Ulladulla Endoscopy and Medical Centre

111 Princes Highway,
PO Box 110, Ulladulla, 2539
Tel.: 4455 5422, Fax.: 4454 2263
www.ulladullaendoscopy.com.au

PATIENT ADMISSION REQUEST

Title	Surname	Given Names

Gender	Date of Birth	Marital Status
Male/Female	/ /	Single/Married/De Facto/Separated/Divorced/Widowed

Home Address	Post Code

Postal Address	Post Code

Telephone Number	Work Number	Mobile Number
( )	( )	

Email

Medicare Card No	Medicare Reference No	Medicare Card Expiry Date
		/

Pension/Health Care Card or Veterans Affairs No (if applicable)	Type of Veterans Affair Card	Expiry Date

Health Fund Name	Membership Number	Level/Excess if known

Country of Birth	Other cultural background (eg, Mediterranean, Asian, African)

Is English your first language?	Yes	No	If not, do your require an interpreter?	Yes	No	Please specify language

Are you of Aboriginal or Torres Strait Islander origin?	Yes	No

Aboriginal		Torres Strait Islander		Aboriginal and Torres Strait Islander	

Who can we contact in the event of an emergency?	
Name	Relationship to you

Telephone Number	Work Number	Mobile Number
( )	( )	

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OPERATION REQUEST

Admission Date: _____ **Surgeon:** **Dr Philip Larkin**

I _____ hereby give my consent for myself / my child

_____ to undergo the procedure of _____

_____

the nature and effect of which has been explained to me by ***Dr Philip Larkin*** and to such further or alternative treatment as may be found necessary as a consequence of such procedure.

- I understand that complications can be associated with this procedure and these have been explained to me.
- I also consent to the administration of local or general anaesthetic for this purpose.
- I understand that unexpected procedures may be necessary and I request these are carried out if required.
- I understand that if I require admission to hospital for further care, I will be responsible for the costs incurred.
- I have been informed of the likely results and material risks of the above procedure and of any financial interest the practitioner may have in Ulladulla Endoscopy and Medical Centre.

Following this surgery, I understand that impairment of medical alertness may persist for several hours following anaesthesia, and I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement during that period.

I will arrange to have a responsible adult escort me home after discharge from hospital.

Please note that the hospital acknowledges it's obligations under the Privacy Act 1988 (as amended). Personal Information will be used primarily to ensure that optimal care is provided, but may be used for other purposes. The hospital's personal Information is available on request and the General Manager is happy to answer any questions concerning the policy.

I acknowledge that I have read and understood the above information.

.....	.....	.....
Signature of patient / parent / guardian	Date	Signature of Medical Practitioner