

PATIENT PRE ADMISSION HISTORY

MEDICAL HISTORY - Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	F.H. Genetic	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic or F.H.	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease, T.B., Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Renal	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension or F.H.	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (CNS)	<input type="checkbox"/>	<input type="checkbox"/>	F.H. Twins	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Group B STrep	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

OPERATIONS: _____

PAST OBSTETRICS HISTORY

Where (Delivery)	Date	Wks	Abnormal Conditions Present During Preg.	Labour (Duration)	Mode of Delivery	Infant		A S.B. NND	Puerperium
						Sex	Bth.Wt.		

ANAESTHETIC HISTORY

	YES	NO
Have you ever had any previous anaesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or a member of your family ever had special problems with anaesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? <input type="text"/> per day	<input type="checkbox"/>	<input type="checkbox"/>
Do you consume alcohol? <input type="text"/> standard drinks per week	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES - Are you allergic to any of the following? YES NO

Penicillin	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	Adhesive Plaster	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sulphonamides	<input type="checkbox"/>	Tetanus Toxoid	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	Latex	<input type="checkbox"/>		

ANTENATAL COMPLICATIONS: _____

MEDICATION

	YES	NO
Are you taking any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>
Please give details:		

Medication	Dose	Frequency

SPECIAL WISHES / REQUIREMENTS IN LABOUR: _____

PREFERRED FEEDING METHOD: Breast Formula Type: _____

MIDWIFE RESPONSIBLE FOR REVIEW OF PATIENT HISTORY

Comments: _____
 Information verified Signature: _____ Print: _____ Date: _____

TO BE COMPLETED BY PATIENT

WAVERLEY PRIVATE HOSPITAL

Admission questionnaire for patients regarding SARS / Avian Influenza / undiagnosed related Respiratory Infection & Creutzfeldt-Jakob Disease (CJD)

Unit Record Number: _____

Surname: _____

Given Names: _____

DOB: _____ Doctors: _____

(ATTACH PATIENT ID LABEL)

In order to ensure the safety of all our patients, visitors and staff it is essential that you complete the following questionnaire regarding recent travel history and your current state of health. This vigilance is a recommendation of the Australian Government Department of Health and Ageing and the Department of Human Services, Victoria.

1. Have you travelled to the following Avian Influenza / SARS affected areas recently?

Cambodia	Laos	Mongolia
China	Malaysia	Russia
Hong Kong	Vietnam	Kazakhstan
Indonesia	Taiwan (Tapei China)	Turkey
Singapore	Thailand	Romania

(November 2005)

Yes

No

2. Have you been back in Australia for 14 days or less?

Yes

No

3. Do you have signs or symptoms of a respiratory infection or a fever?
(Significant, only if patient answers "YES" to question (1) and (2).)

Yes

No

NB: If patient answer YES to all 3 questions please contact Infection Control Consultant immediately

In addition, the countries on this form may be updated at regular intervals, your HICMR Consultant will keep you informed of same.

1. Have you had a dura mater graft? (prior to 1989).

Yes

No

2. Do you have a family history of two or more first degree relatives with Creutzfeldt-Jakob disease or other unspecified progressive neurological disorder?

Yes

No

3. Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?

Yes

No

4. Have you received human pituitary hormones prior to 1985?

Yes

No

**WAVERLEY
PRIVATE HOSPITAL**

Consent Form (Maternity)
Request/Consent form for Childbirth (Delivery)
Procedure and Treatment

Unit Record Number: _____

Surname: _____

Given Names: _____

DOB: _____ Doctors: _____

(ATTACH PATIENT ID LABEL)

PART A Provision of Information to Patient - to be completed by Medical Practitioner

I, Doctor _____ (insert Name of Medical Practitioner)

have informed this patient that although the normal process of childbirth is natural, events may arise during the delivery of the baby/babies which will necessitate medical intervention. I have explained to the patient the nature of and medical risks associated with such interventions and given her the opportunity to ask questions regarding the risks and possible complications.

The agreed operation / procedure and treatment that the patient is to undergo is:

_____ (insert name of operation/procedure and/or treatment)

Interpreter Required? Yes No

I, _____, an accredited interpreter, have accurately interpreted the advice given by the medical practitioner name above to _____

Signature of medical practitioner

Date: / /

Signature of medical interpreter

Date: / /

PART B Patient Consent - to be completed by Patient

The Doctor whose name appears in Part A and I have discussed the delivery of my baby/babies. I acknowledge the process of childbirth is a natural event however sometimes medical intervention is required. I have had explained to me the nature of such possible interventions and the associated material risks. These possible interventions can include episiotomy, forceps delivery, vacuum delivery and caesarean sections.

The doctor has told me that

- an anaesthetic, medicines, or blood transfusion may be needed in association with this delivery procedure and these may have some risks
- additional procedures or treatment such as, but not limited to, episiotomy and caesarean section, forceps delivery, vacuum delivery and epidural anaesthetic may be needed if something unexpected occurs during the delivery; and
- I agree to these additional procedures/treatments being carried out if required.
- I understand the nature of the delivery procedure and that it may carry risks to me and my baby/babies.

I have been advised of the material risks associated with the delivery.

I have had the opportunity to ask questions of the Doctor about the risks and possible complications of the delivery and the possible interventions, which may be required, and I am satisfied with the answers and the information I have received.

Ramsay employees will administer care/treatment under my treating Doctor's direction, or in an emergency, medical and nursing care will also be delivered as required.

I consent / do not consent to blood products if needed.

I, _____ understand and consent,

(Insert Full Name of Patient)

to the delivery and any intervention which may be necessary as outlined above for me or my baby/babies.

Date: / /

(Signature of patient)

Address _____ Suburb _____ State _____

Date: / /

(Signature of witness)

Print name of witness _____

Address _____ Suburb _____ State _____