Booking Form

COMPLETE & RETURN TO PARRAMATTA EYE CENTRE AT LEAST ONE WEEK BEFORE YOUR PROCEDURE.

Return by fax, postage paid envelope, email or bring the original form with you on the day of your procedure. We will contact you 1-2 days before your procedure to confirm your arrival time and answer any questions you may have.

PARRAMATTA EYE CENTRE

Level 3, 34 Charles St, Parramatta NSW 2150
P (02) 8833 7133 F (02) 9633 2494 E admin@parramatta**eye**.com.au

To be Completed by the Specialist

Specialists Name:	Procedure Date:
Procedure:	Item Number (Provisional):
Relevant Medical History:	Prosthesis: Lens: ◯ Standard ◯ Toric ◯ Multi-focal ◯ Multi-focal Toric
Special instructions/Equipment required:	Allergies:

To be Completed by the Patient/Guardian

Have you been a patient at Parramatta Eye Centre before: ◯ No ◯ Yes			Procedure Date
Title	First Name	Surname	
Address Postcode			
Date of Birth	Country of Birth	Gender: ◯ Male ◯ Female	
Home Phone	Mobile:	Work Phone	
Language/s	Occupation		
Indigenous: ◯ No ◯ Yes	If yes: ◯ Aboriginal ◯ Torres Straight Islander		
Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Defacto			
Medicare No.	Ref. No.	Expiry Date	
Health Fund	Membership No.	Workcover: No ◯ Yes ◯	
Pension Card No.	Exp. Date	Pharmacy Entitlement No.	
Veteran Affairs Card No.	Exp. Date	Colour	
Emergency Contact Name		Relationship	
Address Postcode			
Phone (Home)	Mobile	Phone (Work)	

Please note that following all procedures you will require a responsible adult or carer to take you home and care for you overnight.

Carer's Name	Phone	Relationship

To be completed by the patient or patient's GP prior to surgery

See your GP at least 1-2 weeks prior to your procedure to complete this form and discuss any questions you may have.

Patient Name:	Procedure Date:
GP's Name:	Optometrist's Name:
GP's Contact Phone:	Optometrist's Contact Phone:
GP's Address:	Optometrist's Address:

Please tick if you have or ever had any of the following?

- ○ Cough
- ○ Anaemia
- ○ Palpitations
- ○ Respitory Illnesses
- ○ Hospital Acquired Infection
- ○ Glaucoma
- ○ Asthma/Breathlessness
- ○ Chest Pain
- ○ Epilepsy or fits
- ○ High Blood Pressure
- ○ Ankle swelling
- ○ MRSA or other infections
- ○ Diabetes - Year diagnosed:_____
  - Are you: IDDM ○ NIDDM ○
  - Year started Insulin:_____
- ○ Other _____

Are you allergic to anything? (e.g. Medications, iodine, latex, food, etc.)

○ No ○ Yes, provide details:

Have you had any adverse reactions or problems with anaesthetic?

○ No ○ Yes, provide details:

What is your current weight?

_____ (kg)

Do you have a pacemaker, defibrillator or replacement heart valve?

○ No ○ Yes, provide details:

Have you had a history of falls in the last 6 months?

○ No ○ Yes, provide details:

In the past two weeks, have you taken any Aspirin, anti-inflammatory or any other blood thinning medications? *(e.g. Cartia or Warfarin)*

○ No ○ Yes, provide details:

Have you ever smoked?

○ No ○ Yes

Date ceased: _____

Daily amount:

Do you drink alcohol?

○ No ○ Yes, number of standard drinks per day:

Are you pregnant, or is there any possibility you might be pregnant?

○ No ○ Yes, provide details:

Do you have a history of pressure injuries or broken skin?

○ No ○ Yes, provide details:

Have you taken steroids, prednisone or cortisone in the past six months?

○ No ○ Yes, provide details:

In the past two weeks, have you had a cold or flu?

○ No ○ Yes, provide details:

Do you have an Advance Care Directive or Treatment Limiting Order?

○ No ○ Yes, provide details:

List all medications you are currently taking (including complimentary medicines). *Attach a separate sheet if needed.*

Name of medication	Strength	No. daily	Name of medication	Strength	No. daily

List all past health problems and operations, including dates. *Attach a separate sheet if needed.*

Details	Date	Details	Date

Signature of Patient/Guardian:

Print Name:

Date:

If Guardian, state relationship to patient (e.g. Parent):