SANDHURST EYE CENTRE

Admission Questionnaire

PATIENT DETAILS

Relationship:	
Surname:	
Initials:	Title:
First Names:	
Residential Address:	
	Code:
DOB:	Age:
ID:	Religion:
Cell/Phone:	Occupation:
Email:	

NEXT OF KIN DETAILS

Name:	
Address:	
	Code:
Relationship:	
Telephone Number:	

MEDICAL AID MEMBER (Account Holders Details)

Members Surname:	
Name:	Title:
Postal Address:	
	Code:
Residential Address:	
	Code:
Home Phone:	Work:
Employer Name:	
Employer Address:	
Occupation:	
Name of Medical Aid:	
Medical Aid Number:	
Members ID:	
Plan:	

OFFICE USE ONLY

Admission Date:	Time:
Medical Aid Confirmation:	
Proc. Code:	
Diagnosis:	
Surgeon:	
Assistant:	
Anaesthetist:	

PAYMENT

Receipt No:	Date:
Amount:	Cash/Cheque/Card

NOTES

DISCHARGE

Date:		Time:
Deposit:	Tel:	TV:
Telephone A/C:		
Amount:	Paid:	M/A:
Valuables Rec/Ret:		

WESTSIDE TRADING (812) PTY LTD
Trading as **SANDHURST EYE CENTRE**

CONDITIONS OF ADMISSION, GUARANTEE AND INDEMNITY

I, the undersigned, request the admission of the aforesaid patient to the above institute and hereby acknowledge:

1. That I am responsible for payment in accordance with the tariff of charges of Westside Trading (812) Pty Ltd, including pharmaceutical charges and subsequent amendments thereto:

2. That all charges and disbursements reflected on my account are payable on presentation or advance thereof.

3. That in the event of any repudiation or non-payment for any reason whatsoever of my account by my medical aid scheme/workman's compensation commissioner/agent or guarantor, I am fully responsible for the immediate payment thereof. I further acknowledge that Westside Trading (812) Pty Ltd reserves the right to convert tariff of changes reflected on my account to private rates if applicable.

4. That neither Westside Trading (812) Pty Ltd nor its employees and/or agents shall be responsible for the loss of any money, valuables, personal effects or other property belonging to or in the possession of the patient.

5. That I further undertake not to institute any claim against Westside Trading (812) Pty Ltd and hereby indemnify Westside Trading (812) Pty Ltd against and shall not hold it responsible for any damages suffered by me or by the above mention person.
    i. In consequence of the use of any appliance, electrical or otherwise, by my doctor or by any member of staff or Westside Trading (812) Pty Ltd against and shall not hold, acting under the supervision of, or in accordance with the instruction of such doctor, and
    ii. In consequence of any operation or any treatment or of the administering of any Anaesthetic or medicine, where by such doctor or any doctor or any person by any member of staff of the Westside Trading (812) Pty Ltd, acting under the supervision of such doctor or under his authority.

6. That I hereby authorise the staff and/or any agent of Westside Trading (812) Pty Ltd or doctor attending, to disclose the nature of the illness or any operation or procedure performed on such patient to the medical scheme/guarantor only for the purpose of claiming the cost of the hospitalisation/medication.

7. I choose my above residential address as my condominium citandi et executandi and undertake to give notice of any changes of address.

8 Shall I fail to pay, I accept liability for payment of all legal costs, including attorney and client fee collection costs and tracing fees. I also accept liability for payment of the interest at a bank overdraft rate on all arrears account due.

9. That I have read this document and am fully aware of the terms and conditions hereof and that above conditions are in accordance with South African Law.

Signed At:_____ This_____ Day of_____ Year_____

Signature of Patient:_____ Full Name of Signatory:_____

Signature of Parent, Guardian or Person who admits the patient, if under age,

Hereby Accepting Liability for The payment of the patients medical costs: _____

Witness:_____

THIS SHADED SECTION FOR OFFICE USE ONLY:

T 011 803 0016 F 011 803 6957 www.AIPA.co.za aipa@bellevy.co.za

ANAESTHETIC CONSENT FORM

Acc Message: .....

ANAESTHESIOLOGIST: ..... DATE: ..... Acc No: .....

▲ **Hospital Sticker** ▲

Designed by specialists
for specialists

▼ CONSENT UPDATED BY:
BEL LEVY & ASSOCIATES (PTY) LTD ▼

HOSPITAL ..... SURGEON .....

PROCEDURE: ..... CODE .....

PREMED / Emrg / A LINE / CVP / PRONE / H&N / <1YR / <28D / PCA / ICU / BMI / BLOCK PL / BLOCK PR
W / T 0011 1215 1218 0032 0034 0043 0044 1221 1204 0018 2800 2802

ICD 10 How? ..... Weight: ..... Height: .....
Where?

BPC TIME 0039	THEATRE TIME 0023 0025
START..... h.....	START..... h.....
END..... h.....	END..... h.....
TOTAL.....	TOTAL.....

Sections A, B and C must be completed by the person responsible for the account.

NAME OF PATIENT : _____ TITLE : _____

DATE OF BIRTH : _____ ID No : _____

OCCUPATION : _____ AGE : _____

PARTICULARS OF PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT:

SURNAME : _____ TITLE : _____ SIGNATURE : _____

FULL NAMES : _____

OCCUPATION : _____ ID No : _____

RELATIONSHIP TO PATIENT : _____ LANGUAGE: _____

POSTAL ADDRESS : _____ HOME ADDRESS : _____

_____ CODE : _____ _____ CODE : _____

TEL No (H) : _____ TEL No (W) : _____ (FAX) : _____

E-MAIL: _____ (CELL) : _____

EMPLOYER'S or BUSINESS NAME : _____

BUSINESS ADDRESS : _____

_____ SPOUSE TEL No : _____

NAME OF MEDICAL AID : _____

MEMBER NAME : _____ Med Aid No : _____

PLAN : _____ AUTH No : _____

FAMILY MEMBER OR FRIEND NOT LIVING WITH YOU IN CASE OF EMERGENCY :

NAME : _____ TEL No (H) : _____ (W) : _____

Please sign on this side!

CONSENT FOR ANAESTHESIA AND AGREEMENT BETWEEN THE AIPA MEMBER WHO IS A SPECIALIST ANAESTHESIOLOGIST AND YOU THE PATIENT.
THIS FORM HAS BEEN COMPILED WITH THE SAFETY OF YOUR ANAESTHETIC IN MIND.

1. I confirm that I have been informed of the purpose of anaesthesia and I confirm that the risks and complications generally associated with anaesthesia have been explained to me. I have been afforded an opportunity to ask questions regarding my anaesthesia. I understand the anaesthetic options offered to me and have made my choice.
2. I understand that no one can guarantee an incident-free anaesthetic.
3. I understand that there is equipment and theatre staff supplied by the hospital which cannot be guaranteed by the anaesthesiologist. I exempt the anaesthesiologist from any adverse managed care requirements of my medical aid as required by the Health Professions Council of South Africa.
4. I agree to not drink alcohol, drive a car, or operate other dangerous equipment; make important decisions or sign contracts for 24 hours after recovery from anaesthesia. I understand that I may not consume alcohol while I am taking any medication prescribed to me by the anaesthesiologist.
5. I authorise the release of any clinical information, including my HIV status to any other member of the medical and paramedical profession responsible for my safety and treatment.
6. I agree to allow my personal data to be forwarded to the relevant organisations as required by law and to allow anonymous data of a clinical and practice management nature, to be collected to help improve the patient healthcare experience.
7. I understand that my anaesthetic will be administered by a Specialist Anaesthesiologist.

PAYMENT

1. The anaesthetic Account is rendered completely independently of the accounts rendered by the hospital and the surgeon.
2. I agree to pay the fee uniquely determined by the anaesthesiologist, estimated at ..... as required by the anti-competitive rules established by the Department of Trade and Industry for the Health Industry.
3. The fee is due and payable immediately on completion of the service. The account is rendered directly to you as required by the Medical Schemes Act No:131 of 1998.
4. I understand that I am personally responsible for payment and not my medical scheme. My medical scheme may not cover the full amount of the account, depending on the medical scheme and the plan option. I AM RESPONSIBLE FOR SUBMITTING THE ACCOUNT TO MY MEDICAL AID AND I UNDERTAKE TO SUBMIT THE ACCOUNT.
5. I agree that interest will be charged in accordance with the National Credit Act under incidental debt up to 2% per month on accounts that have not been settled. I understand that payments on outstanding accounts shall be allocated in the following way; interest, costs and then capital.
6. I also undertake to pay all legal, debt collection and tracing costs on the attorney and own client scale and charges as stipulated by the Debt Collectors Act 114 of 1998 relating to the recovery of fees outstanding on my account in respect of anaesthetic and other professional services rendered.
7. I consent to sharing information on my account with other credit grantors and with the credit bureau.
8. I confirm that the nominated postal address or e-mail address is correct for the purpose of receiving the account. I agree that should either of these addresses change, I will give one week's prior written notice for such change to become effective.
9. I hereby choose the nominated address as my DOMICILUM CITANDI ET EXECUTANDI for all purposes under this agreement and I agree that any notice sent to the nominated address by prepaid registered post or e-mail will be deemed to have been received by me on the third business day after the posting or sending of it. I further agree that any notice received by me by any means and at any address will be valid for all legal purposes notwithstanding that it was not sent by registered post or to my DOMICILUM CITANDI ET EXECUTANDI. I agree that should I wish to change my DOMICILUM CITANDI ET EXECUTANDI, I will give one week's prior written notice for such change to become effective.
10. There can be no unilateral changes to this agreement.

I have read and understood the contract. I confirm that the particulars furnished by me on all of the pages are in all respect s true and complete.

_____ _____ _____

SIGNATURE (Patient) SIGNATURE (Guardian/Custodian) SIGNATURE (Specialist Anaesthesiologist)

PLACE: _____ DATE: _____

WITNESS 1: _____ WITNESS 2: _____

All information is treated as confidential.

HAS THE PATIENT EVER HAD THE FOLLOWING:	Circle one	DETAILS
ALLERGY / unusual reaction to medicines/injections/food?	YES NO	
MEDICINES / PILLS Are you presently taking any? Specify	YES NO	
Including any homeopathic medicines? Specify	YES NO	
Have you taken any Aspirin in the last two weeks? If so, when?	YES NO	
Previous anaesthetics (if so, when and what operation)	YES NO	
Problems with previous anaesthetics (details please)	YES NO	
Any family member with anaesthetic problems (what?)	YES NO	
Porphyria, malignant hyperthermia or scoline apnoea	YES NO	
Cortisone Treatment in past 12 months	YES NO	
Heart disease (eg. Chest pain, heart attack, rheumatic fever)	YES NO	
High blood pressure	YES NO	
Asthma, bronchitus or emphysema	YES NO	
Recent cold, cough or flu	YES NO	
Diabetes or thyroid problems	YES NO	
Jaundice or hepatitis (If so, when?)	YES NO	
Kidney or bladder disease	YES NO	
Heartburn, hiatus hernia, peptic ulcer	YES NO	
Muscle weakness or auto immune illness	YES NO	
Epileptic convulsions / stroke or blackout of any sort	YES NO	
Tendency to bleed or bruise easily	YES NO	
False, loose, crowned or chipped teeth (if so, where?)	YES NO	
Do you have any infections at present?	YES NO	

Weight _____ Age _____ Height _____ Are you pregnant? (if so, how long?)

Do you smoke? (if so, how many per day?) Alcohol consumption: nil/social/moderate/heavy

When last did you eat _____ H _____ and drink fluids _____ H _____

Is there anything else you feel your anaesthesiologist should know?

Please sign overleaf!

O/E PRE-OP

BP PR
COLOUR TEMP
OED JVP
TEETH
H&N
A/W
CVS
RESP
GIT
OTHER
ASA
PREMED

SPECIAL INVESTIGATIONS

CXR
ECG
Hb WCC
INR PTT
Plt Bl. Gluc
Na K
Cl CO
U Cr

MONITORING

ECG | Ur Cath
Oxim | NG Tube
NIPB | Bld Warm
CO_2 | Ext Warm
CVP | Temp
Art

VENTILATION S M

MASK ☐ HME ☐
LMA ☐ SIZE
ETT ☐ SIZE O / N
A/E ☐ CUFF ☐ PACK ☐
Circuit
Ventilator
V_E R
P_I V_T
Fi O_2 PEEP

TIME TOTAL

DRUGS 1 2 3 4 5 6 7 8 9 10

GAS FGF FiO_2(N_2O / Air)
H / I / S / D %

IV FLUIDS

220 F_1O_2
Vtxf
200 pH
pCO_2
180 pO_2
HCO_3
160 BE
Hb
140 K
120
100
80
60
40
SPO_2
Co_2
CVP
Dextrostix
Temp °c
Events ① ② Etc
Blood Loss
Urine Output

LINES (Type & Size) Site
1 ..... G .....
2 ..... G .....
3 ..... G .....
4 .....

EVENTS & POST OP:

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