Code		Date of Birth	/ /							
Phone	Home		Work		Mobile										
Email															

First admission to the hospital:	Please complete both sides of this form in full and return to the day hospital along with the Consent Form as soon as possible prior to your admission. Your responses are valuable to us in planning your admission and care. Alternatively, this form can be completed online at **www.eesc.com.au**
Second / subsequent admissions:	If your last admission was within the past three (3) months and there have been no changes to your personal details or medical condition since your last admission please cross here ☐ and sign at the bottom of this page.

Marital Status	Married / De Facto ☐	Single ☐	Widowed ☐	Divorced ☐	Separated ☐
Ethnicity	Aboriginal ☐	Torres Strait Islander ☐	Both ☐	Neither ☐	
Language Spoken		Country of Birth			
GP's Name		GP's Suburb			

Private Health Insurance / Medicare / DVA / Workcover Details

Medicare, DVA, Pensioner	Medicare No	Ref No:	Expiry Date	
	Dept of Veteran's Affairs File No		Gold ☐	White ☐
	Pension No			
Private Health Fund	Are you in a Health Fund	Yes ☐ No ☐		
	Health Fund Name		Membership No	
Worker's Compensation MVA Third Party	Admission covered by WC Claim	Yes ☐ No ☐	Date of Injury	
	Name of Employer		Employer phone No	
	Admission covered by MVA Claim	Yes ☐ No ☐	Claim Number	
	Insurance Co		Contact number	

Next of Kin / Carer Details:

Next of Kin	Relationship		Given Name		Surname
	Address				
	Telephone No.	Home:	Work:	Mobile:	

Do we have permission to speak to this person regarding your admission and care? Yes ☐ No ☐ or Carer? Yes ☐ No☐
Will this person be your carer on the day of surgery (ie taking you home)? Yes ☐ No ☐

Carer's Details (if not Next of Kin above)	Name		Relationship	
	Telephone No.	Home:	Work:	Mobile:

Patient Privacy Information for personal health information

Epping Surgery Centre ensures that your information is collected, stored and used in compliance to the Australian Privacy Principles (APP) (Privacy Act 1988 & Privacy Amendment Act 2012). Epping Surgery Centre is committed to ensuring that the individual's information is used only for the purposes consented to by the individual. We may communicate with you or your referrer electronically using the highest standards of information security and privacy e.g. online registration, discharge information, patient satisfaction surveys & eNewsletters. You may opt out of this at any time. Video surveillance camera's (CCTV) are used internally throughout our Hospital to improve the patient journey and for safety and security reasons. Epping Surgery Centre complies with the APPs in respect of any personal information collected via its CCTV systems.

I have carefully read all details on this form and confirm that all information given on the Admission forms is correct and true to the best of my ability. I have read the Patient's Rights and Responsibilities and Privacy information in the Patient Booklet, online at the website or on display in the hospital. I am aware that it is a requirement of my admission to have an escort home and a carer overnight following surgery

Patient / Guardian Signature		Date	/ /

* B A R C O D E 1 *

Admission Form MR2

Pre-Admission & Medical Assessment Form

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Pre-Admission & Medical Assessment Form

PATIENT'S NAME		**Date of Birth**	
REFERRED TO SURGEON BY:	**GP** ☐ **Optometrist** ☐ **or Other Specialist** ☐		
	Name:	**Suburb:**	

Medical History

Please indicate responses by crossing the appropriate box. ☒

	Yes	No		Yes	No		Yes	No
Heart trouble			Diabetes			Cold Sores /Herpes Simplex		
Pacemaker or Defibrillator			Kidney disease			Contact dermatitis		
High blood pressure			Organ transplant			Latex / rubber allergy		
Stroke &/or TIA's			Glaucoma / Cataracts			Asthma or Wheezing		
Blood clots			Retinopathy			COPD / CAL / Emphysema		
Bleeding or bruising			Mental Health Illness			Tuberculosis		
Anaemia			Dementia or Alzheimer's			Persistent Cough /Breathlessness		
Hepatitis or HIV			Arthritis or/ limited joint movement			Current chest infection /cold/ fever		
Skin Ulcers or Open Wound			Spina Bifida			Overseas travel in last 3 months		
Growth Hormone (pre 1985)			Paraplegia / Muscle weakness			Are you pregnant?		
Dura Mater graft between 1972 - 1989			Amputee _____			Do you smoke?		
Do you or your family have a history of Cruetzfeldt Jacob Disease (CJD)			Epilepsy / Fits or Faints			Do you drink Alcohol or take recreational drugs? Amount _____ per week		
			Recent Falls					

Have you, or your family, ever experienced any problems with anaesthetics? Yes ☐ No ☐

List of Current Medications - Including vitamins, supplements or herbal preparations

Please attach a GP Management Plan or list on a separate sheet if insufficient space.

I am not currently taking any medications ☐ | Is your surgeon aware that you are on all the medications listed? Yes ☐ No ☐

Warfarin Therapy	Yes ☐ No ☐	If presently taking Warfarin, please provide below the details of the most recent INR test.					
	Date		INR		Date ceased		Plavix ☐ Isocover ☐

Drug	Dosage	Frequency

Allergies & Adverse Drug Reactions

Nil Known ☐ **Please use extra sheet if insufficient space.**

Drug or Other	Reaction Type	Date

Illnesses and Conditions

Please use extra sheet if insufficient space.

Operations and approximate dates

Please use extra sheet if insufficient space.

Weight & Height	kg cm	Is there anything else you feel we should know?

Patient / Guardian Signature		Date	/ /

MR2A

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