



**Please read and complete this form carefully. If you need an interpreter call 9326 2666 and we will arrange one for you.**

**Declaration**

In accordance with the Health Records Act 2001 and the Privacy Act 1988 - I provide consent for the collection of necessary personal health information and agree to the transfer of relevant health information to other healthcare providers who may be participating in my treatment when requested. It is my understanding that the EDPC staff will make reasonable steps to ensure I am generally aware of the circumstances under which this information is released.

- 1. Privacy Statement
- 2. Australian Charter of Healthcare Rights (ACHCR) - available in multiple languages. Please ask.
- 3. Complaints management process.
- 4. Child Safety Statement

- I understand fees are the responsibility of the patient, parent or guardian (unless DVA, Army, TAC or WorkCover).
- I understand Medicare does not cover admission to a private or public hospital.
- I will inform my doctor of any advanced care directives or treatment limiting orders at my first consultation I will ring my doctor if there are changes to my medical or medication history prior to surgery.
- I am aware my doctors are obligated to discuss any unforeseen changes to my treatment plan with myself or my carer.
- To the best of my ability the attached medical history is true and correct.

Title: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Country Of Birth: \_\_\_\_\_

Are you of Aboriginal or Torres Strait Island Descent?     YES     NO

Occupation: \_\_\_\_\_

Contact Details: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Postal Address (if different): \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Next of Kin: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Medicare No: \_\_\_\_\_

Reference No (number next to your name): \_\_\_\_\_ Expiry: \_\_\_\_\_

Do you have Hospital Insurance?                                     YES     NO

Do you have Dental Extras?     YES     NO

Name of Health Fund: \_\_\_\_\_

Membership No: \_\_\_\_\_ Veteran Affairs No: \_\_\_\_\_

TAC / Work Cover Claim No: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_

Name of Local Doctor: \_\_\_\_\_

Person Responsible for Account (if different from above): \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Signature: Patient | Carer \_\_\_\_\_ Date: \_\_\_\_\_

NEXT PAGE



**Your past and current medical history is important to us. We rely on you to provide accurate information.**

What is your age? \_\_\_\_\_ Height? \_\_\_\_\_ cm Weight? \_\_\_\_\_ kg BMI \_\_\_\_\_

Do you have any allergies or alerts?  Y  N

Have you had problems with your lungs, asthma or trouble breathing?  Y  N

Are you taking medication or CPAP for breathing problems?  Y  N

Have you had any problems with your heart or blood pressure?  Y  N

Do you have a pacemaker or artificial heart valve?  Y  N

Do you have diabetes?  Y  N

Have you had any problems with your liver?  Y  N

Do you have kidney disease?  Y  N

Have you had any other serious illnesses?  Y  N

Do you have a history of any bleeding tendencies?  Y  N

Have you had an anaesthetic?  Y  N

What was the Procedure? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were there any complications with the surgery or anaesthetic? \_\_\_\_\_

Are you taking any drugs or tablets?  Y  N

If Yes please note - Name and Dose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any substance abuse problems with drugs or alcohol?  Y  N

Have you had episodes of delirium, Alzheimer, cognitive impairment, memory loss or mental health issues?  Y  N

Do you have a current infection or contagious disease?  Y  N \_\_\_\_\_

Have you recently travelled overseas?  Y  N

If Yes were you hospitalised for more than 24 hrs?  Y  N

Have you recently taken Aspirin or other blood thinning medication? (Pradaxa / Clopidogrel / Warfarin / Anti-inflammatory drugs).  Y  N

Last Dose taken? \_\_\_\_\_

Do you smoke?  Y  N How many per day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you have any physical disabilities?  Y  N

Details: \_\_\_\_\_

\_\_\_\_\_

Have you had two or more accidental falls in the past 12 months?  Y  N

Do you have an Advanced Care Plan and other treatment-limiting orders?  Y  N

Details: \_\_\_\_\_

\_\_\_\_\_

Do you have a hearing aid, prosthesis, contact lenses or body piercing?  Y  N

Do you have any loose teeth, caps or crowns?  Y  N

Have you had recent pathology tests?  Y  N The laboratory name: \_\_\_\_\_

Have you had recent X-rays?  Y  N Facility name: \_\_\_\_\_

\_\_\_\_\_

**Female patients**

Are you pregnant?  Y  N

Breast feeding?  Y  N

**Is there something you would like to discuss privately with your doctor?**  Y  N

Reviewed by Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

Referred to Anaesthetist: \_\_\_\_\_ Date: \_\_\_\_\_

Pre-operative recommendations: \_\_\_\_\_

\_\_\_\_\_