

CATARACT/OPHTHALMIC SURGERY INSTRUCTIONS

- This is a day-surgery procedure and involves an intravenous sedation/twilight anaesthetic
- You will be at Ulladulla Endoscopy for around 4 hours.
- Please avoid having any skin cancer excisions/surgery 2 weeks prior to cataract surgery.

What **YOU** need to do prior to the surgery:

1. You must return the following to us at least **TWO WEEKS BEFORE** your surgery:
 - pre-op questionnaire & GP Letter,
 - ECG & Blood tests,
 - provide a full/complete current medication list, ie, what you are taking, dose and the time you take it (including, herbal medications). You can ask your GP/Pharmacist to assist by providing this.

WARFARIN

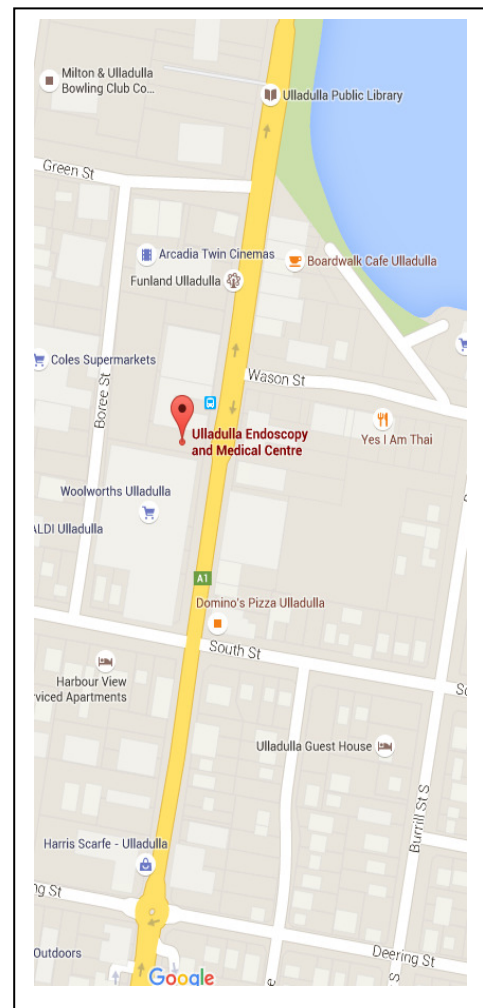
If you are on Warfarin -

You **MUST** have an INR attended the Thursday before your procedure. Please bring the results with you on the day of the surgery.

2. Have your appointment time confirmed 3 days before surgery.
3. Organise for someone to drive you home (or we can organise a taxi for you). They must come inside to collect you.
4. Know what payment is required on the day:
 - If you are covered by a health fund, we submit your bills directly to the fund for the Anaesthetist and Day Surgery.
 - Payment of your excess is required on the day of your procedure (please phone us or your health fund to find out if you have an amount to pay). Please note this is for the Day Surgery and Anaesthetist only Dr Larkin's staff will inform you of the Surgeon's fees.
 - If you do not have health fund cover, Dr Larkin will ask for direct payment for your procedure.

On the day of surgery:

1. You need to **FAST** before your procedure.
2. **DO NOT** Eat or drink 6 hours prior to the procedure.
3. **DO NOT** take your morning medication on the day. Panadol may still be taken for a headache (6 hours before) if required. Please bring your medications with you for the Anaesthetist to review.
4. Wear comfortable clothes including **SHORT SLEEVES**.
5. Bring your walking stick or walking frame with you if you usually use this to walk at home.
6. Leave valuables and jewellery at home. **DO NOT** wear nail polish.
7. Have someone to pick you up, they must come inside to collect you.
8. For your safety it is a requirement of this facility that you have a responsible adult care for you overnight postoperatively until the next day.



TO WHOM IT MAY CONCERN

Dear Doctor

RE: Name: _____ DOB: _____

Procedure Date: _____

Your patient is scheduled to have an ophthalmic operation at Ulladulla Endoscopy and Medical Centre with Dr Philip Larkin.

As part of our pre-operative screening we would be very grateful if you would supply the patient with a copy of their health summary and a current medication list.

We would also appreciate your assistance by answering the following questions in relation to screening for Creutzfeldt-Jakob Disease (CJD) and Transmissible Spongiform Encephalopathy's (TSE's):

Screening Question	YES	NO
1. Do you think the patient may have CJD?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient had two or more first or second degree relatives with CJD?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have an unexplained progressive neurological illness of less than 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature prior to 1986?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient previously had surgery on the brain or spinal cord that included a dura mater graft prior to 1990?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the patient been involved in a "look-back" for CJD or shown you a "medical in confidence" letter regarding their risk for CJD?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the patient had a dura mater graft prior to 1990?	<input type="checkbox"/>	<input type="checkbox"/>

If you require any further information please do not hesitate to contact me.

Yours sincerely

Dr Jessie Hoang
Diretor

PRE-OPERATIVE QUESTIONNAIRE

Name: _____ DOB: _____

General Practitioner: _____ Location: _____

Health Insurance? Yes / No _____ Pension? Yes / No _____

Please fill out this pre-operative form and return it to Ulladulla Endoscopy & Medical Centre at least 2 weeks prior to your surgery along with you GP letter.

History	YES	NO
1. Do you have any medical allergies? (list the type and reaction)	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any other allergies including latex, lotion allergy, food? (list the type and reaction)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do suffer from anxiety or phobias?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have dentures, crowns, loose teeth, dental issues, etc? (please circle or list)	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have an advanced care directive (living will) or "power of attorney" in place? If yes, please provide us a copy on or before your procedure date	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you (or have you ever) smoke(d)? If yes, how many per day? <input type="checkbox"/> ex-smoker	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you drink alcohol? (how many / how often)?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Risk	YES	NO
8. Do you have any heart trouble, eg: chest pain, heart attacks, stents, AF, heart murmur, artificial heart valve, heart operations, pacemaker, or heart defects?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have high blood pressure or other blood pressure problems?	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Issues	YES	NO
10. Do you have breathing problems, eg: Asthma, Bronchitis, Emphysema, chronic lung disease, obstructive sleep apnoea, etc? (please circle or list)	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you get shortness of breath in normal activities (require rest breaks)?	<input type="checkbox"/>	<input type="checkbox"/>
Health Screening	YES	NO
12. Do you have diabetes? If yes, what type? <input type="checkbox"/> Insulin Dependent?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have anaemia?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you had a stroke or TIA or other neurological issues?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have epilepsy, Parkinson's or another seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have any other serious illnesses or other health issues that may impact on your procedure? If yes, please provide details	<input type="checkbox"/>	<input type="checkbox"/>

18. Are you currently pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Previous Procedures	YES	NO
19. Have you had any previous surgeries? If yes, please provide details	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have any joint replacements/metal plates/pins/screws or implants/devices in your body?	<input type="checkbox"/>	<input type="checkbox"/>
Risk Screening	YES	NO
22. Do you use a walking stick or walking frame?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you get dizzy or lose balance easily or are unsteady on your feet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you take medication that leaves you disorientated?	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you had a fall in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you currently have a skin ulcer or have had a history of a skin ulcer? (please provide details)	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you have fragile skin or find that your skin bruises or tears easily?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you require assistance to change position or get in and out of a chair or bed?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you a past history of deep vein thrombosis (DVT, PE)?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have a reliable adult to stay with you for the first night after your operation? (NB: Failure to have a suitable adult to stay with you may result in cancellation of your procedure.)	<input type="checkbox"/>	<input type="checkbox"/>
Infection Risk	YES	NO
31. Do you have an artificial heart valve, heart murmur or recent surgery?	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you have hepatitis or HIV?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you ever had MRSA, VRE, ESBL, C. Difficile diarrhoea, CRE or CPE?	<input type="checkbox"/>	<input type="checkbox"/>
Medications	YES	NO
34. Do you take any regular medications? If yes, please provide a full/complete current medication list, ie, what you are taking, dose and the time you take it (including, herbal medications). You can ask your GP/Pharmacist to assist by providing this.	<input type="checkbox"/>	<input type="checkbox"/>
35. Are you on Warfarin, Plavix, Xarelto, Pradaxa, Cartia or other blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE SUPPLY YOUR <input type="checkbox"/> ECG <input type="checkbox"/> BLOOD TESTS <input type="checkbox"/> GP LETTER <input type="checkbox"/> MEDICATION LIST		

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 Affairs 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 you 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			
()		()					

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 its 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