PARRAMATTA EYE
HOSPITAL & DAY SURGERY

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

ADMISSION FORMS

In order to confirm your admission we must receive these forms at least one week prior to your procedure.

Please take the time to read and complete the forms carefully.

BY BUS: The Free 900 Parramatta Shuttle Bus comes every 10 minutes

BY TRAIN: Parramatta Railway Station is located on the Main Western line, served by Sydney Trains T1 Western & T5 Cumberland lines, NSW Train Link Blue Mountains line, Central West XPT & Outback Xplorer. From the station take the Free 900 Parramatta Shuttle Bus at Argyle St

BY CAR: Pick-up & drop-off for 2 minutes outside Parramatta Eye, in front of Riverside Cafe

P1 - Metered Street Parking - Charles St & Philip St

P2 - Wilson Parking - 130 George St (3 minute walk)

P3 - Secure Parking - Riverbank, 330 Church St (9 minute walk)

P4 - Secure Parking - 2-10 Wentworth St (11 minute walk)

P5 - Westfield Shopping Mall - Parramatta Westfield, then Free 900 Parramatta Shuttle Bus

P6 - Secure Parking 180 George St (3 minute walk)

GENERAL GUIDELINES

- Please allow adequate travelling and parking time so that you arrive on time and relaxed
- If your appointment is after hours please press intercom button located on the right hand side of the glass entry doors so that we can allow access
- You are most welcome to bring a friend or family member along who can be present during the operation
- Please ensure mobile telephones are switched off prior to going into theatre
- Contact us if you have a cold or feel unwell as soon as possible
- Please bring a pair of sunglasses with you to wear, as your eyes may be glare sensitive initially when you leave the centre
- You MUST arrange for someone to drive you home, or some other form of transport

FASTING

At the time your appointment or consultation is made, you will be told how long you should fast for. Please adhere to the instructions you are given

As a general guideline, if your operation is in the morning DO NOT eat, drink or smoke from MIDNIGHT before your operation

If your operation is in the afternoon DO NOT eat, drink or smoke after 6am on the day of your operation. **Not even a drink of water is allowed.**

WHAT TO WEAR

- Please wear clean, loose and comfortable clothes
- Before the operation, you may shower or wash as normal
- We suggest that you wash your hair the day before surgery. It is recommended that you do not wash your hair again for ONE WEEK after the operation
- Do not wear any make up, perfumes, aftershave, spray deodorant or hairspray
- Leave your jewellery or any valuables at home. We don't accept liability for any items brought into the Hospital.

MEDICATIONS

Please follow any instructions given by your doctor or the staff. General guidelines on the day of your procedure are:

- Do not take your diabetic medications, but you must bring them with you
- You may take your other usual medications with only a sip of water if required
- Take any heart or blood pressure medications with only a sip of water
- If you are taking Warfarin or Clexane medication, it is important that you provide the centre with a recent INR blood test result taken a few days prior to admission
- Continue to take any blood thinners unless instructed by your surgeon, anaesthetist or General Practitioner

MEALS

Parramatta Eye Centre will provide a small meal and drink after your surgery along with some medications. Food or alcoholic drinks should not be brought to you by visitors without the permission of your Nurse.

ACCOUNTS FEES

If you are a member of a health fund, we will conduct an eligibility check for you to establish your level of cover and any excess payable. It is your responsibility to disclose health fund details to us.

Prior to your admission, it is important you check with your health fund regarding the following:

- Identify whether your level of health fund cover adequately covers the cost of your procedure
- Identify whether an excess is payable for your admission, and if so, the amount
- If you have been a member of a health fund for less than 12 months, and if your condition or any symptoms of your condition existed prior to you joining the health fund, your fund may not accept liability for the costs of your admission. If there is a question regarding pre-existing symptoms, your health fund has the right to obtain details in this regard from your General Practitioner, Optometrist or Specialist

PAYMENT PROCEDURE

The treatment fee can be paid by cash, credit card or bank cheque. Cheques should be made payable to Parramatta Eye Hospital & Day Surgery. **Personal cheques will not be accepted**. Payment on the day of treatment is required before any treatment may proceed.

If you are using finance options please ensure that payment has been arranged prior to your treatment.

- Private patients - the portion of your estimated hospital account not covered by your health fund, e.g. an excess or co-payment must be paid on admission.
- Repatriation (DVA) patients - the hospital will lodge a claim on your behalf.
- Work Cover / Third Party patients - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.
- Uninsured patients - total payment (aside from any ancillary charges) must be made on admission.
- Other costs which may be incurred during your stay are payable on discharge.

MEDICAL RECORDS AND PRIVACY

Records will be kept of your illness and treatment. They are confidential and the contents will be divulged only with your consent or where justified by law. You are entitled to view your medical record at any time in the company of a clinical staff member. We comply with the Privacy Act 1988, and the NSW Health Records and Information Act 2002, including the way we collect, store, use and disclose health information.

DISCHARGE INFORMATION

- Patients and their carers will be informed of their approximate discharge time on admission.
- You must arrange for someone to escort you home
- You must not drive a car until the doctor advises. (your motor vehicle insurance may not cover you in any unfortunate circumstances)
- Before you leave the hospital, make sure that you or your relatives/friends know how to care for you at home
- Check with your Nurse/Doctor about continuing medication, follow-up appointments, etc.
- Please contact the Nursing Staff if you have any concerns, problems or suggestions during your stay

--- TEAR ALONG THE FOLD ---

YOU MUST COMPLETE & RETURN FORMS 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.

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Admission Form

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 Year

Title | First Name | Surname

Address

Date of Birth | Occupation | Gender ◯ Male ◯ Female

Home Phone | Mobile | Work Phone

Are you an Australian citizen No ◯ Yes ◯ | Country of birth | Language

Are you of Aboriginal/Torres Straight Islander (TSI) decent ◯ No ◯ Yes — If yes, ◯ Aboriginal ◯ TSI ◯ Both Aboriginal & TSI

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Defacto

MEDICARE CARD: No. | Ref. No. (next to your name on card) | Exp. Date

PRIVATE HEALTH FUND: Name | Membership No.

Have you paid an excess this year? No ◯ Yes ◯ — Have you changed the level of cover in the past 12 months? No ◯ Yes ◯

PENSION CARD: No. | Exp. Date

VETERAN AFFAIRS CARD: No. (DVA) | Exp. Date | Gold ◯ White ◯ Orange ◯

PAYMENT BY THIRD PARTY: Workcover ◯ TAC ◯ *The approval letter for this admission from your insurance company must accompany this form.*

Insurance Company Name | Address | Phone

Date of Accident | Claim No. | Authorized by

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

Carer/Emergency Contact Name | Relationship

Address

Phone (Home) | Mobile | Phone (Work)

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

Complete this form and discuss with your GP if you have any questions.

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

Have you now or ever had any of the following? **PLEASE ONLY TICK THOSE APPLICABLE TO YOU**

- ○ Cough
- ○ Anaemia
- ○ Palpitations
- ○ Respitory Illnesses
- ○ Hospital Acquired Infection
- ○ Glaucoma
- ○ Asthma/Breathlessness
- ○ Chest Pain
- ○ Epilepsy or fits
- ○ High Blood Pressure
- ○ Ankle swelling
- ○ Cognitive impairment
- ○ 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:

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:

What is your current weight?

_____ (kg)

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

PAYMENT OF ACCOUNT

I understand a portion of my estimated hospital fees is not covered by a health fund and must be paid on admission. Any additional fees incurred during my operation are payable upon discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason. I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of Patient/Guardian

Print Name

Date

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

and Contact Ph.