

**PLEASE READ AND COMPLETE THIS INFORMATION PACK CAREFULLY**

For a smooth and efficient process, we greatly value your role in completing all necessary paperwork at least 2 weeks before your scheduled treatment. Your early submission allows our healthcare team to prepare adequately for your care, ensuring a seamless experience for you.



3AI Care

| 17 Windsor Ave, Springvale Vic 3171

| T: (03) 9969-2015

| E: [health@3aicare.com.au](mailto:health@3aicare.com.au)

| [www.3aicare.com.au](http://www.3aicare.com.au)

Patient's Name \_\_\_\_\_



## WELCOME TO 3AI CARE.

Dear valued patient,

We are honoured to welcome you to 3AI Care.

Our collaboration with the Ascend Dental Group & ADAS is a testament to our commitment to providing you with the best possible care.

This comprehensive health questionnaire is a crucial tool for our team to fully understand your healthcare needs. If you need any assistance in completing this questionnaire, please do not hesitate to reach out to 3AI Care, ADAS, or your dental clinic.

Please ensure that all healthcare information you submit is correct and up to date.

Sincerely,  
The 3AI Care Team

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### ***SAFETY AND QUALITY INFECTION PREVENTION AND CONTROL***

3AI Care has a comprehensive infection prevention and control program in place.

Our facility and staff are regularly audited for compliance with:

- National infection prevention and control guidelines.
- Australian Standards for reprocessing of reusable instruments (AS 4187).
- Australian Commission of Safety and Quality in Healthcare [ACSQHC] National Safety and Quality Health Service Standards.

### ***HAND HYGIENE AUSTRALIA PROGRAM***

3AI Care is committed to the Hand Hygiene Australia program and conducts regular compliance audits.

### ***FAILURE TO ARRIVE/ CANCELLATIONS***

Clinical indicators are measures of elements of clinical care that may, when assessed over time, provide a method of assessing the quality and safety of care.

3AI Care collects a number of clinical indicators that can be benchmarked against published national data. These include:

- Failure to arrive
- Unplanned delay in discharge
- Cancellation after arrival due to:
  - pre-existing medical condition
  - acute medical condition
  - administrative issue
  - organizational issue
- Medication error
- Adverse drug reaction
- Unplanned return to the operating room
- Hospital acquired infection
- Patient falls

### ***DISCHARGE INFORMATION***

3AI Care provides comprehensive information both before and after your surgery to assist patients in being fully informed, prepared and in control of their planning for discharge and post-discharge follow-up.

### ***HOW CAN YOU HELP US MANAGE SAFETY AND QUALITY?***

We value our patients and their carers.

Please feel free to let one of our staff know if you would like to assist with reviewing any of our Safety and Quality initiatives.

## **RIGHTS AND RESPONSIBILITIES**

### ***My Rights:***

- I can access services to address my healthcare needs.
- I receive safe and high-quality health services, and I am provided with professional, skilled and competent care.
- The care provided shows respect for me and my culture, beliefs, values and personal characteristics.
- To receive open, timely, and appropriate communication about my health care in a way that I can understand.
- I may join in making decisions and choices about my care and about health service planning.
- My personal privacy is maintained, and proper handling of my personal health and other information is ensured.
- I can comment on or complain about my care and have my concerns dealt with properly and promptly.

### ***My Responsibilities:***

- To answer questions about my health honestly and thoroughly.
  - To comply with discharge instructions or inform medical and/or nursing staff if you do not intend to do so.
  - To be courteous, considerate and respectful towards others.
  - To respect the privacy of others.
  - To fulfil your financial obligations.
  - To raise concerns if you are unhappy with any services.
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## **PRE-ADMISSION INFORMATION**

Pre-admission is an important part of your day surgery care.

To ensure we can confirm your admission, financial and other arrangements, we ask that:

- Your doctor completes the relevant consent forms.
- You forward your completed admission forms no less than two weeks prior to the day of your procedure at 3AI Care, in one of the following ways:
  - In person or by post: 3AI Care, 17 Windsor Avenue, Springvale, VIC 3171
  - By email: [health@3aicare.com.au](mailto:health@3aicare.com.au)

If you require any assistance, please contact the staff at 3AI Care who will be happy to help.

**BEFORE ADMISSION: NURSE TELEPHONE CALL**

Once we have received your completed admission forms, an admissions nurse will contact you to confirm your admission details and discuss the information you have provided and any special requirements you may have.

**BEFORE ADMISSION: ADMINISTRATION MANAGER TELEPHONE CALL**

Our Administration Manager will contact you to discuss any relevant out of pocket expenses. All expenses are to be paid in full at least two days before the day of your procedure.

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**ON THE DAY OF ADMISSION**

Please ensure you have the following with you on admission:

- Medicare card
- Medications in original packaging
- Comfortable clothing, with the following recommendations:
  - a loose, dark coloured, short sleeved polo-shirt or loose neck T-shirt
  - loose and comfortable pants
  - non-slip footwear
  - Should you wish to, feel free to bring a warm jumper and blanket for your recovery care
- For maximal anaesthetic safety, men must be clean shaven on the day of their procedure
- Children may also bring a comforting item (soft toy/blanket)

We will endeavour to admit you as close as possible to your procedure time.

However, to enable staff to prepare you adequately and safely for your procedure, there may be a waiting period between your admission and procedure times.

On admission, our nursing staff will interview you to complete your admission and administer any necessary premedication.

You will then be shown to the admissions area where you will meet your anaesthetist.

**Please do not...**

- Bring valuables, as 3AI Care does not accept liability for any personal items brought into the facility.
- Wear jewellery other than a simple wedding band
- Wear makeup, foundation, or moisturiser.

### **SPECIAL NEEDS**

Please advise the admission nurse when they contact you if you have any special needs, specific dietary requirements, treatment-limiting orders or advanced care directives.

### **CHILDREN HAVING SURGERY**

Our staff will strive to ensure your child's needs are met. A favourite toy may help allay pre-operative anxiety. A parent or guardian must remain with the child in the waiting room and will then be invited to rejoin their child after surgery in the recovery room.

We must clarify that the parent/guardian attending to the child must not be responsible for any other children during these peri-operative periods. We recommend two adults for the journey home, allowing for transportation and care duties to be managed independently.

A familiarisation visit to 3AI Care can be arranged to help your child feel more at ease.

**3AI Care** will confirm your admission time 24 hours prior to the procedure

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### **TIME AT 3AI CARE**

You will be required to stay in the facility until you are clinically safe for discharge.

This varies from person to person, though on average will be for up to 1-2 hours after your operation.

### **TRANSPORT HOME**

You must have a responsible adult drive you home and stay with you overnight.

This is for your own safety, as you may be at risk of falls within the first 24 hours after an anaesthetic.

### **TAKING CARE AT HOME**

Following anaesthesia, residual drug effects may continue for up to 24 hours.

Therefore, during this period:

- Do not drive a vehicle or operate any machinery.
- Do not take any further sedatives unless prescribed by your doctor.
- Do not drink alcohol.

On discharge, you will be given written instructions which you can refer to during your convalescence.



## **IMPORTANT INFORMATION ABOUT YOUR PROCEDURE**

### ***PRESCRIPTION MEDICATION***

If you take prescription medication and are required to do so within the fasting period, please ensure you only take a small sip of water and do not consume anything at all for the last hour before your admission time.

When you arrive for your procedure, please inform your doctors of the time of your last medication consumption.

Please note that if you are taking blood thinners (eg. Aspirin, Warfarin), you will be required to stop taking them for a period of time before your procedure. Please consult your doctor as early as possible before discontinuing any prescribed medication.

On the day of your procedure, please bring ALL your prescription medications with you, including inhalers (eg. Ventolin)

### ***NON-PRESCRIPTION PRODUCTS***

Please stop taking all non-prescribed substances (eg. vitamins, herbal products) with immediate effect until after your procedure.

### ***SMOKING & ALCOHOL***

Smokers may suffer from delayed recovery or have an increased predisposition to complications.

Avoidance of smoking and improving general health with light to moderate exercise (e.g. walking) in the period leading up to the procedure helps improve recovery and reduce the risk of complications.

Please DO NOT consume any alcoholic beverages within 48 hours of your procedure.

### ***GETTING HOME***

It is essential legal and medical requirement that you make arrangements for a responsible person to take you home and stay with you for the first 24 hours after your procedure.

Once at home, please follow the post-operative instructions provided and limit your physical activities.

Do not drive or operate any machinery for 24 hours following your procedure and avoid making any binding legal or financial decisions.

In certain instances, prescriptions for post-operative medication will need to be collected by you or your carer around the time of your discharge, and can be facilitated at any of several local pharmacies.

Medical and carers' certificates can be provided on the day by your dentist if required.

### ***FASTING INSTRUCTIONS***

- For your safety under anaesthesia, a period of pre-operative fasting is essential.
- Fasting means **NO FOOD** (including chewing gum, mints, milk, smoothies) for the prescribed period listed below.
  - **Morning patients:** Please fast from **Midnight the night before your procedure.**
  - **Afternoon Patients:** Please fast from **0600hrs on the morning of your procedure.**
- Plain water, in sips to relieve thirst, can be consumed until two hours before your admission time.



## **Privacy Policy**

### **YOUR HEALTH INFORMATION**

*In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988*

We respect your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our facility and to whom this information may be disclosed. The policy of this practice is to follow these procedures.

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them, if in our judgement, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.
3. We may also use parts of your health information and dental records for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation or written summary of our records, our usual fees will apply for these services.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the strictest confidence. Disclosure will not be made to any person not involved in either your treatment or the administrations of this practice; or any person who is NOT a participant of a relevant training or education program, without your prior consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please note that your treatment plan will often be posted to your referring doctor or dentist, as required by Medicare. If you have any objections, you must let us know in writing.

Please sign below as confirmation that you have read and understood our privacy policy, and that you consent to the use of your health information in this manner.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

### ***Feedback***

3AI Care strives to ensure a safe and comfortable experience before, during and after your treatment at our facility. If you are in any way dissatisfied with your experience, we strongly encourage you to contact our designated Complaints Officer at [info@adas.net.au](mailto:info@adas.net.au)

If you wish to make a suggestion to improve our delivery of care, or if we have failed to meet your expectations in any other way, we want to hear from you. Your complaint or suggestion will be treated in a respectful, professional and confidential manner.

If it cannot be resolved to your satisfaction via phone or email conversation, 3AI Care & ADAS have an established pathway to formally address your concerns, in compliance with government regulations. Our Complaints Officer will guide you in formalising your complaint. Our policy in handling of complaints and grievances is fully aligned with established practices and standards and is guided by AHPRA.

Upon receipt of the completed Health Questionnaire – A non-refundable booking fee of \$65.00 will be processed on your nominated credit card by 3AI Care. This secures your booking with 3AI Care. The booking fee is only applied once. All subsequent general anaesthetics @ 3AI Care are secured on the initial payment.

If your procedure needs to be rescheduled due to COVID-19, staff being furloughed due to COVID-19, or you become COVID-19 POSITIVE, the booking fee will be transferred to your rescheduled date.

## **PATIENT INFORMATION AND HEALTHCARE QUESTIONNAIRE**

TO HELP IDENTIFY ANY HEALTH PROBLEMS THAT MAY NEED TREATMENT BEFORE YOUR PROCEDURE, PLEASE ANSWER ALL OF THE QUESTIONS IN THIS FORM AS ACCURATELY AS POSSIBLE.

### **Section 1: Patient or Guardian to complete**

#### **PERSONAL DETAILS:**

Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Mobile: \_\_\_\_\_ Landline: \_\_\_\_\_

Email: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Reference No. \_\_\_\_\_ Expiry: \_\_\_\_\_

Interpreter required: \_\_\_\_\_ If yes, which language?

Do you have a medical power of attorney? Please circle: Yes/Not Applicable

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

If you have an advanced care directive, please attach written details.

**Marital Status:**

Single ☐ Married ☐ De-Facto ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer not to say ☐

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**Occupation:**

**Nationality:**

**Languages spoken at home:**

**Religion:**

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**Are you of Aboriginal or Torres Strait Islander descent** Yes ☐ No ☐

If yes:      Aboriginal ☐ Torres Strait Islander ☐ **BOTH** Aboriginal and Torres Strait islander ☐

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**Person responsible for the account**

**Is the patient responsible for this account?**

No ☐ (please complete the section below)

Yes ☐ (go to the next question)

☐ Name: \_\_\_\_\_

☐ Relationship to patient: \_\_\_\_\_

☐ Telephone:      Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

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**Next of Kin/Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mobile: \_\_\_\_\_ Other (work/landline): \_\_\_\_\_

**Pick up person/Carer:**

**Same as Next of Kin/Emergency Contact?**

YES ☐ NO ☐

**If not, please provide details below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mobile: \_\_\_\_\_ Other (work/landline): \_\_\_\_\_

**Your address after surgery:**

\_\_\_\_\_  
\_\_\_\_\_

**Family/Local Doctor's Details:**

Doctor's Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### **HEALTH INFORMATION**

Age:	years	Height:	cm	Weight:	kg
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**ALLERGIES:** Do you have any allergies? Specify allergy and reaction:

Latex/Rubber?
Medication/Lotions/Solutions?
Tape/Foods/Other?

\*\*Please attach a separate page if necessary

### **PREVIOUS OPERATIONS/PROCEDURES/HOSPITAL STAYS:**

List all operations, procedures, hospital admissions (including dates):

### **DETAILS OF PREVIOUS ANAESTHETICS:**

Have you or a family member ever had a reaction to an anaesthetic? Please provide details:
Do you or any family members have a history of Malignant Hyperthermia? YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have any questions relating to this anaesthetic? Please specify:



### **REGULAR MEDICATIONS**

**Do you take any medications?** This includes tablets, inhalers, eye drops, vitamins, herbal remedies etc.  
Please list below: (attaching a separate page if necessary)

Name of medication	Dose	Frequency	Reason for use

### **OZEMPIC**

**Do you take Ozempic?** Yes ☐ **NO** ☐

**Dosage:**

**Frequency:**

### **BLOOD THINNING MEDICATIONS:**

**Do you take any of the following blood thinning medications?**

Warfarin ☐ Clopidogrel/Plavix/Iscover ☐ Dabigatran ☐ Aspirin ☐

Any other blood thinners ☐ (Details: \_\_\_\_\_)

### **BISPHOSPHONATE MEDICATION FOR BONE OR METASTATIC DISEASE:**

Are you taking or have you taken any bisphosphonate medication (eg. Fosamax, Alendronate, Risedronate, Tiludronate, Disodium Pamidromate, Zoledronic Acid, Etidronate or Sodium Clodronate) for:

Osteoporosis ☐ Paget's Disease ☐ Cancer involving bone ☐  
Multiple Myeloma ☐ Other ☐

If you have previously taken any bisphosphonates:

When did you stop?

How long did you take them?

**DENTAL INFORMATION:**

Do you have any loose teeth, dentures, crowns/bridges or dental implants?    Yes ☐ No ☐

If yes, please provide details:

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Do you have any of the following:

Click or grate when you open/close your mouth:                      Yes ☐ No ☐

Limited mouth opening:    Yes ☐ No ☐

Sinus problems/Previous sinus surgery                                      Yes ☐ No ☐

Fractured Nose:    Yes ☐ No ☐

Any complications with previous dental treatment?                      Yes ☐ No ☐

If yes, please provide details:

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**GENERAL MEDICAL CONDITIONS:**

<b><i>Have you ever had, or do you have any of the following? Please tick YES or NO</i></b>	<b><i>NO</i></b>	<b><i>YES</i></b>	<b><i>If yes, please add comments/details</i></b>
High Blood Pressure			How is it controlled?
Low Blood Pressure			
Heart Attack/Chest Pain Angina/Cardiac Disease			
Irregular Heart Beat Atrial Fibrillation (AF)			
Palpitations			
Other Heart Conditions (specify)			
Pacemaker			Type:
Heart valve replacements Heart stents			
Respiratory problems Asthma/Bronchitis			Do you use: Nebulisers/Inhalers/Home oxygen
Shortness of Breath			
Tuberculosis			
Obstructive Sleep Apnoea (OSA) Has your condition been diagnosed with a sleep study?			Do you use CPAP?
Diabetes			Type 1/Type 2/Uncertain (please circle) Control achieved with Insulin/Tablets/Diet* (please circle)
Speech/Swallowing problems			
Any recent weight loss >5kg			Total weight lost?

<b>Have you ever had, or do you have any of the following?</b> <i>Please tick YES or NO</i>	<b>NO</b>	<b>YES</b>	<b>If yes, please add comments/details</b>
Any recent decrease in appetite			

Epilepsy/Fits/Seizures/ Migraines/Blackouts/ Fainting			Last seizure?
Strokes/Mini Strokes (TIAs)			Weakness/symptoms?
Infectious Diseases: HIV/Hepatitis/STIs			

Hospital acquired infections (eg. VRE/MRSA)			
Creutzfeldt-Jakob Disease (CJD)			
Blood clots/ Bleeding disorders/Anaemia/ Blood Transfusions			
Bowel/Bladder problems			
Kidney problems			
Liver Disease			
Reflux/Indigestion/Hiatus Hernia/Ulcers			
Mental Health problems: (eg Depression/Anxiety etc)			

<b>Have you ever had, or do you have any of the following? Please tick YES or NO</b>	<b>NO</b>	<b>YES</b>	<b>If YES, please add comments/details</b>
Short-term memory loss Dementia/Delirium/ Episodes of confusion/Wandering			
Skin conditions/Existing wounds/ Broken skin			

<b>Have you ever had, or do you have any of the following? Please tick Yes or No</b>	<b>NO</b>	<b>YES</b>	<b>If yes, please add comments/details</b>
Have you taken any Prednisolone, Cortisone, or any other steroids in the last 6 months			
Acute or chronic pain			Location: Severity:
Cancer			Details: Date of diagnosis:
<b>Female Patients</b> Are you pregnant?			
Are you breastfeeding?			
Any other medical conditions?			
Any further information – eg.needle phobia?			

**LIFESTYLE:**

DO YOU:	NO	YES	
Drink alcohol?			Number of standard drinks? How often?
Smoke tobacco?			Cigarettes/day: Year started? Date ceased (if applicable):
Vape?			How many puffs per day: Year started? Date ceased (if applicable):
Use recreational drugs?			Substance: Amount: How often?
Have vision or hearing impairment?			Details: Aids Used:

<b>Do you have assistance with</b> Mobility Hygiene Meals Medication			Stick/Frame/Crutches/Wheelchair Council/Other Council/Other Dosette/Webster/family/other
How many flights of stairs can you walk <b>UP</b> without stopping			>Two flights /One flight/ Half a flight

**SOCIAL:**

DO YOU LIVE:	NO	YES	
Alone?			Additional information:
With others?			
Care Facility/Hostel?			
Do you care for others at home?			Specify:



## RESPONSIBILITY & CONSENT STATEMENT

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me (or the above-mentioned patient) at undue medical risk.

I give my consent to procedures, anaesthetics and medications to be administered for diagnostic purposes or dental treatment being performed on myself or a person I am the legal/medical guardian for.

Latex in Theatre:

3AI limits latex items in theatre; however, certain required dental instruments may contain latex.

I understand and acknowledge that the operating theatre may not be completely latex-free.

I understand and acknowledge that I am financially responsible for the services provided for myself (or the above-named), regardless of insurance coverage, Medicare benefits or tax refunds.

I agree and accept that I will be liable for cancellation fees if less than 5 working days' notice of cancellation is provided.

The 3AI fee is \$1,800.00 and the ADAS fee: \$1,350.00.

**I also understand that any legal and debt collection fees associated with an unpaid account will be at my expense.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO COSTS

I hereby acknowledge that all costs incurred as a result of the provision of services and treatment at 3AI Care remain my sole responsibility. Costs attributable to my dental treatment as provided by my dental practitioner are also my responsibility, for which I am liable.

I understand that the cost of my anaesthesia is separated into three categories:

**Dental Treatment** I understand that the balance of the dental fees is independently arranged with my treating dental provider.

**Facility Fee** The facility fee is \$850.00 per hour, billed in 15-minute increments.  
Patients are charged only from the time they enter the clinical area at 3AI.

**Anaesthetic Fee** The anaesthetic fee is \$1,350.00 per hour, billed in 15-minute increments.  
Patients are charged only from the time they are in the care of the anaesthetic team.

Anaesthetic Fee	Medicare & Safety Net rebate
<u>General Dental Procedures</u> \$1,350.00 for the first hour, then \$675.00 per half-hour increment.	<u>Medicare Rebate</u> One-third of fees up to the Safety Net, and then approximately 80% of the balance.

<sup>^</sup> **Please Note** The rebates shown are provided as a guide only and may vary from patient to patient depending on safety net entitlements. As of 1<sup>st</sup> July 2018, changes introduced by the government in the new budget will further affect your rebate entitlements. Please check new conditions with Medicare and your safety net so that you can accurately estimate your out-of-pocket expenses.

## How do I check the amount of my expected rebate?

We strongly recommend you contact your Medicare office to enquire about your extended Medicare safety net.

The safety net amount is usually approximately \$2500.00 - \$3000.00/year.

Once your anaesthesia cost exceeds this, you will be reimbursed approximately 80% of the cost of your treatment fee.

You will be required to pay for the anaesthesia service on the day of your procedure.

Once your payment is processed, you will be provided with an anaesthesia tax invoice.

**ANAESTHETIC CONSENT**

I, \* (the patient / authorised person), have had the nature, consequences and risks of an anaesthetic procedure explained to me by:

Name of Anaesthetist

I understand and am satisfied with the explanations provided and hereby consent to the anaesthetic procedure.

Patient / Authorised Person's Signature:

Date:

Anaesthetist's Signature:

Date:

**3. CONSENT VIA INTERPRETER (IF APPLICABLE)**

I, (Full name of interpreter \_\_\_\_\_

have given a verbal translation of this form in (language) \_\_\_\_\_ covering the details of the dental and anaesthetic procedures described above.

You can submit the tax invoice online via the Medicare smart phone application (Medicare App) or via your local Medicare office. Invoices submitted for reimbursement via the smart phone app are often processed significantly faster than those submitted in person.

**ANAESTHETIC PAYMENT AUTHORISATION:**

I authorise for the appropriate amount for the Anaesthetic & Facility fees to be charged to the credit card details provided below:

Payment Type:

☐ Visa

☐ MasterCard

Card Number

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Expiry (MM/YY)

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Security Code

(CVC – the three-digit code on the back of your card):

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**Name on Card:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

NB: American Express payments are not accepted.

Please note that these details must be completed prior to your paperwork being processed.

Failure to complete the above details may result in your surgery being delayed or cancelled.

If you wish to discuss your fees in further detail, please contact:

Anaesthesia fees: ADAS on (03) 8362-7007 or via [info@adas.net.au](mailto:info@adas.net.au)

Facility fees: Michalis at 3AI Care on (03) 9969-2015 or via [health@3aicare.com.au](mailto:health@3aicare.com.au)

### Hospital Transfer Details

**Ambulance Cover: YES** or **NO** *(Please Circle)*

**Ambulance Victoria Membership Number: #** \_\_\_\_\_

If an ambulance transfer to another facility is deemed medically necessary and you do not have an ambulance subscription/cover, there may be an out-of-pocket expense for the ambulance transfer.

If you wish to get obtain ambulance cover – please visit:

<https://www.ambulance.vic.gov.au/membership/>

#### In case of emergency:

**Would you like to be transferred to a: PUBLIC or PRIVATE Hospital** *(Please Circle)*

#### Private Health Insurance Details

**Health Fund:** \_\_\_\_\_

**Member Number:** \_\_\_\_\_

#### Emergency Family Contact

**Name:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_

**Telephone (home):** \_\_\_\_\_

**Telephone (work):** \_\_\_\_\_

**Blood Group (if known)** \_\_\_\_\_

**Allergies/Sensitivities:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

Dear Patient,

Upon discharge from 3AI, please be aware of an important requirement mandated by legislation.

You must arrange for someone to stay with you overnight after your anaesthetic.

Without this critical safety arrangement, we will **NOT** be able to proceed with your scheduled procedure.

Ideally, a responsible adult must stay with you for a minimum of 24 hours after your procedure and anaesthetic.

This legal requirement is in place to ensure that you are supported for 24 hours after your anaesthetic. If these plans change in any way, you must let us, or your surgeon/dentist know immediately. Even if you feel that you will be physically capable of attending to your own needs, it is essential to have someone with you for the first 24 hours after your surgery.

<b><u>Your Appointed Person</u></b>
<b>Name:</b>
<b>Mobile:</b>

The responsible anaesthetist will review this questionnaire once the appointed person's details have been completed and verified.

**Anaesthetist's review**

Dr. \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights**.

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.



PUBLISHED JULY 2019

## I have a right to:

### Access

- Healthcare services and treatment that meets my needs

### Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

### Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

### Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

### Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

### Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

### Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services