Latrobe Regional Hospital

Request for Elective Surgery Admission

INSTRUCTIONS FOR DOCTORS:

- Please complete the GREEN section (Request for Admission) and Consent for Medical Treatment
- Please supply any relevant results, letters and reports for hospital records

INSTRUCTIONS FOR PATIENTS:

- Please complete all the PINK Sections
- If you require assistance with completing any section of the booklet, please see your General Practitioner or Clinic Nurse
- Please provide consent for communication with your General Practitioner
- When completed, please return the Request for Elective Surgery Admission intact to:

  Patient Services Unit
  Latrobe Regional Hospital
  PO Box 424
  Traralgon, Vic, 3844

- We require this completed booklet to assist with management of your fitness for surgery and discharge planning and in order to prevent and unnecessary delays
- Please notify the hospital (5173 8025) if you change your name, address or phone number
- Please note Latrobe Regional Hospital is *Smoke Free.*

Hospital Use Only

MRN:		Preadmission Required ☐Yes ☐No
Date Referral Received:		☐ Pre admission clinic
Placed on Waiting List:		☐ Phone review ☐ Anaesthetic Review
Triage Notes:		
The following documentation has been sent to patient ☐Yes ☐No **Enc**: 1.Your rights & responsibilities: 2. Patient Information consent for anaesthetic: 3. Latrobe Regional Hospital Pre-operative fasting for elective surgery: 4. Victorian Public Hospitals – information for patients: 5. Patient Information "Stay safe at LRH".		

Latrobe Regional Hospital

DOCTOR TO COMPLETE

Request for Elective Admission

MR NUMBER...

SURNAME...

GIVEN NAMES..

DATE OF BIRTH... Sex: M F

Please fill in if no Patient Label available

PATIENT NAME:

Date of Birth ..../.........../............. ☐ Male ☐ Female

Category of Clinical Urgency

☐ Category 1 (Urgent within 30 days)
☐ Category 2 (Semi-urgent desirable within 90 days)
☐ Category 3 (Desirable within 365 days)

Diagnosis:

Clinical Indicators:

Proposed Surgery/Procedure:

☐ Day Case ☐ Inpatient Proposed length of surgery:....................mins Proposed length of stay:...............days

Proposed Date of Admission:

Can the patient continue antiplatelet or anticoagulant therapy preoperatively? ☐ Yes ☐ No – please advise:

Known Alerts/Allergies: ☐ Latex ☐ Drug ☐ Infectious ☐ Diabetic Type............................
☐ Security/BoC ☐ Frailty ☐ Other?...

Special Requirements: (equipment, prostheses, consumables, cell saver)

☐ Patient is suitable for **ERAS**

SURGEON DETAILS:

Referring Consultant:...
(print name)

Signed____ Date _______/_______/_______

Hospital Office Use only: ☐ **Programmed Procedure** **Due Date:**

REQUEST FOR ADMISSION

Latrobe Regional Hospital

CONSENT TO MEDICAL TREATMENT

MR NUMBER..

SURNAME...

GIVEN NAMES..

DATE OF BIRTH.. Sex: M F

Please fill in if no Patient Label available

A) CONSENT TO TREATMENT

I, Dr____declare that:

(Print given names) (Print family name)

I have informed the patient about their condition and the various ways in which it may be appropriately treated. I have also explained the relevant foreseeable risks of the chosen procedure / treatment. I have given the patient the opportunity to ask questions and express specific concerns and have addressed these.

DOCTOR'S SIGNATURE____Date: ____/____/____

I, ____

(Print given names) (Print family name)

Hereby request and consent to the carrying out upon myself / my ______________________________

(state relationship to patient)

the following procedure / treatment / course of treatment:_________________________________

____

I understand that other unexpected procedures / treatments are sometimes necessary and I request and consent to these being carried out if required.

☐ I have completed the REFUSAL OF MEDICAL TREATMENT section on the back of this form for any procedures / treatments that I am unwilling to undertake.

I hereby confirm that I understand the above procedure and associated risks. I also understand that complications may occur or the expected result may not be achieved even though the procedure / treatment is carried out with due professional care.

PATIENT'S SIGNATURE ____ Date: ____/____/____

(signature of patient / parent / guardian / next-of-kin)

B) CONSENT TO ANAESTHETIC SERVICES

- I have read the anaesthetic information brochure provided to me and am satisfied that I understand it.
- The risks and benefits of the relevant anaesthetic options have been discussed with me.
- I understand, to my satisfaction, the following anaesthetic techniques to be used:

  ____

  (proposed anaesthetic – to be completed by anaesthetist)

- All of my questions and specific concerns regarding the anaesthetic have been addressed satisfactorily.

I hereby confirm that I understand the anaesthetic/s and associated risks and I consent to the same.

PATIENT'S SIGNATURE ____ Date: ____/____/____

(signature of patient / parent / guardian / next-of-kin)

I, Dr____ declare that:

(Print given names) (Print family name)

- I have explained the risks, benefits and alternatives of the proposed anaesthetic.
- I provided the patient with the opportunity to ask questions and express specific concerns and these have been addressed.

ANAESTHETIST'S SIGNATURE______________________________________Date: ____/____/____

CONSENT TO MEDICAL TREATMENT

PATIENT CONSENT FOR PLACEMENT ON WAITING LIST

MR NUMBER...

SURNAME...

GIVEN NAMES...

DATE OF BIRTH... Sex: M F

Please fill in if no Patient Label available

GENERAL PRACTITIONER (GP)

GP Surname____ Given Name_________________________________

Clinic____

Address____

CONSENT FOR PLACEMENT ON WAITING LIST/ RELEASE OF INFORMATION TO NOMINATED GP

I, ____

(Print given names) (Print family name)

have been advised of my need for the aforementioned surgical procedure and

1. I understand the reason and give consent for my referral to the waiting list
2. I understand that I have been given an urgency category and will be booked for surgery according to my clinical need
3. I am aware that as a public patient on the waiting list of a public hospital that;
   i) the surgeon may not be my referring specialist
   ii) my surgery may be performed by a Registrar
4. I understand that health information about me, relevant to the proposed procedure, will be provided to the hospital so that I can receive the necessary treatment. The hospital will also be advised about the contact details of my General Practitioner
5. I authorise the hospital to release health information about me to my GP

PATIENT'S SIGNATURE ____ DATE: _____/_____/_____

(signature of patient / parent / guardian / next of kin)

Latrobe Regional Hospital

ADMISSION DETAILS

MR NUMBER……………………………………………………………………

SURNAME……………………………………………………………………

GIVEN NAMES……………………………………………………………………

DATE OF BIRTH…………………………………………………… Sex: M F

Please fill in if no Patient Label available

ALL PATIENTS MUST COMPLETE THIS SECTION

PATIENT DETAILS

Have you ever been a patient at the Latrobe Regional Hospital? ☐Yes ☐No

Patient: Title:…………Surname:……………………………………Given Names:……………………………………………

Maiden/Previous Name:……………………………………………………………

Date of Birth……./……../………. ☐Male ☐Female ☐Self-described (please specify)

Preferred pronoun………………………….. Marital Status…………………………………………………

(Married/Separated/Divorced/Defacto/Widowed/Single)

Address:…………………………………………………………………………………………… Postcode:………………………

Postal Address:………………………………………………………………………………… Postcode:………………………

Phone: Home……………………………………Work………………………………………Mobile……………………………………………

Email………………………………………………………………………………………………………

Country of Birth ……………………………………………… If Australia, which State……………………………………

Language Spoken……………………………………………… Interpreter required? ☐ Yes ☐ No

Religion……………………………………………………… Pastoral care visit required? ☐ Yes ☐ No

Are you an Aboriginal? ☐ Yes ☐ No Are you a Torres Strait Islander? ☐ Yes ☐ No

Next of Kin / Person to be contacted in the event of an emergency

Name……………………………………………………………………… Relationship…………………………………………………

Address………………………………………………………………………………………………… Postcode…………………

Phone……………………………………… Work………………………………… Mobile…………………………………………

If the primary contact person is not your next of kin please circle - Carer/Guardian/DHHS

Name:……………………………………………Relationship…………………………………Contact Number:……………………

Admitting Surgeon:………………………………………………………

Medicare Number: __ __ __ __ __ __ __ __ __ __ Patient Number: __ Expiry Date: ……../……../……..

Pension Number: __ __ __ __ __ __ __ __ __ __ Expiry Date: ……./……../……..

Health Care Card: __ __ __ __ __ __ __ __ __ __ Expiry Date: ……./……../……..

DVA Number: ……………………………………… Card Type: ☐ Gold ☐ White ☐ Other

I elect to be admitted as a Private Patient covered by Health Insurance ☐ Yes ☐ No

Health Fund:………………………………………………………Membership Number:……………………………………………………

Phone Number:……………………………………………… Level of Cover:……………………………………………………………

If this admission relates to one of the following, please complete:

TAC Claim Number……………………………………………………… Date of Accident: …………/…………/……………

Workcover Claim Number:………………………………………… Workcover Employer:……………………………………

PATIENT TO COMPLETE

MR NUMBER……………………………………………………………………………………………

SURNAME………………………………………………………………………………………………

GIVEN NAMES……………………………………………………………………………………….

DATE OF BIRTH…………………………………………………………………… Sex: M F

Please fill in if no Patient Label available

PLEASE COMPLETE THE FOLLOWING QUESTIONS	YES	NO	Please provide details (eg date) if yes
Do you have or have you had a **serious illness or disability?**			
Have you ever suffered from **chest pain /angina / heart attack?**			
Do you have a **cardiac stent / heart valve replacement / pacemaker?**			
Do you suffer from **atrial fibrillation (AF) / heart palpitations?**			
Have you had **rheumatic fever?**			
Do you have **hypertension / high blood pressure?**			
Do you have any other **heart / cardiac problems**?			
Have you ever had a s**tress test, echocardiogram, heart surgery,** been under the care of a heart specialist?			
Cardiologist's Name Address &/or Phone Number:	When did you last visit the Specialist? _____/_____/_____		
Without stopping, can you **walk** ☐ 5 kms >?	☐ 2 flights of stairs?	☐ 1km?	☐ <1km?
Do you suffer from **asthma?**			
Do you suffer from **emphysema / COPD?**			
Have you had a recent **chest infection**, **bronchitis** or **pneumonia**?			
Do you have **sleep apnoea / CPAP machine?**			
Do you have any other **lung / respiratory problems (eg TB)**?			
Do you have any **gastrointestinal** or **bowel problems?**			
Do you suffer from **hepatitis, jaundice, other liver disease?**			
Do you have any **kidney / bladder** problems?			
Do you suffer with **headaches / migraines?**			
Do you have **dizzy spells / fainting?**			
Have you had a **stroke / TIA / head injury?**			
Do you suffer with **seizures, epilepsy** or **blackouts?**			
Have you had any **blood clots (legs or lungs)?**			
Do you have **diabetes?**			If yes when were you diagnosed?
☐ Type 1 ☐ Type 2 ☐ Unsure	How is the diabetes treated ☐ Insulin ☐ Tablets ☐ Diet		
Have you had any **bleeding disorders** or been **anaemic?**			
Do you take **blood thinning medications?**			
Have you had a **blood transfusion?**			
Could you be **pregnant?**			
Have you **joint replacement**/ **prostheses / implants?**			
Have you had any **unplanned weight loss / loss of appetite?**			
Do you have a **hearing impairment?**			

HEALTH ASSESSMENT

HEALTH ASSESSMENT page 2

HEALTH ASSESSMENT

MR NUMBER...

SURNAME...

GIVEN NAMES..

DATE OF BIRTH.. Sex: M F

Please fill in if no Patient Label available

What is your current weight? __________ Kg **What is your height? ___________cm**

PLEASE COMPLETE THE FOLLOWING QUESTIONS	**YES**	**NO**	**Please provide details if yes**
Do you take any **unprescribed recreational drugs?**			
Do you **smoke?**			How many per day?
Did you smoke in the past?			When did you stop?
Do you drink **alcohol?**			How many per day?
ANAESTHETIC			
Have you or a blood relative ever had a problem with a **general anaesthetic?**			
Have you suffered from **severe nausea** after an a**naesthetic?**			
Do you have problems with **neck / jaw** movement?			
Do you suffer from **heartburn / indigestion / reflux?**			
Do you have any **capped teeth / loose teeth** or **dentures?**			
Do you have a difficult **intubation** history?			
INFECTIONS			
Are you aware of yourself or family members being a carrier of **Creutzfeldt-Jakob Disease (CJD)?**			
Have you had **Multi Resistant Organism (MRO) infection?**			
Have you had **Vancomycin Resistant Enterococci (VRE) infection?**			
Have you had **Carbapenemase Producing Enterobacteriaceae (CPE) infection?**			
Do you have any **current skin wounds?**			
DISCHARGE PLANNING			
Day only surgery requires you to have an overnight carer and transport home. **Have you made provision for this?**			Name: Contact No:
Do you use community services such as **district nurse/ home help** / **meals on wheels?**			
Do you live in **residential care accommodation?**			
Do you normally need help with day to day activities such as s**howering / bathing / preparing meals?**			
Have you **fallen / lost your balance** in the last 12 months?			
Are you solely responsible for the **care of another person at home?**			
Do you **live alone?**			
Do you have **family / friends** close by who will help you after hospital if needed?			
Will you or your carer require a **medical certificate?**			
Would you like to speak to a **Social Worker** about any issues at home?			

HEALTH ASSESSMENT

MR NUMBER………………………………………………………………………………………
SURNAME………………………………………………………………………………………
GIVEN NAMES……………………………………………………………………………………
DATE OF BIRTH……………………………………………………………… Sex: M F
Please fill in if no Patient Label available

OPERATIONS	YEAR	HOSPITAL

PLEASE COMPLETE THE FOLLOWING QUESTIONS	YES	NO	PLEASE PROVIDE DETAILS IF YES
Are you currently undergoing treatment or waiting for treatment by another **Surgeon/Physician/Specialist**?			
Do you have a **Latex Allergy**?			
Are you allergic to any **food types**?			
Are you allergic to any **Medications**?			

Do you take medications? ☐ Yes ☐ No

*IF **YES** PLEASE OUTLINE ANY MEDICATIONS THAT YOU ARE CURRENTLY USING*
List ALL medications including over the counter medications
(including herbal remedies), pain killers and puffers.

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

Name of person completing Health Assessment form:_______________________________________

Signature:_______________________________________ Date _____/_____/_____

Relationship to patient (if applicable) _______________________________________

Latrobe Regional Hospital

ADMISSION NURSING ASSESSMENT

MR NUMBER……………………………………………………………………………
SURNAME……………………………………………………………………………
GIVEN NAMES………………………………………………………………………
DATE OF BIRTH……………………………………………… Sex: M F
Please fill in if no Patient Label available

ADMISSION NURSING ASSESSMENT

Name of staff member completing (please print):	Designation:	Date:	Time:

Does patient **live**: ☐ With Spouse/family ☐ With friend/s ☐ Alone ☐ Supported Accommodation

Does the patient have **transport** home? ☐ Yes ☐ No If yes → Provide Name & contact

Name:
Number:

Please tick appropriate answer	**YES**	**NO**	**Give further details where indicated**
Has the **procedure** been confirmed with the patient?			
Has the **Health Assessment** previously filled in by Patient been checked?			
Does the patient have **dentures?**			If yes → are dentures with patient? Yes ☐ No ☐
Does the patient have impaired **vision**?			If yes → did patient bring aids? Yes ☐ No ☐ Aid:
Does the patient have a **hearing** impairment?			If yes → did patient bring aid? Yes ☐ No ☐ Aid:
Is the patient a **diabetic**?			If yes what is the control? Diet ☐ Medications ☐ Insulin ☐
Have **medications** been brought in?			If yes → provide details below:

If having joint replacement, did the patient use **pre-op wash** prior to admission? Yes ☐ No ☐

	YES	**NO**	
Does the patient have any **allergies**?			If yes : ☐ Documented on medication chart ☐ Red band attached ☐ Alert sheet completed
Does the patient have any **wounds, ulcers** or **dressings**?			If yes → refer to Wound Consultant if appropriate:
Pressure risk assessment completed?			☐ Strategies implemented and documented in care plan if applicable
Falls risk assessment completed?			☐ Strategies implemented and documented in care plan if applicable
Venous Thromboembolism (VTE) risk assessment completed?			☐ Strategies implemented and documented in care plan if applicable
Does the patient have **rapidly worsening dementia or ataxia**?			
Does the patient have an **infectious** condition eg: MRSA/VRE/CPE/Gastro/Shingles?			If yes: ☐ Alert Sheet Completed
Has the patient received **Rights & Responsibilities & "Stay safe at LRH"** information?			If no → please provide patient with brochure
Does the patient have an **Advance Care Plan**?			
Has the patient be referred for **Advance Care Plan** information and advice?			

Discharge Checklist:

- ☐ Patient confirmed medically safe for discharge
- ☐ Prescription sent to Pharmacy
- ☐ Family notified of Discharge
- ☐ Transport arrangements confirmed
- ☐ Appointments made & given to patient/family
- ☐ IVC Removed
- ☐ Equipment/dressing provided
- ☐ Medical Certificate provided
- ☐ Services notified of discharge
- ☐ Instructions provided to patient/family

Discharge sign off: **Date:**