NSW GOVERNMENT Health

Facility:

FAMILY NAME

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020001

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

(For patients 14 years and above – not for Guardianship Act purposes.)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr ..... have discussed with this patient the various ways of treating
insert name of medical practitioner

the patient's present condition including the following proposed procedure/treatment:

.....
insert site name and reasons for procedure or treatment; do not use abbreviations

.....

.....

.....

I have informed this patient of the matters detailed below including the nature, likely results, and material risks of the proposed procedure of treatment.

..../...../20..... .....
SIGNATURE OF MEDICAL PRACTITIONER DATE TIME

Interpreter present* ..../...../20..... .....
SIGNATURE OF INTERPRETER DATE TIME

PATIENT CONSENT

To be completed by Patient

Dr ..... and I have discussed the present condition and the various ways
insert name of medical practitioner

in which it might be treated, including the above procedure or treatment.

The doctor has told me that

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
I have been told that another doctor may perform the procedure/treatment.*
I **request and consent** to the procedure/treatment described above for me.

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to have the following aspects of the recommended procedure or treatment: .....
insert objection

.....

....
medical practitioner's acknowledgement

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/do not consent*** to a blood transfusion if needed.

..../...../20.....
SIGNATURE OF PATIENT DATE

....
PRINT NAME OF PATIENT TIME

.....
ADDRESS

.....

*delete where not applicable

NH606006 - 190813

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT SMR020.001

NSW GOVERNMENT Health

Facility:

REQUEST/CONSENT FOR - MEDICAL PROCEDURE TREATMENT

FAMILY NAME	
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

(For patients 14 years and above – not for Guardianship Act purposes.)

USE OF REMOVED TISSUE (SEE SECTION 33 of CIRCULAR)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of my condition.

I **consent/do not consent*** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

.....
insert terms, if any

This consent extends only to tissue, which is removed for the purposes of the above procedure.

....
SIGNATURE OF PATIENT DATE ...../...../20.....

SMR020001

*delete where not applicable

NO WRITING

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

Facility:

Booking Clerk to attach patient label here

ADULT HEALTH QUESTIONNAIRE

Patient / Parent / Carer to complete all sections of this form

PATIENT / PARENT / CARER PLEASE ANSWER ALL QUESTIONS

ADULT HEALTH QUESTIONNAIRE

Patient Details

Family Name: | **Given Names (in full):**

Have you ever been known by another name? ☐ No ☐ Yes *(list please)* | **Your Date of Birth:** ____ / ____ / ____

Sex: ☐ Male ☐ Female | **Home Address:**

Religion: | **Postal Address if different from home address:** (Home address must be filled in)

Email address:

Home Phone: **Mobile:** **Work:**

Marital Status: ☐ Married / de facto ☐ Never Married ☐ Widow ☐ Divorced ☐ Separated

Medicare Number: **Ref number next to patient:**

Are you of Aboriginal or Torres Strait Islander Descent?
☐ No ☐ Yes If yes ▸ ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

What language do you speak at home? | **Do you need an interpreter?** ☐ No ☐ Yes

Have you been a patient in any of these hospitals before?
☐ Blue Mountains ☐ Hawkesbury ☐ Lithgow ☐ Nepean ☐ Springwood

Person For Notification

Name of contact person: | **Relationship to patient:**

Address of contact person: ☐ same as patient or

Home Phone: **Mobile:** **Work:**

Financial Details

Do you have Private Health Insurance? ☐ No ☐ Yes (if yes, please complete following details)
Fund/Insurer Name: _____ Membership Number: _____
Type of cover: ☐ Single Room ☐ Shared Room ☐ Basic ☐ Extras

If you are not in a Private Health Fund, do you choose to be a self-funded private patient?
☐ Yes ☐ No ☐ NA – I have private insurance

Do you have a Veteran's Affairs card? ☐ No ☐ Yes (if yes, please complete following details)
Card Colour: ☐ Gold ☐ Orange ☐ White DVA Card No: _____

Are you covered by Workers Compensation? ☐ No ☐ Yes, if yes ▸ | **Employer's Name:**

Are you covered by Third Party? ☐ No ☐ Yes, if yes ▸ | **Employer's Address:**

Are you an overseas visitor? ☐ No ☐ Yes, if yes ▸ Do you have travel insurance? ☐ No ☐ Yes
Travel insurance details:

General Practitioner

Who is your local GP?

Address of GP:

GP Phone number:

Form Completed by

☐ Patient ☐ Parent ☐ Carer ☐ Other, please specify:

Name:

Signature: | **Date:** ____ / ____ / ____

PATIENT / PARENT / CARER PLEASE ANSWER ALL QUESTIONS

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ADULT HEALTH QUESTIONNAIRE

Patient / Parent / Carer to complete all sections of this form

Have you seen any other specialist doctor in the last 5 years? ☐ No ☐ Yes, if yes ▸ please list

Reason for seeing Dr	Dr's name	Dr's phone number	Last visit

Have you had any serious illness, sickness or treatment eg excessive bleeding or blood clots?
☐ No ☐ Yes, if yes ▸ please specify:

Have you had any previous operations?

1. Operation: _____ Hospital: _____ Yr: _____
   Surgeon: _____ Telephone No: _____
2. Operation: _____ Hospital: _____ Yr: _____
   Surgeon: _____ Telephone No: _____
3. Operation: _____ Hospital: _____ Yr: _____
   Surgeon: _____ Telephone No: _____
4. Operation: _____ Hospital: _____ Yr: _____
   Surgeon: _____ Telephone No: _____

Do you use any regular medications? (pills, injections, puffers, herbal, recreational drugs & non prescribed medications), medications of addiction and/or complementary medications (eg krill oil) ☐ No ☐ Yes

If Yes ▸ Please list them below (If you need extra space add a separate sheet of paper)

Name of medication	How much?	How often?

Name of medication	How much?	How often?

Have you ever had a blood transfusion? ☐ No ☐ Yes If yes ▸ what year? _____

Do you take/use blood thinning medication regularly? ie aspirin, warfarin, plavix ☐ No ☐ Yes

Please confirm with anaesthetist at pre-admission regarding when to cease these medications prior to surgery

Do you have any allergies? (especially to medicines or sticking plaster, iodine, food or latex) ☐ No ☐ Yes

If Yes ▸ What are they? What reaction do you have? _____

Have you or any family member had a problem with an anaesthetic? (e.g. a bad reaction) ☐ No ☐ Yes

If Yes ▸ What happened? _____

Can you normally walk without stopping or becoming short of breath?

More than 2 flights of stairs ☐ No ☐ Yes
2 flights of stairs ☐ No ☐ Yes
1 flight of stairs ☐ No ☐ Yes
Half a flight of stairs ☐ No ☐ Yes
Around the house ☐ No ☐ Yes

NO WRITING

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

Facility:

ADULT HEALTH QUESTIONNAIRE

Patient / Parent / Carer to complete all sections of this form

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____ / ____ / ____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

How tall are you? _____ cm **How much do you weigh?** _____ kg

Do you have difficulty opening your mouth wide or limited neck movement? ☐ No ☐ Yes

Have you had any recent anaesthetics? (Including at the dentist) ☐ No ☐ Yes

If Yes ▸ **When was the last one?** _____

Do you have any questions, worries or concerns about the anaesthetic that you would like to talk to us about?

☐ No ☐ Yes If Yes ▸ What are they? _____

Do you have or have you ever had?	**NO**	**YES**	
High blood pressure	☐	☐	If Yes ▸ When _____
Chest pain or angina	☐	☐	If Yes ▸ How often _____
Heart attack	☐	☐	If Yes ▸ When _____
Have you had heart surgery? e.g. heart valve, pacemaker/defibrilator	☐	☐	If Yes ▸ What _____
Lung problems needing hospital	☐	☐	If Yes ▸ What type _____
Troublesome shortness of breath	☐	☐	If Yes ▸ When do you get it _____
Chronic bronchitis	☐	☐	If Yes ▸ When _____
Asthma or wheezing	☐	☐	If Yes ▸ When _____
Should you be using a puffer (e.g. Ventolin)?	☐	☐	If Yes ▸ How often _____
Other lung or breathing problems (e.g. sleep apnoea)	☐	☐	If Yes ▸ What type _____
Reflux of acid or food - heartburn/hiatus hernia	☐	☐	If Yes ▸ How often _____
Diabetes	☐	☐	If Yes ▸ Do you use insulin ☐ No ☐ Yes or do you take diabetic tablets ☐ No ☐ Yes
Glaucoma	☐	☐	
Malignant hyperthermia	☐	☐	
Epilepsy or fits	☐	☐	If Yes ▸ How often _____
Stroke	☐	☐	If Yes ▸ When _____
Blackouts or fainting	☐	☐	If Yes ▸ When _____
Blood clots or a bleeding disorder	☐	☐	If Yes ▸ What type _____
Anaemia	☐	☐	If Yes ▸ When _____
Previous blood transfusion	☐	☐	If Yes ▸ When _____
Kidney condition	☐	☐	If Yes ▸ What type _____
Hepatitis or liver condition	☐	☐	If Yes ▸ What type _____
Has your doctor prescribed for you Prednisone, cortisone or other steroids	☐	☐	If Yes ▸ When _____
Is there a condition that runs in the family e.g. thalassemia, muscular dystrophy?	☐	☐	If Yes ▸ What condition _____
Do you have any other health issues not mentioned above e.g. hormone therapy, poor teeth, rheumatoid arthritis, depression?	☐	☐	If Yes ▸ What _____
Any infectious disease ('golden staph', HIV, TB)	☐	☐	If Yes ▸ When _____
Are you pregnant?	☐	☐	
Do you smoke or did you smoke in the past?	☐	☐	If Yes ▸ How much _____
When did you stop smoking?			Date ____ / ____ / ____
Do you drink alcohol?	☐	☐	If Yes ▸ How much per week _____
Have you completed this questionnaire for yourself?	☐	☐	If No ▸ What is your relationship to the patient _____

Name of person completing form: _____

Signature of person completing the form: _____ Date ____ / ____ / ____

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

Facility:

DISCHARGE PLANNING QUESTIONNAIRE

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____ / ____ / ____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PATIENT / PARENT / CARER PLEASE ANSWER ALL QUESTIONS

1. Age _____
2. Do you speak English at home? ☐ Yes ☐ No
   If not, which language to you speak? _____
   Do you need an interpreter? ☐ Yes ☐ No
3. What is your understanding of how long you will be in hospital?
   ☐ Day only ☐ Overnight ☐ 1 - 2 days
   ☐ 2 - 5 days ☐ Unsure ☐ Greater than 1 week
4. Have you made arrangements for someone to take you home from hospital?
   (A responsible adult must accompany Day Only patients home, and must stay with them at least for the first night after surgery). ☐ Yes ☐ No
5. Do you live
   ☐ alone
   ☐ with family
   ☐ with carer
   ☐ nursing home
   Where do you live
   ☐ house/unit
   ☐ boarding house
   ☐ hostel
   ☐ other _____
6. Do you care for another person on a regular basis? ☐ Yes ☐ No
7. Have alternative arrangements been made to look after this person? ☐ Yes ☐ No
8. Do you normally need assistance to walk? ☐ Yes ☐ No
9. Do you use a walking aid such as a stick or frame? ☐ Yes ☐ No
10. What type? _____
11. Do you have difficulties walking up or down stairs? ☐ Yes ☐ No
12. Do you have difficulties with your sight/hearing? ☐ Yes ☐ No
    Please describe _____
13. On discharge do you anticipate any problem with:
    Bathing/Showering ☐ Yes ☐ No
    Dressing ☐ Yes ☐ No
    Toileting ☐ Yes ☐ No
    Cooking ☐ Yes ☐ No
    Cleaning ☐ Yes ☐ No
    Shopping ☐ Yes ☐ No
    Business matters ☐ Yes ☐ No
    Other _____ ☐ Yes ☐ No
14. On discharge, do you anticipate that help will be required at home? ☐ Yes ☐ No
    Please describe _____
15. What arrangements have been made for someone to care for you when you get home?
16. Do you currently use any of the following services?
    ☐ Community Nurse ☐ Personal Care Assistance
    ☐ Meals On Wheels ☐ Home Help
    ☐ Day care/Therapy Unit ☐ Other

Thank you for completing this form.
The information you have provided will help in planning your discharge from hospital.

HOSPITAL USE ONLY

Expected length of stay _____ Total needs score _____ Intervention required ☐ Yes ☐ No
Telephone intervention ☐ Yes ☐ No Action _____
Screened by _____ (RN) Signature _____ Date ____ / ____ / ____
Referrals to be made to:
☐ Social Work ☐ CNC Discharge Liaison ☐ Physiotherapy
☐ Stomal Therapy ☐ Occupational Therapy ☐ Referral to Outreach
☐ D & A ☐ Interpreter _____
☐ Other _____
Appointment made by (administrative staff) _____ Signature _____ Date ____ / ____ / ____
Appointment date ____ / ____ / ____

NBMHK 0540 DISCHARGE PLANNING QUESTIONNAIRE

NO WRITING