**Brighton Plastic Surgery**
**204-206 New Street, Brighton, Victoria 3186**
**Telephone: (03) 9592 0522/Fax: (03) 95920320**

***PATIENT LABEL***

**Surgeon:** ________________ Day ______________________Date__________________ Admission Time _______________AM/PM

**Procedure:**___________________________________________________________________________________________

___________________________________________________________________________________________________

**Type of Anaesthetic:** ☐ Local Anaesthetic ☐ IV Sedation ☐ General Anaesthetic

***PATIENT DETAILS***

Patient Surname_________________________________Other Names____________________________________________________

Address_____________________________________________________________________________ Post Code_________________

For confidentiality and privacy reasons, what telephone number(s) would you like us to contact you on?

☐ (Home):________________ ☐ (Work):___________________ ☐ (Mobile)_____________________________

Occupation_______________________________________________________ Place of Birth____________________________

Are you a Torres Strait Islander/Aboriginal Yes/No

Date of Birth____________________ Age _________ Religion__________________________________

Next of Kin____________________________Relationship to you __________________Contact No______________________

Person responsible for transport home/carer (Name)_________________________________Contact No__________________

Have you been a patient at Brighton Plastic Surgery before? Yes/No If Yes, when? (year): ______________________

Medicare No:______________________________________________Reference No:__________ Expiry Date:_____________

Veterans Affairs No:__________________________ Language spoken at home:________________________________

Ambulance Membership No:_____________________________________________

***ACCOUNT DETAILS***

Who is responsible for account? ☐ Self ☐ Next of kin ☐ Workcover ☐ TAC ☐ Veterans' Affairs ☐ Other

If other, is the person aware that they are responsible for paying this account? ☐ No ☐ Yes

Title: Last name: Given names:

Relationship to patient: Contact number:

***INSURANCE CLAIM DETAILS***

***All excesses attached to your hospital insurance fund are paid on the day of surgery and are an out of pocket fee (not rebatable)***

☐ Privately insured ☐ Nil insured ☐ Veterans' Affairs ☐ Overseas patient

Fund Name: Membership number:

Level of Cover: Contributor's Name:

***WORKCOVER/TAC*** ***(please attach accident details)***

☐ Workcover ☐ TAC Claim no.

Date of injury: Name of Insurance Company:

Employer's contact details:

***PATIENT DECLARATION***

I agree to be admitted to Brighton Plastic Surgery in full knowledge that all fees and charges have been explained to me and if I have an excess payable on my health fund, this amount will be confirmed with me prior to admission. I release the Hospital from any claims for whatever loss, theft, or damage of my personal property which may occur whilst a patient at Brighton Plastic Surgery.

Patient Signature_______________________________________________Date_________________________

***Your procedure time will be confirmed by Brighton Plastic Surgery 48 hours prior***

***Please turn over and complete the back of this page***

Office Use only - Individual Health Identifier (IHC):

*List details of any previous OPERATIONS*

| OPERATION | YEAR |
|---|---|
| | |
| | |
| | |
| | |
| | |

***PATIENT LABEL***

***Please answer these questions by TICKING the boxes***

| | NO | YES |
|---|---|---|
| *Have you had an anaesthetic before?* | ☐ | ☐ |
| *Have you or any relative ever experienced complications with an ANAESTHETIC?* | ☐ | ☐ |
| *Do you have any neck or jaw stiffness?* | ☐ | ☐ |
| *Are you ALLERGIC to any drugs, food, tapes, latex or rubber? If yes, give details* | ☐ | ☐ |
| *Did you/do you smoke?*<br>*When did you cease? ___/___/_______*<br>*How many per day?* | ☐ | ☐ |
| *Do you drink alcohol?*<br>*If yes, indicate daily intake.* | ☐ | ☐ |
| *Do you use or have used in the past year any recreational drugs?* | ☐ | ☐ |
| *Have you been admitted overnight to any hospital or residential aged care facility overseas in the past 12 months?* | ☐ | ☐ |
| *Have you ever had a test that showed you had Hepatitis B, Hepatitis C, HIV, MRSA, VRE or CRE?* | ☐ | ☐ |
| *Is there a possibility that you may be pregnant?* | ☐ | ☐ |
| *Do you have any special needs? (eg. needle phobia)* | ☐ | ☐ |
| *Do you take ASPIRIN regularly, WARFARIN or 'blood thinning' medication?* | ☐ | ☐ |
| *Have you had any treatment for excessive bleeding or bleeding disorder?* | ☐ | ☐ |
| *Have you had Blood clots in the brain, lungs, or legs?* | ☐ | ☐ |
| *Do you have or have had Anaemia?* | ☐ | ☐ |
| *Have you ever had a Blood transfusion? If yes, did you have a bad reaction to the transfusion?* | ☐ | ☐ |
| *Have you had a Stroke?* | ☐ | ☐ |
| *Do you have or have had High Blood Pressure?* | ☐ | ☐ |
| *Have you had Rheumatic fever?* | ☐ | ☐ |
| *Have you had a heart attack or heart problem (including chest pain, ANGINA, heart palpitations)?* | ☐ | ☐ |
| *Have you had Heart Surgery? If yes, when?*<br>☐ *pacemaker,* ☐ *cardiac stents*<br>☐ *heart valve replacement,* ☐ *other* | | |

| | NO | YES |
|---|---|---|
| *Do you suffer from ASTHMA?*<br>*Do you use a puffer (eg. Ventolin)?* | ☐ | ☐ |
| *Do you have or have had troublesome shortness of breath, persistent cough or sleep apnoea?* | ☐ | ☐ |
| *Have you ever had bronchitis or pneumonia? If yes, when?* | ☐ | ☐ |
| *Do you or have you had any kidney disease?* | ☐ | ☐ |
| *Are you a diabetic? If yes, Type 1 or Type 2?* | ☐ | ☐ |
| *Have you ever had Hepatitis, jaundice or liver problems?* | ☐ | ☐ |
| *Do you have stomach or peptic ulcers, Hiatus hernia, reflux, indigestion or heartburn?* | ☐ | ☐ |
| *Do you or have you had any psychiatric conditions?* | ☐ | ☐ |
| *Do you suffer from Epilepsy, fits, blackouts or faints?* | ☐ | ☐ |
| *Do you suffer from eczema or any other skin condition?* | ☐ | ☐ |
| *Do you currently have any skin wounds, pressure sores or skin ulcers?* | ☐ | ☐ |
| *Do you have any joint replacements?* | ☐ | ☐ |
| *Have you or any member of your family had or been exposed to infectious/communicable disease in the last 2 weeks? (eg. Flu, shingles, measles)* | ☐ | ☐ |
| *Have you had any other serious illness?* | ☐ | ☐ |

*Any further comments?*

*List names/doses of all TABLETS/MEDICINES you are currently taking (including unprescribed drugs/herbal/complimentary medicines)*

*How do you plan to get home when you are discharged?*

*Where will you be staying the night of your surgery?*

*Who will be staying with you on the night of your surgery and for how long?*

| *Height:* | *Weight:* | *BMI: (office use only)* |
|---|---|---|

*Do you require Brighton Plastic Surgery to organise accommodation the night of your surgery? Yes/No*

***For patients who will have a general anaesthetic or sedation:***

*Following surgery I will have a responsible adult drive me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia. I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.*

*Signed_____________________________________Date__________________*

***For all patients:***

*I will follow discharge instructions and attend appointments as advised. The answers I have given to all questions are true to the best of my knowledge.*

*Signed________________________Date__________________*