LAKEVIEW
PRIVATE HOSPITAL

AFFIX LABEL HERE

PRE-ADMISSION FORM

Please return these forms at least 14 days prior to admission.
Your responses are valuable in planning your admission and caring for you.

PATIENT TO COMPLETE - Please print clearly. Tick whichever is applicable to you

PERSONAL DETAILS

Have you been admitted to LPH before? ☐ Yes ☐ No

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ______

Surname			Given names		
Address					
Suburb		State		Postcode	
Date of birth	/ /	Age		Sex	☐ M ☐ F ☐ Other
Phone (M)		Phone (H)		Phone (W)	
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 name			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 no.	__ __ __ __ __ __ __ __ __	☐ White ☐ Gold	Exp. / /

PATIENT HISTORY

What is your height:	cms / ft / in	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 with you on the day of surgery

MEDICATION	YES	NO	REASON FOR TAKING
Do you take any anti-coagulant or blood thinning therapy? (Warfarin, Coumadin, Plavix, Iscover, Aspirin, Eliquis)			Name of medication: Date last taken: / /
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/Frequency

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PREVIOUS OPERATIONS / PROCEDURES (Provide attachment if required)					
Operation	Year	Surgeon	Operation	Year	Surgeon

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?	YES	NO	DETAILS
Diabetes: ☐ Type 1 ☐ Type 2 Managed by: ☐ Diet ☐ Tablets ☐ Insulin			
Cancer			Site:
Stroke			Date: / /
High blood pressure			
Heart conditions: ☐ Heart attack ☐ CAD ☐ Chest pain ☐ Angina ☐ Atrial fibrillation ☐ Open heart surgery ☐ Ablation procedure			
☐ Pacemaker ☐ Palpitations ☐ Irregular heart beat ☐ Heart murmur			*PAC nurse request report
☐ Prosthetic heart valve ☐ Any other heart condition			Specify:
Blood clots in your lungs or legs			*Follow VTE Risk Assessment
Any leg swelling?			
Bleeding disorders			*PAC nurse request report
☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Hay fever ☐ Tuberculosis			
Do you have sleep apnoea?			If Yes, state treatment:
Do you snore?			*PAC nurse to complete STOPBang
☐ Hiatus Hernia ☐ Gastrointestinal ulcers ☐ Bowel disorder			
Reflux, are your symptoms present with food			
Problem with swallowing?			
☐ Liver disease ☐ Hepatitis B ☐ Hepatitis C ☐ HIV			*Contact Infection Control
☐ Kidney ☐ Bladder problems ☐ Incontinence			
Thyroid problems			
☐ Epilepsy ☐ Fits ☐ Blackouts ☐ Migraines			Specify:
Any jaw or neck problems?			
Arthritis			
☐ Depression ☐ Anxiety ☐ Dementia ☐ Cognitive impairment ☐ Other mental illness			
Are you pregnant?			
Physical disabilities			Aids / Assistance needed
Do you have any current wounds or breaks in your skin?			
History diagnosis of MRSA, C.Diff, VRE or ESBL?			*Contact Infection Control
A 'look back' for Creutzfeldt-Jakob disease (CJD) or an 'In Medical Confidence' letter notifying you of a potential exposure to CJD?			If 'Yes', when:
Do you have any other conditions or infections that may require further explanation?			

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?			

PROSTHESIS / AIDS / OTHERS	YES	NO	DETAILS
Do you have: ☐ Glasses ☐ Contact lenses			
Do you have: ☐ Hearing aid ☐ Other hearing appliances			
Do you have dentures: ☐ Full ☐ Partial ☐ Caps ☐ Crowns ☐ Loose teeth			Specify location:
Do you use a: ☐ Walking stick ☐ Crutches ☐ Wheelchair			

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:

LIFESTYLE	YES	NO	DETAILS
Provide your home language, if not English. Do you require an interpreter?			
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:
Do you have a fear of falling or have you fallen within the last 12 months?			*Refer to Physiotherapy
Have you experienced fainting or dizziness in the last 12 months?			

GENERAL PRACTITIONER AND SPECIALIST DOCTORS

GP Name:	Phone:
Address:	
Please list any specialist doctors that you have recently consulted:	

DISCHARGE PLANNING	YES	NO	DETAILS
Do you live alone?			
Who is taking you home and looking after you, once discharged? Name:			
Relationship: Phone:			
Are you solely 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			

YOU MUST HAVE SOMEONE RESPONSIBLE ARRANGED TO TAKE YOU HOME AND TO BE WITH YOU OVERNIGHT, ON YOUR FIRST NIGHT HOME.

WORKERS COMPENSATION OR THIRD PARTY CLAIMS

Employer			
Case Manager		Phone	
Email			
Date of your accident	/ /	Claim No	
Has the claim been accepted by the insurance company?	☐ Yes ☐ No ☐ Unsure		
Insurance company			
Address			

SURGEON TO COMPLETE

Doctor		Admission Date	/ /	Operation Date	/ /	Expected length of procedure	
Provisional diagnosis						☐ GA ☐ LA ☐ Sedation	

				OFFICE USE	Initial
Planned procedure				a. Booked by	
				b. Equip. advised	
Item Number/s				c. Pre-Admit Level 3 notified	
Radiology	☐ II	☐ Radiographer	☐ Booked	d. PAC Pack required	
Stay required	☐ Day Surgery	☐ Inpatient ___ nights	☐ CMU	e. Data entry	
Rehab unit	☐ Inpatient ___ nights	☐ Day Program		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	