It is essential that the hospital receives the pre-admission form as soon as possible following your visit to the doctor in order to minimise delays on your day of admission.

Please take the time to read and fill out the relevant documents carefully.

Please retain the first 3 perforated pages for your information.

Thank you.
Welcome to Tweed Day Surgery

Our Address is:

Suite 4, 38-44 Boyd Street, Tweed Heads, NSW 2485

Postal Address: PO Box 797, Tweed Heads, NSW 2485

Our Telephone number is (07) 55 995 522

Our Fax number is (07) 55 991 666

Admission Information:

You will only be contacted if we require further information, or to confirm health fund details.
Tweed Day Surgery

Patient Information

Welcome and thank you for choosing Tweed Day Surgery. We hope that your stay with us will be as comfortable and pleasant as possible.

Pre-Admission Information

Pre-admission is an important part of your hospital care. To ensure we can confirm your admission, financial and other arrangements, **we ask that you:**

- Your specialist will complete the Doctor’s Referral/Consent form.
- Compete the Patient History form.
- Complete in full the Patient Pre-Admission forms and return to the Hospital no later than 48 hours prior to admission.

You can do this in several ways:

- **In Person** at Reception (Open Mon - Fri 8am - 5 pm).
- **By Fax** (07) 5599 1666
- **By Post** to arrive no later than 48 hours prior to your admission.
- Please ensure that you bring the following with you to the Hospital on the day of admission:
  - Medicare card
  - Pension card / Health Care card
  - Repatriation / Veterans’ Affairs card
  - If your account is subject to WorkCover or a Third Party claim, forward full details of the claim including a letter from your insurance company accepting liability for this admission to our pre-admission office at least 48 hours prior to your procedure.

Your doctor will notify the Hospital of the date of your procedure / operation and inform you of the day of admission. The doctor will also explain your procedure or operation and complete the consent form with you.

If you have any questions about hospital procedures, completion of forms, cost or health insurance status, our staff will be happy to assist you.

General Information:

- Tweed Day Surgery is a smoke-free environment.
- Limited parking is available.
Tweed Day Surgery

Accounts / Fees
If you are a member of a health fund it is important that you contact your Health Fund prior to admission to confirm:

a) That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation outlined in the Pre-Admission Form.

b) If an excess is payable for this admission.

c) If you have been a member of your Health Fund for less than 12 months your fund may not accept liability for the costs of this admission. eg. if your condition or any symptoms of your condition existed prior to your joining. If there is a question regarding pre-existing symptoms your health fund has the option to obtain details from your GP or specialist.

Pharmacy and Pathology, imaging and x-ray may attract an additional charge. Practitioner’s fees may be billed separately by the practitioner.

Payment Procedure
- Private patients - the hospital will lodge a claim on your behalf. Should your insurance include an excess this must be paid on admission. Any additional costs incurred during your stay are payable prior to discharge. eg. extra endoscopy procedure

- Repatriation (DVA) patients - the hospital will lodge a claim on your behalf.

- WorkCover patients - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed

- 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 must be made on admission.

- Other costs which may be incurred during your stay are payable on discharge.

Payment may be made by cash, credit or eftpos.

Medical Records and Privacy
Records will be kept of your illness and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law.

Tweed Day Surgery complies with the Privacy Act 1988, including the way we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our Hospital (eg. to your health fund, to our insurer, to an external company contracted by Tweed Day Surgery to evaluate customer satisfaction).
DO
Unless otherwise ordered by your doctor or staff at Tweed Day Surgery

- Shower the morning of the procedure
- Wear garments that are comfortable and easy to change out of & into.
- Check with Tweed Day Surgery staff before organising a time for your pick up. Generally the recovery staff will ring your pick up person 1/2 hour prior to the discharge time. You will be informed of your approximate length of stay on admission.
- Bring into the Day Surgery any medications you will require after the surgery, e.g. Insulin.
- Bring into the Day Surgery any relevant x-rays.
- You MUST organize someone to drive you home.
- You MUST organize someone to stay overnight with you, after general anaesthetic or IV sedation.
- Bring enough money to pay any accounts, on admission.

DO NOT
Unless otherwise ordered by your doctor or staff at Tweed Day Surgery

- Eat or drink (this includes chewing gum & smoking) anything during your fasting hours as per instructions received from your specialist
  Or
  Endoscopy instruction sheet
  Or
  Tweed Day Surgery staff
- Wear jewellery of any kind (wedding ring is accepted)
- Wear make-up or nail polish
- Bring valuables of any kind or large amount of money. Tweed Day Surgery does not accept liability for any items brought into the hospital.

Discharge Information

- You will be informed of your approximate length of stay on admission
- You must not drive a car until at least 24 hours post anaesthesia (your insurance may not cover you)
- You will receive written discharge instructions.
- Before leaving make sure you are comfortable about how to care for yourself.
- Check with your specialist about continuing medication if you’re not sure.
- Make sure you have your x-rays returned to you. Make sure you empty your locker.
- Please ask your nurse if you have any concerns, problems or suggestions during your stay.
WHERE WE ARE LOCATED

SUITE 4, 38 - 44 BOYD ST
TWEED HEADS
07 5599 5522
To be completed by Patient.

Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admitting Doctor: .................................................................

Date of Admission: ........../........../........... Time: .........................

Personal Details

Title: ...................... Surname: ........................................................ Previous Surname (if applicable): ............................................................

Given Names: .................................................................................. Preferred Name: ..............................................................................

Address: ................................................................................................ Suburb: .......................................................... State: ....................

Postcode: ....................... Telephone (Home): .................................. (Business): .................................................. Mobile: ....................

Sex: □ Male □ Female Date of Birth: ........../........../........... Age: ........................................................

Marital Status □ Single □ Married □ De Facto □ Separated □ Divorced □ Widowed

Occupation: .................................................................................... Religion..................................................................................

Are you an Australian Resident? □ Yes □ No Country of birth: .......................................................... If Australian specify state: ..............................................................

Are you of Aboriginal / Torres Strait Islander (TSI) descent? □ No □ Yes, Aboriginal □ Yes, TSI □ Yes, both Aboriginal and TSI

Person to contact (Next of Kin)

Name: ............................................................................................. Relationship to patient: ............................................................

Address: ................................................................................................ Suburb: .......................................................... State: ....................

Postcode: ....................... Telephone (Home): .................................. (Business): .................................................. Mobile: ....................

Second Contact / Power of Attorney: .................................................................................................................. Telephone: .......................
This form must be FULLY completed in order for your admission to be processed.

Section B: WorkCover or Third party

☐ WorkCover or ☐ Third Party

• The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company: ............................................................................................................................................

Address Street: ............................................................................................................................................................................................................

......................................................................................................................................................................................................................................

Suburb: ................................................................................................... State: .......................................................... Postcode: ................................

Telephone: ............................................. Claim No: ............................................................................................................. Authorised by: .....................................................

Has your insurance company accepted liability? ☐ Yes ☐ No Please specify reason (if no): .............................................................

WorkCover Patients Only - Employer Details: Name of Employer: ...................................................................................................................................

Address Street: ............................................................................................................................................................................................................

......................................................................................................................................................................................................................................

Suburb: .......................................................... State: ................................. Postcode: .............................

Telephone: ............................................. Date of Accident: ........../........../..........

Has your employer completed a Report of Injury Form? ☐ Yes ☐ No

Have you completed a WorkCover Claim Form? ☐ Yes ☐ No

How Will You Claim For This Admission (please tick ✓ one box only)

☐ Private Health Insurance - Please complete Sections A and C
☐ WorkCover / Third Party / TAC - Please complete Sections B and C
☐ Repat / Veterans' Affairs - Please complete Entitlements and Section C
☐ Uninsured - Please complete Section C only

Previous Hospital Hospitalisation

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year: ..............................

Is this admission for a child? ☐ No ☐ Yes

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes

Which Hospital? ...................................................... Dates: ..............................

GP / Local Doctor

Full name of GP: ............................................................................................................................................................................................................

GP Address: ...................................................................................................................................................................................................................

GP Telephone: ............................................................................................ GP Facsimile: ............................................................................................

Section C: Payment of Account - all patients to complete

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. I have signed a patient estimate of expenses form and 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 person responsible for account: ................................................................................................................... Date: ........../........../..........

Please Print Name: ...................................................................................................................
To be completed by Specialist. Please PRINT clearly

Please Admit

Mr, Mrs, Miss, Master: ................................................................. Date of Admission: ........../........../...........
Surname                   Given Names
Address: ........................................................................................................................................................................................................................
Telephone: ........................................................................................................................................................................................................
Home                     Business

Clinical Details

Present symptoms: .......................................................................................................................................................................................................

Principal diagnosis, i.e. the condition which best accounts for patient’s stay in hospital: ...............................................................................................................................................................................................

Other conditions present: ...............................................................................................................................................................................................

Medications: ..................................................................................................................................................................................................................

ALLERGIES: ..............................................................................................................................................................................................................

Operation

Proposed operation / treatment: ........................................................................................................................................................................................................

Date of Operation: ........../........../...........

Specific pre-operative instructions (including tests required): ..............................................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................

SPECIALIST REFERRAL FORM

UR Number: ..............................................................................................................................................................................................................
Surname: ..............................................................................................................................................................................................................
Name: ..............................................................................................................................................................................................................
Date of Birth: ................................................................. Gender:...................................
Dr: ..............................................................................................................................................................................................................

Patient Details

Specialist Referral Form

To be completed by Specialist. Please PRINT clearly

Please Admit

Mr, Mrs, Miss, Master: ................................................................. Date of Admission: ........../........../...........
Surname                   Given Names
Address: ........................................................................................................................................................................................................................
Telephone: ........................................................................................................................................................................................................
Home                     Business

Clinical Details

Present symptoms: .......................................................................................................................................................................................................

Principal diagnosis, i.e. the condition which best accounts for patient’s stay in hospital: ...............................................................................................................................................................................................

Other conditions present: ...............................................................................................................................................................................................

Medications: ..................................................................................................................................................................................................................

ALLERGIES: ..............................................................................................................................................................................................................

Operation

Proposed operation / treatment: ........................................................................................................................................................................................................

Date of Operation: ........../........../...........

Specific pre-operative instructions (including tests required): ..............................................................................................................................................................................................................................

Specialist Signature: ..............................................................................................................................................................................................................
PART A: Provision of Information to Patient (To be completed by Medical Practitioner)

I, Doctor .................................................................
(insert name of medical practitioner)

have informed: .................................................................
(insert name of patient / parent / guardian)

of the nature, likely results, and material risks of the recommended operation / procedure and/or treatment. 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 named above to .................................................................

Signature of Medical Practitioner

Date: ........../........../..........                                Date: ........../........../..........    

PART B: Patient Consent (To be completed by Patient)

The doctor whose name appears in Part A above and I have discussed my / my child’s / my charge’s present condition and the various alternative ways in which it might be treated. The doctor has told me that:

• The administration of the anaesthetic, medicines and/or a blood transfusion may be needed in association with this operation / procedure and/or treatment and these carry some risks.

• Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations / procedures and/or treatments being carried out if required as long as they are related to the primary procedure set out in Part A.

• Even though the operation / procedure and/or treatment is carried out with all due professional care, the operation / procedure and/or treatment may not give the expected result.

• The operation / procedure and/or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature of the procedure / treatment and that undergoing the operation / procedure and/or treatment carries risk.

I have been advised of the material risks associated with this operation / procedure and/or treatment.

I have had the opportunity to ask questions about the operation / procedure and/or treatment and I am satisfied with the answers and information I have received.

I understand that I may withdraw my consent at any time prior to the operation / procedure and/or treatment.

I consent / do not consent to a blood transfusion if needed. (circle one)

I request, understand and consent to the operation / procedure and/or treatment as outlined above in Part A.

Signature of patient / parent / guardian

Date: ........../........../..........                                Date: ........../........../..........    

Print name of patient / parent / guardian

Address: ..............................................................................................................

Signature of witness to patient’s signature

Date: ........../........../..........                                Date: ........../........../..........    

Print name of witness

Address: ..............................................................................................................
**PATIENT HISTORY FORM**

To be completed by Patient.
Please PRINT clearly.

<table>
<thead>
<tr>
<th>ADMISSION DETAILS</th>
<th>NO</th>
<th>YES</th>
<th>COMMENTS OR FURTHER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this admission due to a past or present injury?</td>
<td></td>
<td></td>
<td>Cause of injury:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Place: (e.g. School, Home)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date / /</td>
</tr>
<tr>
<td>Have pathology / blood test / autologous blood been taken for this admission?</td>
<td></td>
<td></td>
<td>Pathologist:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Results with:</td>
</tr>
<tr>
<td>Have X-rays been taken for this admission?</td>
<td></td>
<td></td>
<td>With patient □ With doctor □</td>
</tr>
<tr>
<td>What is your: Height ......... cms Weight ......... kgs Blood Group (if known) .......................</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you given blood for transfusion during this admission?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been overseas in the last 10 days?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you recently taken blood thinning / arthritis medication (Aspirin Based)?</td>
<td>Name of Medication:</td>
<td></td>
</tr>
<tr>
<td>Have you been instructed to cease this medication?</td>
<td>Date last taken / / or still taking □ Yes</td>
<td></td>
</tr>
<tr>
<td>Have you taken any anti-coagulant therapy (Warfarin)?</td>
<td>Date last taken / / or still taking □ Yes</td>
<td></td>
</tr>
<tr>
<td>Have you taken any steroids or cortisone tablets / injections in the last 6 months?</td>
<td>Name of Medication:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date last taken / / or still taking □ Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERAL MEDICAL CONDITION</th>
<th>SPECIFY DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>□ Type 1 □ Type 2 □ Unsus</td>
</tr>
<tr>
<td></td>
<td>Managed by □ Diet □ Tablets □ Insulin</td>
</tr>
<tr>
<td>Cancer</td>
<td>Site:</td>
</tr>
<tr>
<td>Stroke</td>
<td>Date: / / Residual problems</td>
</tr>
<tr>
<td>Infectious diseases / recent infections</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
</tr>
<tr>
<td>Heart attack / chest pain / angina (Circle Type)</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Palpitations / irregular heart beat / heart murmur</td>
<td></td>
</tr>
<tr>
<td>Pacemaker</td>
<td>Make Model Last checked: / /</td>
</tr>
<tr>
<td>Prosthetic heart valve</td>
<td>Type</td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>Tendency to bleed / blood clots / bruise easily</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Asthma / bronchitis / pneumonia / hayfever (Circle Type)</td>
<td></td>
</tr>
<tr>
<td>Liver disease / hepatitis (Specify type A, B, C)</td>
<td></td>
</tr>
<tr>
<td>Kidney / bladder problems</td>
<td></td>
</tr>
<tr>
<td>Hiatus Hernia / gastrointestinal ulcers / bowel disorder</td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
</tr>
<tr>
<td>Epilepsy / fits / febrile convulsions</td>
<td></td>
</tr>
<tr>
<td>Depression / dementia / other mental illness</td>
<td></td>
</tr>
<tr>
<td>Migraines</td>
<td></td>
</tr>
<tr>
<td>Eye disease</td>
<td></td>
</tr>
<tr>
<td>Recent cold or flu</td>
<td></td>
</tr>
<tr>
<td>Female patients - could you be pregnant?</td>
<td>Number of weeks:</td>
</tr>
<tr>
<td>Impairment eg. vision, hearing, mobility</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Tweed Day Surgery**
**PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS**

Have you had previous operations? Please list dates and operations performed:

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**NO**  **YES**  **SPECIFY DETAILS**

Have you or anyone in your immediate family ever had a reaction to an anaesthetic?  
Details of reaction:

**PROSTHESIS / AIDS / OTHERS**

- Glasses / Contact Lenses
- Hearing aid or other hearing appliance
- Body Piercing
- Dentures / Caps / Crowns / Loose Teeth
- Artificial joints or limbs
- Metal plates / pins

**LIFESTYLE**

- Have you ever smoked?  
  - Daily amount  
  - or date ceased / /  
- Do you drink alcohol?  
  - Daily amount  
- Do you use recreational drugs?  
  - Type  
  - Daily amount  
- Do you require a special diet?  
  - Type of Diet  
- Do you exercise?  
  - ☐ < 30mins per day  
  - ☐ 30mins per day  
  - ☐ 30mins per day plus aerobic activity 3 times per week  
- Do you require an interpreter?  
  - Language spoken at home  
  - Name of Person

**ALLERGIES**

- Do you have any allergies to medications, food, sticky plaster, latex / rubber (eg. balloons, gloves) or other substances?  
  - Specify details and reaction

**QUESTIONS RELATING TO CREUTZFELDT-JAKOB DISEASE**

- Have you ever had a dura mater graft / brain surgery between 1972 - 1989?  
- Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?  
- Are you listed on the “Australian Human Pituitary Hormone Program” database?  
- Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?  

**DISCHARGE PLANNING**  
(This information is necessary in order to help you plan a safe return to home after discharge.)

- Do you live alone?  
  - Name of person:  
  - Relationship:
- Are you solely responsible for the care of another person at home?  
- Do you currently receive community support services?  
- Do you require assistance with any aspect of day to day living?  
  - Details  
- Do you have multiple health problems?  
  - Details
- Where do you plan to go after discharge?  
  - How will you get there?

**NURSE USE ONLY**

Name of Admitting Nurse: ...................................................  
Signature: ..................................................  
Designation: ..................................................  
Date .................../........../...........  
Time .................

NB: IF “YES” TO CJD, DISCHARGE PLANNING, LATEX / RUBBER, FOOD, STICKY PLASTER ALLERGY, ASTHMA / HAYFEVER or SARS / OVERSEAS QUESTIONS PLEASE REFER TO RELEVANT POLICY
Please list all the medications you take currently. Including: prescription medicines. Over the counter medicines Herbal and Natural Medicines: Patches, creams, suppositories, injections. Medicines come in many forms including tablets, liquids, inhalers and drops.

ALL MEDICATIONS MUST BE BROUGHT TO THE HOSPITAL IN ORIGINAL PACKAGING.

Some medications prescribed by your Doctor can come in different strengths. Please stipulate the strength you are taking in milligrams. For example Lipitor can be prescribed in 10mg, 20mg or 80mg tablets. Please see the examples below and list your medications in the same way.

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Number of Tablets</th>
<th>How often &amp; When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EG: Lipitor</td>
<td>10mgs</td>
<td>1</td>
<td>8pm every day</td>
</tr>
</tbody>
</table>

Patient or Guardian Signature: ................................................................. Date: .................................

Name (print): ..............................................................................................................
Healthscope is committed to the right to privacy and protection of personal and health information in accordance with privacy laws. (Privacy Act 1988 as amended).

Personal information we collect from you will be used primarily to ensure that you receive the optimal care.

Please provide your consent to the use of your personal information for the purposes described below, by initialising boxes and signing and dating the form where indicated. (any boxes left blank will denote that consent is withheld)

I hereby consent to the use of personal information for the purposes below:

A ☐ To assist other medical practitioners, health care professionals and facilities who are involved in my care and who may treat me in the future, but only to the extent necessary to treat my particular condition I have consulted the medical practitioner or facility about.

B ☐ To inform Next of Kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.

C ☐ To assist in education, research projects, and quality improvement activities that enhance service delivery and facility planning.

D ☐ To enable the hospital to provide members of the Returned Services Organisations and Ministers of Religion with sufficient details to enable them to visit me whilst in hospital.

E ☐ To enable the hospital to provide my personal information to medical practitioners, health care professionals and facilities for administrative purposes.

F ☐ To communicate marketing and promotional activities to me.

Irrespective of any request received, I direct you NOT to provide my personal information to (please specify):

(Names): ..........................................................................................................................................................................................

.........................................................................................................................................................................................................

Signature: ............................................................ DATE this .................................. day of ......................................... 20 .................

............................................................................................................................................................................... (name printed in full).
HOSPITAL CONSENT

I (Patient or Parent / Guardian) .......................................................................................................................... consent for myself / (circle as appropriate) other (specify) ...........................................................................................................................................

performed on myself / other (specify) .............................................................................................................................................

I have engaged Dr. ............................................................................................................ .................. (insert both first and last names) as my private treating doctor to undertake the medical management of my medical condition and provide medical services to me. I acknowledge that my private treating doctor is not an employee, servant or agent of the hospital and I will not hold the Hospital responsible or liable for any injury to me caused by negligence or breach of duty by my private treating doctor, or any other doctor, or health professional engaged by me or my private treating doctor to provide me with medical, pathological, radiological or other medical type services.

I acknowledge that the hospital will provide facilities for nursing services and paramedical services to assist my medical management and services, and is liable for any injury to me caused by any negligence or breach of duty by it in respect of these services provided to me.

I acknowledge that this facility had not given me any advice as to the medical treatment / procedures to be undertaken and I understand this is to be the responsibility of my Doctor.

I acknowledge that the facility uses nursing and staff to assist my Doctor in the provision of care and treatment. I understand that during this admission other unexpected treatments / procedures are sometimes necessary and I agree to these if required.

I consent to the facility transferring me to another hospital where this is considered necessary for my well-being.

By signing this consent, I confirm that I have read the terms of this consent and understand them.

......................................................................................                             ......................................................................................
Patient / Parent / Guardian Signature Date

......................................................................................                             ......................................................................................
Signature Witnessed By Print Witness name / Designation