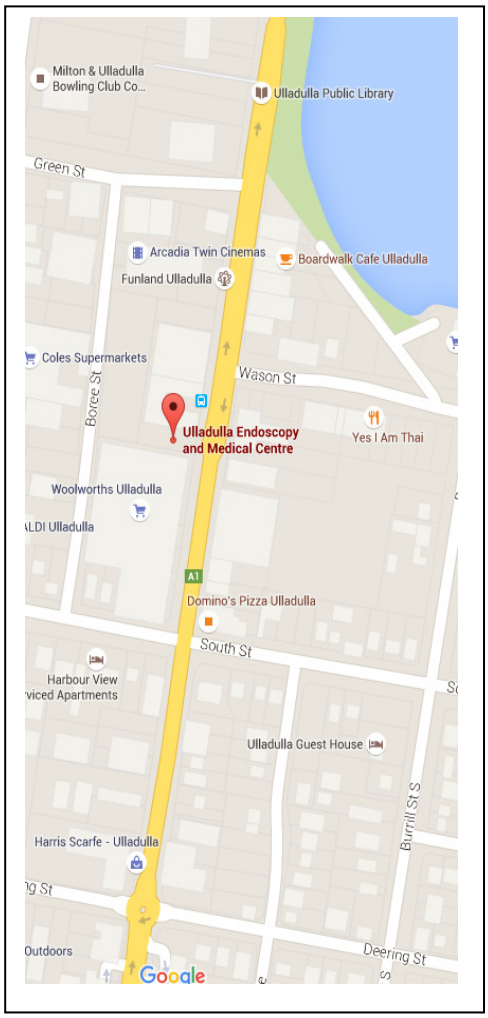
Ulladulla Endoscopy and Medical Centre

111 Princes Highway
PO Box 110, Ulladulla, 2539
Tel: 02 4455 5422, Fax: 02 4454 2263
ulladullaendoscopy.com.au

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 & health summary,
   - 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. **CHECK** with us regarding the medication you can take 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.

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.

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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/CONSENT

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

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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)	☐	☐
2. Do you have any other allergies including latex, lotion allergy, food? (list the type and reaction)	☐	☐
3. Do suffer from anxiety or phobias?	☐	☐
4. Do you have dentures, crowns, loose teeth, dental issues, etc? (please circle or list)	☐	☐
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	☐	☐
6. Do you (or have you ever) smoke(d)? If yes, how many per day? ☐ ex-smoker	☐	☐
7. Do you drink alcohol? (how many / how often)?	☐	☐
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?	☐	☐
9. Do you have high blood pressure or other blood pressure problems?	☐	☐
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)	☐	☐
11. Do you get shortness of breath in normal activities (require rest breaks)?	☐	☐
Health Screening	**YES**	**NO**
12. Do you have diabetes? If yes, what type? ☐ Insulin Dependent?	☐	☐
13. Do you have anaemia?	☐	☐

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14. Do you have thyroid disease?	☐	☐
15. Have you had a stroke or TIA or other neurological issues?	☐	☐
16. Do you have epilepsy, Parkinson's or another seizure disorder?	☐	☐
17. Do you have any other serious illnesses or other health issues that may impact on your procedure? If yes, please provide details	☐	☐
18. Are you currently pregnant or breastfeeding?	☐	☐
Previous Procedures	**YES**	**NO**
19. Have you had any previous surgeries? If yes, please provide details	☐	☐
20. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	☐	☐
21. Do you have any joint replacements/metal plates/pins/screws or implants/devices in your body?	☐	☐
Risk Screening	**YES**	**NO**
22. Do you use a walking stick or walking frame?	☐	☐
23. Do you get dizzy or lose balance easily or are unsteady on your feet?	☐	☐
24. Do you take medication that leaves you disorientated?	☐	☐
25. Have you had a fall in the last 3 months?	☐	☐
26. Do you currently have a skin ulcer or have had a history of a skin ulcer? (please provide details)	☐	☐
27. Do you have fragile skin or find that your skin bruises or tears easily?	☐	☐
28. Do you require assistance to change position or get in and out of a chair or bed?	☐	☐
29. Have you a past history of deep vein thrombosis (DVT, PE)?	☐	☐
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.)	☐	☐
Infection Risk	**YES**	**NO**
31. Do you have an artificial heart valve, heart murmur or recent surgery?	☐	☐
32. Do you have hepatitis or HIV?	☐	☐
33. Have you ever had MRSA, VRE, ESBL, C. Difficile diarrhoea, CRE or CPE?	☐	☐

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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.	☐	☐
35. Are you on Warfarin, Plavix, Xarelto, Pradaxa, Cartia or other blood thinners?	☐	☐
Screening Question	**YES**	**NO**
36. Do you have Creutzfeld-Jacob Disease (CJD)?	☐	☐
37. Have you had two or more first or second degree relatives with CJD?	☐	☐
38. Have you experienced an unexplained progressive neurological illness of less than 12 months?	☐	☐
39. Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short statue prior to 1986?	☐	☐
40. Have you previously had surgery on the brain or spinal cord that included a dura mater graft prior to 1990?	☐	☐
41. Have you been involved in a "look-back" for CJD or shown you a "medical in confidence" letter regarding their risk for CJD?	☐	☐
42. Have you had a dura mater graft prior to 1990?	☐	☐
PLEASE SUPPLY YOUR ☐ ECG ☐ BLOOD TESTS ☐ HEALTH SUMMARY ☐ MEDICATION LIST		