LAKEVIEW
PRIVATE HOSPITAL

Email to:
admissions@lakeviewprivate.com.au

SURGEON TO COMPLETE

Doctor		Admission date	/ /	Operation date	/ /	Expected length of procedure	

Provisional diagnosis		GA ☐ LA ☐	Sedation ☐
Planned procedure		**OFFICE USE**	Initial
		a. Booked by:	
		b. Equip. advised	
Item No.		c. Pre-Admit Level 3 notified	
Radiology	☐ II ☐ Radiographer ☐ Booked	d. PAC Pack required	
Stay required	☐ Day stay ☐ Inpatient _____ nights ☐ CMU	e. Data entry	
Rehab unit	☐ Inpatient _____ nights ☐ Outpatient	f. Fund check (Estimation request sent)	
Pre-admission clinic attendance required?	☐ Yes ☐ No	g. Patient contacted about excess via:	
Special requirements		Phone / Email / Date	
		/ /	
		h. Reviewed by PAC	

PATIENT TO COMPLETE – PART 1 Return these forms at least fourteen days prior to admission.

PERSONAL DETAILS:

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other *(Please circle)*

Surname		Given names			
Address					
Suburb		State	NSW	Postcode	
Date of birth	/ /	Age		Sex	☐ M ☐ F
Ph. (H)		Ph. (W)		Ph. (M)	
Email					
Marital status	☐ S ☐ M ☐ W ☐ D ☐ Sep			Occupation	
Country of birth		Language at home			
Indigenous status	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Decline to answer				
Overseas visitor	☐ Yes ☐ No	Religion			

PERSONS TO CONTACT

Next of kin		Relationship	
Contact no.		Address	
		Emergency contact no.	

PRIVATE HEALTH FUND

Health fund name	
Health fund no.	

ENTITLEMENTS

Medicare card no. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Card ID no. ____		Exp. / /
Pension card no. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___			Exp. / /
Safety Net card no. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___			
Veteran's Affairs card no. ___ ___ ___ ___ ___ ___ ___ ___		White ☐ Gold ☐	Exp. / /

Please complete the following section if you have a workers compensation or third party claim:

Your employer's name		Ph.	
Address			
Contact person		Ph.	
Date of your accident	/ /	Claim No.	
Has the claim been accepted by the insurance company?	☐ Yes ☐ No ☐ Unsure		
Insurance company			
Address			

PATIENT TO COMPLETE – PART 2

PATIENT HISTORY FORM

Please PRINT clearly.
Your responses are valuable in planning your admission and caring for you during your stay.

AFFIX LABEL HERE

BINDING MARGIN — DO NOT WRITE

ADMISSION DETAILS

What is your height: _____ cms/ft/ins	What is your weight: _____ kgs/lbs

ALLERGIES -	YES	NO	LIST ALLERGY AND REACTION
Do you have allergies to medications, food, sticking plaster, latex/rubber (eg. balloons, gloves) or other substances? If you have an EpiPen, please bring it to admissions.	☐	☐	

MEDICATIONS	YES	NO	REASON FOR TAKING
Do you take any anti-coagulant or blood thinning therapy? (Warfarin, Coumadin, Plavix, Iscover, Aspirin, Eliquis)	☐	☐	
Do you take any steroids (such as Prednisolone) or anti-inflammatory drugs?	☐	☐	Name of medication: Date last taken: ____/____/____

ALL REGULAR MEDICATIONS (not listed above)	Dose/Freq	ALL REGULAR MEDICATIONS (not listed above)	Dose/Freq

PREVIOUS OPERATIONS/PROCEDURES

Operation	Year	Surgeon	Operation	Year	Surgeon

Do you have or have you ever had any of the following conditions?	YES*	NO	DETAILS
Diabetes: ☐ Type 1 ☐ Type 2 Managed by: ☐ Diet ☐ Tablets ☐ Insulin	☐	☐	
Cancer	☐	☐	Site:
Stroke	☐	☐	Date: ____/____/____
High blood pressure	☐	☐	
Heart conditions (please circle): heart attack / coronary / chest pain / angina / atrial fibrillation / open heart surgery / ablation procedure			
Palpitations / irregular heart beat / heart murmur (please circle)	☐	☐	
Pacemaker / prosthetic heart valve / any other heart condition (please circle)	☐	☐	Specify:
Blood clots in your lungs or legs	☐	☐	(If Yes, nurse to apply TED stockings)
Do you have any leg swelling?	☐	☐	
Bleeding disorders?	☐	☐	
Asthma / bronchitis / pneumonia / hay fever / tuberculosis (please circle)	☐	☐	
Do you have sleep apnoea?	☐	☐	If Yes, state treatment:
Do you snore?	☐	☐	(PAC nurse to complete STOPBang)
Hiatus Hernia / gastrointestinal ulcers / bowel disorder (please circle)	☐	☐	
Do you have reflux, are your symptoms present without food?	☐	☐	
Do you have any problem with swallowing?	☐	☐	
Liver disease / hepatitis (specify type: B, C) or HIV (please circle)	☐	☐	
Kidney / bladder problems / incontinence (please circle)	☐	☐	
Thyroid problems	☐	☐	
Epilepsy / fits / blackouts / migraines (please circle)	☐	☐	Specify:
Do you have any jaw or neck problems?	☐	☐	
Arthritis	☐	☐	
Depression / anxiety / dementia / other mental illness (please circle)	☐	☐	
Are you pregnant?	☐	☐	

AFFIX LABEL HERE

Can you walk without stopping	YES	NO	DETAILS
Around the house?	☐	☐	
Half a flight of stairs?	☐	☐	
One flight of stairs?	☐	☐	
Two flights of stairs?	☐	☐	
More than two flights of stairs?	☐	☐	

Do you have or have you ever had any of the following?	YES	NO	DETAILS
Physical disabilities?	☐	☐	
Wounds or breaks on your skin?	☐	☐	
History, diagnosis of MRSA, hepatitis, C. Diff, VRE or ESBL?	☐	☐	Contact infection control if YES
A 'look back' for (CJD) Creutzfeldt-Jakob disease or an 'In Medical Confidence' letter notifying you of a potential exposure to CJD?	☐	☐	If Yes, when:
Do you have any other condition or infections that may require further explanations?	☐	☐	

GENERAL PRACTITIONER AND OTHER DOCTORS

Who is your regular GP? Name: Phone:

Address: _____

Please list any specialist doctors that you have recently consulted:

PREVIOUS REACTIONS	YES	NO	DETAILS
Have you or anyone in your immediate family ever had a reaction to an anaesthetic? eg. malignant hyperthermia	☐	☐	Details of reaction:
Have you ever had a reaction to a blood transfusion?	☐	☐	Details of reaction:

PROSTHESIS / AIDS / OTHERS	YES	NO	DETAILS
Do you have glasses / contact lenses (please circle)	☐	☐	
Do you have a hearing aid or other hearing appliances	☐	☐	
Do you have dentures: full, partial / caps / crowns / loose teeth (please circle)	☐	☐	Specify location:

LIFESTYLE	YES	NO	DETAILS
Do you speak English at home? If No, which language do you speak?	☐	☐	
Do you currently smoke?	☐	☐	Daily amount:
Are you an ex-smoker?	☐	☐	Date ceased: _____/_____/_____
Do you require Nicotine Replacement Therapy?	☐	☐	
Do you drink alcohol?	☐	☐	Daily amount:
Do you use recreational drugs?	☐	☐	Type: Daily amount:
Do you require a special diet?	☐	☐	Type of diet:
Have you a fear of falling or have you fallen within the last 12 months?	☐	☐	
Have you experienced fainting or dizziness in the last 12 months?	☐	☐	

DISCHARGE PLANNING	YES	NO	
YOU MUST HAVE SOMEONE TO ESCORT YOU HOME. IF YOU ARE A DAY PATIENT, YOU MUST ALSO HAVE A CARER WTH YOU OVERNIGHT TO ENSURE YOUR SAFETY AT HOME. THESE ARRANGEMENTS MUST BE IN PLACE BEFORE YOUR ADMISSION. PLEASE SEE BELOW			
Do you live alone?	☐	☐	
Who is taking you home and looking after you after discharge? Name: Relationship: Contact number:			
Are you soley responsible for the care of another person at home?	☐	☐	
Do you currently receive community support services?	☐	☐	
Do you require assistance with any aspect of day to day living?	☐	☐	
Where do you plan to go after discharge?	☐ Home	☐ Rehabilitation	

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