DELIVER THIS FORM TO:
DARWIN DAY SURGERY
Level 1, 7 Gsell Street, Wanguri NT 0810
Ph: (08) 7922 2250 Fax: (08) 7922 2288
OR EMAIL TO:
Email: reception@darwindaysurgery.com.au
Postal Add: PO BOX 40947, Casuarina NT 0811

Darwin Day Surgery

SHORT STAY: PATIENT ADMISSION & CONSENT F-29

Surname ..... Given names ..... U.R.....

Title: Mr Ms Mrs Miss Dr D.O.B: ..... Country of birth: .....

Marital status: Married / Widowed / Divorced / Separated / Defacto / Single / Student

Race: Caucasian / Aboriginal / Torres Strait islander / Other Occupation: .....

Language spoken other than English, please state: ..... Do you need an interpreter? **YES** **NO**

Address: ..... Suburb: ..... Post code: .....

Postal address (if different from above): ..... Post code: .....

Email Address: .....

PH: Home ..... Wk ..... Mobile .....

Referring Doctor: **Clinic Name**: **Provider No**:

Medicare No: __ __ __ __ __ __ __ __ __ __ ID No: ___ **Exp date** /20 **DVA Number**: Card Type:

Uninsured Patients: Fee estimation payable

Do you have Private Health Insurance: Yes / No

Private Health Fund Name: ..... Membership No: .....

Do you have Hospital Cover: Yes / No Excess $ Co-payment $

Service Personnel (circle relevant): Army / RAAF - Darwin / RAAF – Tindal / Navy

Rank: PMKs: DAN: Unit:

Workers Compensation / MACA / Third Party Date of Accident: .....

Employer: ..... Phone: ..... Fax: .....

Address: .....

Insurance Company: ..... Claim No: .....

Payment of Account

I understand and agree to pay all hospital accounts, including the event where my health fund / insurance claim should be declined for whatever reason.

Person responsible for account: **Signature**: ..... **Date**: .....

Day Surgery Admission – To be completed by *Admitting Medical Officer*

Admitting Medical Officer: ..... Date of Procedure: ..... Admission time: .....

Proposed Operation: .....

Type of Anaesthetic: **GENERAL** **SEDATION** **LOCAL** Duration of procedure: .....

Anaesthetist pre-op consult required? **Yes / No** Pre–admission nurse appointment required? **Yes / No**
Medications discussed with Patient (*including complimentary therapies*) **Yes / No**

Darwin Day Surgery

SHORT STAY: PATIENT ADMISSION & CONSENT F-29

Patient Consent Form

Request for surgical operation, procedure or treatment

I, ……
(patient name)

of:……
(patient address)

agree to the surgical operation/procedure of;

……

……

……

being performed by: ……

My relationship to the patient is:……
(self, parent, guardian etc)
I also agree to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this procedure. I understand that other unexpected treatment is sometimes necessary and I agree to this if it is urgently required.

Doctor: …… has explained to me the need of medical attention and I have discussed with him/her the different ways in which the condition may be best treated. We have discussed alternative treatments available to the condition, the nature and effects of the procedure chosen and the possible risks from the procedure itself. I am satisfied that it is in my interest to have the procedure and I agree to him/her performing the procedure.

I understand that if I am discharged on the same day as my anaesthetic/sedation and my surgery/procedure I should not drive a motor vehicle or operate machinery or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours. I understand that I must be accompanied by a responsible adult.

I have read this form, understand it and have had an opportunity to ask questions concerning the procedure and have satisfied myself as to these questions.

Patient / Guardian Signature: …… Date: ……

Surgeons Name: ……

Signature of Surgeon: ……

Additional notes by admitting Medical Officer to Theatre Manager: ……
……
……

CODING ITEM NUMBERS: ……
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