PARRAMATTA
EYE CENTRE

ADMISSION FORMS

In order to confirm your admission, we must receive these forms at least one week prior to your surgery. ***Please take time to read and complete the forms carefully.***

Our focus is on providing excellent eye care for every patient, through compassion, surgical expertise and innovation.

PARRAMATTA EYE CENTRE

CONTACT

Phone: (02) 8833 7133

Fax: (02) 9633 2494

Email: admin@parramattaeye.com.au

HOURS

Monday - Friday: 8.00am to 5.00pm

GETTING THERE

Level 3, 34 Charles St

Parramatta NSW 2150

BY BUS: From Parramatta station, take route 545 and stop at George St, after Smith St (AON building - first stop)

BY TRAIN: Parramatta Railway Station is located on the Main Western line, served by Sydney Trains T1 Western & T5 Cumberland lines, NSW Train Link Blue Mountains line, Central West XPT & Outback Xplorer.

BY CAR: Pick-up & drop-off for 2 minutes outside Parramatta Eye, in front of Riverside Cafe

P1 - Metered Street Parking - Charles St & Phillip St

P2 - Octagon Parking - Phillip St - next to the Black Seed Cafe (2 minute walk)

P3 - Secure Parking - 2-10 Wentworth St (11 minute walk)

P4 - Westfield Shopping Mall - Parramatta Westfield

P5 - Secure Parking - 180 George St (3 minute walk) - Under Construction

PARRAMATTA EYE CENTRE - PATIENT INFORMATION

Welcome and thank you for choosing the Parramatta Eye Centre. We hope that your treatment with us will be as comfortable and pleasant as possible.

PRE-ADMISSION INFORMATION

Pre-admission is an essential part of setting up your care plan on the day of surgery. Please ensure all the documentation regarding your admission including health, medical and financial sections are completed.

You can send us the completed forms by one of the following ways:

1. Visiting the centre in person at Level 3, 34 Charles St, Parramatta NSW 2150

2. Download and print the form, then either:

- Email a scanned copy of the documents to admin@parramattaeye.com.au
- Fax to (02) 9633 2494
- Post to Parramatta Eye Centre, Level 3, 34 Charles St Parramatta NSW

Your surgeon will notify the Hospital of the date of your procedure/operation and inform you of the date of admission.

The surgeon 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.

ON THE DAY OF ADMISSION

- Please bring your current medications with you
- Refrain from applying make up, artificial nails/nail paint on the day of surgery
- Please wear loose comfortable clothes
- Before the operation you may shower or wash as normal. We suggest that you wash your hair the day before surgery. Most doctors will advise you not to wash your hair again for ONE WEEK after your surgery to prevent direct water contact with your eye.
- Avoid using perfumes, aftershave, deodorant and hair spray
- Leave your jewellery or any valuables at home. We don't accept liability for any items brought into the hospital.
- Relatives/friends are welcome to wait in the day surgery while patients have their procedure and recover, however are not permitted in theatre

GENERAL GUIDELINES

- Please allow adequate travelling and parking time so that you arrive on time and relaxed
- If your appointment is after hours please press intercom button located on the right hand side of the glass entry doors so that we can allow access
- Please ensure mobile phones are switched off prior to going into theatre
- Contact us if you have a COVID symptoms, cold or feel unwell as soon as possible
- Please bring a pair of sunglasses with you to wear, as your eyes may be glare sensitive initially when you leave the centre
- You MUST arrange for an adult to; drive you home, or accompany you in a taxi or Uber (NO public transport is allowed); and care for you for 24 hours

FASTING

At the time of your pre-operative call, you will be told how long you should fast for. Please adhere to the instructions you are given.

As a general guideline:

- SIX (6) hours fasting is required for solid food; and
- TWO (2) hours fasting for clear and thin fluid (NO milk)

MEDICATIONS

Please follow any instructions given by your doctor or the staff. General guidelines on the day of your procedure are:

- Do not take your diabetic medications, but you must bring them with you. Administration of Insulin will be advised by staff from the hospital when they call to confirm your surgery
- You may take your other usual medications with only a sip of water if required
- Take any heart or blood pressure medications with only a sip of water
- **If you are taking Warfarin or Clexane medication, continue to take it.** Also, it is important that you provide the centre with a recent INR blood test result taken a few days prior to admission
- Continue to take any blood thinners unless instructed by your surgeon, anaesthetist or General Practitioner

ACCOUNTS AND FEES

If you are a member of a health fund, we will conduct an eligibility check for you to establish your level of cover and any excess payable. It is your responsibility to disclose health fund details to us.

Prior to your admission, it is important you check with your health fund regarding the following:

- Identify whether your level of health fund cover adequately covers the cost of your procedure
- Identify whether an excess is payable for your admission, and if so, the amount
- If you have been a member of a health fund for less than 12 months, and if your condition or any symptoms of your condition existed prior to you joining the health fund, your fund may not accept liability for the costs of your admission. If there is a question regarding pre-existing symptoms, your health fund has the right to obtain details in this regard from your General Practitioner, Optometrist or Specialist.

Please note that medical and allied health practitioner's fees may be billed separately by the practitioner.

Any compounding drops will incur an additional fee which will be discussed with patient at the time of surgery booking.

PAYMENT PROCEDURE

Payment may be made by cash, bank cheque, most credit cards or eftpos. Check access to these funds prior to the admission date.

Cheques should be made payable to Parramatta Eye Centre. Personal cheques will not be accepted. Payment on the day of treatment is required before any treatment may proceed.

If you are using finance options please ensure that payment has been arranged prior to your treatment.

- Private patients - the portion of your estimated hospital account not covered by your health fund, e.g. an excess or Facility Fee co-payment, must be paid on admission
- Repatriation (DVA) Gold patients - the hospital will lodge a claim on your behalf
- Work Cover/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 (aside from any ancillary charges) must be made one (1) week before admission

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

MEDICAL RECORDS AND PRIVACY

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

You are entitled to view your medical record at any time in the company of a clinical staff member. We comply with the Privacy Act 1988, and the NSW Health Records and Information Act 2002, including the way we collect, store, use and disclose health information.

DISCHARGE INFORMATION

Patients and their carers will be informed of their approximate discharge time on admission.

- You must arrange for someone to escort you home
- You must not drive a car until the day following your operation/procedure or anaesthesia (your motor vehicle insurance may not cover you)
- Before you leave the day surgery, make sure that you or your relatives/friends know how to care for you at home
- Check with your Nurse/Doctor about continuing medication, follow-up appointments, etc.

Please contact the Nursing Staff if you have any concerns, problems or suggestions during your stay.

MEALS

Parramatta Eye Centre will provide light refreshments and a drink after your surgery along with some medications.

CHARTER OF RIGHTS

Your admission documents will include a Charter of Rights that details your rights and responsibilities throughout your time at the Parramatta Eye Centre.

Please read it carefully and address any concerns to our staff prior to your admission.

- - - TEAR ALONG THE FOLD - - -

PARRAMATTA
EYE CENTRE
Level 3, 34 Charles St, Parramatta NSW 2150
P (02) 8833 7133 F (02) 9633 2494
E admin@parramattaeye.com.au

Please complete surname and DOB as a minimum.

MRN	
Surname	
Given Name	
Date of Birth	

OR AFFIX LABEL HERE

ADMISSION FORM

YOU MUST COMPLETE & RETURN FORMS TO PARRAMATTA EYE CENTRE AT LEAST ONE WEEK BEFORE YOUR PROCEDURE.

Return by fax, postage paid envelope, email or bring the original form with you on the day of your procedure.
We will contact you one to two days before your procedure to confirm your arrival time and answer any questions you may have.

Specialists Name	Procedure Date
Procedure	Item Number (Provisional)
Relevant Medical History	Prosthesis / Lens
Please specify any Mobility/Assistance aids in use, e.g. Wheelchair, Hoist, Hearing Aids	Allergies

Have you been a patient at Parramatta Eye Centre before ◯ No ◯ Yes — Procedure Year

Title | First Name | Surname

Address

Date of Birth | Occupation | Gender ◯ Male ◯ Female

Home Phone | Mobile | Work Phone

Are you an Australian citizen ◯ No ◯ Yes | Country of birth | Preferred Language

If Aboriginal/Torres Straight Islander (TSI) decent, please indicate: ◯ Aboriginal ◯ TSI ◯ Both — Interpreter Required? ◯ No ◯ Yes

Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Defacto

MEDICARE CARD: No. | Ref. No. (next to your name on card) | Exp. Date

PRIVATE HEALTH FUND: Name | Membership No.

Have you paid an excess this year? ◯ No ◯ Yes — Have you changed the level of cover in the past 12 months? ◯ No ◯ Yes

Pension Card: No. | Exp. Date

Veteran Affairs Card: No. (DVA) | Exp. Date | Type ◯ Gold ◯ White ◯ Orange

Payment by Third Party: ◯ Workcover ◯ TAC — The approval letter for this admission from your insurance company must accompany this form.

Insurance Company Name | Address | Phone

Date of Accident | Claim No. | Authorised by

Please note that following all procedures you will require a responsible adult or carer to take you home and care for you overnight.

Carer/Emergency Contact Name | Relationship

Address

Phone (Home) | Mobile | Phone (Work)

To be completed by the patient or patient's GP prior to surgery

Complete this form and discuss with your GP if you have any questions.

Patient Name:	Procedure Date:
GP's Name:	Optometrist's Name:
GP's Contact Phone:	Optometrist's Contact Phone:
GP's Address:	Optometrist's Address:

PLEASE ONLY TICK THOSE APPLICABLE TO YOU - Have you now or ever had any of the following?

- ○ Chronic Cough
- ○ Anaemia
- ○ Palpitations
- ○ Respiratory Illnesses
- ○ Hospital Acquired Infection
- ○ Glaucoma
- ○ Asthma/Breathlessness
- ○ Chest Pain
- ○ Epilepsy or fits
- ○ High Blood Pressure
- ○ Ankle swelling
- ○ Cognitive impairment
- ○ Diabetes - Year diagnosed:_____
  - Are you: ○ IDDM ○ NIDDM
  - Year started Insulin:_____
- ○ Other _____

Are you allergic to anything? (e.g. Medications, iodine, latex, food, etc.)

○ No ○ Yes, provide details:

Have you had any adverse reactions or problems with anaesthetic?

○ No ○ Yes, provide details:

Do you have a pacemaker, defibrillator or replacement heart valve?

○ No ○ Yes, provide details:

Have you had a history of falls in the last 6 months?

○ No ○ Yes, provide details:

In the past two weeks, have you taken any Aspirin, anti-inflammatory or any other blood thinning medications? (e.g. Cartia or Warfarin)

○ No ○ Yes, provide details:

Have you ever smoked?

○ No ○ Yes

Date ceased:_____

Daily amount:

Do you drink alcohol?

○ No ○ Yes, number of standard drinks per day:

Are you pregnant, or is there any possibility you might be pregnant?

○ No ○ Yes, provide details:

Do you have a history of pressure injuries or broken skin?

○ No ○ Yes, provide details:

Have you taken steroids, prednisone or cortisone in the past six months?

○ No ○ Yes, provide details:

What is your current weight?

_____ (kg)

In the past two weeks, have you had a cold or flu, or had contact with a COVID patient?

○ No ○ Yes, provide details:

Do you have an Advance Care Directive or Treatment Limiting Order?

○ No ○ Yes, provide details:

List all medications you are currently taking (including supplements). Attach a separate sheet if needed.

Name of medication	Strength	No. daily	Name of medication	Strength	No. daily

List all past health problems and operations, including dates. Attach a separate sheet if needed.

Details	Date	Details	Date

PAYMENT OF ACCOUNT

I understand a portion of my estimated hospital fees is not covered by a health fund and must be paid on admission. Any additional fees incurred during my operation are payable upon discharge. I 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 Patient/Guardian

Print Name

Date

If Guardian, state relationship to patient (e.g. Parent)

and Contact Ph.