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Office use only – Affix patient label here

Bryan Botterill
23/12/1988 Male
URN:
6/7 Wastell Street
Northcote VIC 3070

Patient Admission Form

Please complete this form and return as early as possible prior to surgery.

Patient admission details

Admission date: 18/11/2024 | Admitting doctor: Dr Colby Hart

Procedure: Right Cataract Removal + I O L

Have you been a patient at this hospital before? ☐ Yes ☒ No

Have you been admitted to hospital in the last 7 days? ☐ Yes ☒ No
If *Yes* – Name of hospital:
Reason for admission:
Admission date: Discharge date:

Patient details

Title: Mr | Surname: Botterill

First name: Bryan | Middle name: Kim

Preferred name: Bryan | Previous name(s):

Date of birth: 23/12/1988 | Gender: Man, or boy, or male | Sex at birth: Male | Legal sex: Male

Residential address: 6/7 Wastell Street Northcote VIC 3070

Postal address (if different to above): 6/7 Wastell Street Northcote VIC 3070

Home phone: | Work phone: | Mobile phone: 0423379146

Email address: bryanbotterill@gmail.com

Marital status: Never Married (Single)

Indigenous status: No

(QLD hospitals only) Are you of Australian South Sea Islander Ancestry?

Country of birth: Australia | State (if born in Australia): VIC

Preferred language: English | Interpreter required: ☐ Yes ☒ No

Religion: No Religion

Employment status: Other

Referring doctor/general practitioner (GP)

Referring doctor surname: Leong | Referring doctor first name: Kenneth

Practice name: Life Stories Medical

Practice address: 501A High Street Northcote VIC 3070 | Practice phone number: 039828757

Is your referring doctor your GP? ☒ Yes ☐ No If *No*, please complete below.

GP surname: | GP first name:

Practice name:

Practice address: | Practice phone number:

Uploading my health record

Do you consent to uploading your admission details to My Health Record? ☒ Yes ☐ No

Next of kin

Title: Ms | Surname: St Pierre | Given name(s): Ashley

Relationship to patient: Partner | Best contact number: 0476530730

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Bryan Botterill
23/12/1988 Male
URN:
6/7 Wastell Street
Northcote VIC 3070

Patient Admission Form

Emergency contact

Title: Mr	Surname: Botterill	Given name(s): Len
Relationship to patient: Father	Best contact number: 0413146217	

Entitlements (complete for all that apply)

Medicare number: 3568-59697-1 Reference number: 1 Expiry date: 07/2026

☒ Eligible Australian Resident ☐ Eligible overseas visitor (Reciprocal rights) ☐ Ineligible ☐ Not known

Do you have any types of pension/concessional benefits card?

☐ Pension card Number: Expiry date:
☐ Concession card Number: Expiry date:
☐ Safety Net card Number: Expiry date:

Veteran's Affairs number: Card Colour:

Australian Defence Force – Service Number/EP ID: DAN (if known):

How will you claim for this admission (please tick one box only)

☐ Private Health Insurance – *complete Section A and C*
☐ Department of Veteran's Affairs/Australian Defence Force – *complete entitlements above*
☐ Worker's Compensation, Third Party, Motor Vehicle – *complete Section B and C*
☒ Self-funded – *complete Section C only*
☐ Overseas Insurance – *complete Section B and C*
☐ Public – *continue to Patient health history*

Section A: Private health insurance

Insured patients: It is recommended you contact your health fund prior to admission to confirm whether the reason for admission is covered under your selected level of cover. Informing the health fund of the item numbers provided by your doctor's rooms will assist your fund with confirming eligibility. You may wish to ask them if there are any additional costs you should expect, such as an excess or co-payment which will be payable on admission.

Health fund name:	
Membership number:	Reference number:

Section B: Worker's compensation, motor vehicle, other third party or overseas insurance

Claim number:	Date of accident/injury:
Insurance company name:	Contact number:
Address:	

Worker's compensation only – *Approval letter for admission (from your insurance company) must accompany this form.*

Employer name:	Contact number:
Address:	

Section C: Person responsible for account

Is the patient responsible for this account? ☒ Yes *(go to next section)* ☐ No *(complete this section)*

Title: Mr	Surname: Botterill	First name: Bryan
Previous name(s):		
Residential address: 6/7 Wastell Street Northcote VIC 3070		
Postal address (if different to above): 6/7 Wastell Street Northcote VIC 3070		
Home phone:	Work phone:	Mobile phone: 0423379146
Email address: bryanbotterill@gmail.com		
Relationship to patient:		

Confirmation details

Patient/guardian name: Bryan Botterill	Signature:	Date: 02/11/2024

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(Office use only – Affix identification label here)

URN:

Surname: Botterill

Given name(s): Bryan

Date of birth: 23/12/1988 Sex at birth: Male

Patient Health History
(Adult)

Please complete this form and return to the hospital at least three days prior to the date of your procedure.

Admission date: 18/11/2024	Admitting diagnosis:

Patient details

Title: Mr	Surname: Botterill	Given name(s): Bryan	
Gender: Man, or boy, or male	Sex at birth: Male	Legal sex: Male	Date of birth: 23/12/1988

Please indicate if you ever had any of the following conditions and provide relevant details where prompted.

Cardiac			If *Yes*, provide further details:
Heart attack	☒ No	☐ Yes	Year:
Angina or chest pain	☒ No	☐ Yes	
Heart failure or heart/valve disease	☒ No	☐ Yes	
Atrial fibrillation, palpitations or other irregular heart beat	☒ No	☐ Yes	Specify:
High blood pressure	☒ No	☐ Yes	
Low blood pressure	☒ No	☐ Yes	
Rheumatic fever	☒ No	☐ Yes	
Cardiac surgery (e.g. pacemaker, internal defibrillator, prosthetic heart valves, grafts, stents, other implants/devices)	☒ No	☐ Yes	Operation(s)/date(s):

Haematology			If *Yes*, provide further details:
Have you ever had a blood transfusion?	☒ No	☐ Yes	Describe any reaction: Year transfused:
Blood clots in legs (DVT)/lungs (PE)	☒ No	☐ Yes	
Blood disorders (e.g. anaemia)	☒ No	☐ Yes	
Tendency to bleed or bruise easily	☒ No	☐ Yes	

Respiratory and sleep disorders			If *Yes*, provide further details:
Asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asbestosis, pneumonia or shortness of breath	☒ No	☐ Yes	Do you use: ☐ Nebulisers ☐ Puffers ☐ Home oxygen
Tuberculosis	☒ No	☐ Yes	
Sleep apnoea	☒ No	☐ Yes	Do you use CPAP machine: ☐ Yes ☐ No

Neurology and mental health			If *Yes*, provide further details:
Epilepsy or fits	☒ No	☐ Yes	
Anxiety, depression, PTSD or other mental health disorder	☐ No	☒ Yes	Depression
Parkinson's, multiple sclerosis or motor neuron disease	☒ No	☐ Yes	
Stroke (CVA) or TIA	☒ No	☐ Yes	Year: List any impairments:
Dementia, Alzheimer's	☒ No	☐ Yes	
Difficulties with problem solving, attention span or understanding	☐ No	☒ Yes	Encephalitis - Memory issues
Delirium or confusion when ill or in hospital	☒ No	☐ Yes	

Renal			If *Yes*, provide further details:
Kidney disease, renal impairment	☒ No	☐ Yes	On dialysis: ☐ Yes ☐ No
Bladder problems (e.g. incontinence, retention)	☒ No	☐ Yes	

Endocrinology			If *Yes*, provide further details:
Thyroid problems (e.g. goitre)	☒ No	☐ Yes	
Diabetes	☒ No	☐ Yes	☐ Type 1 ☐ Type 2 ☐ Gestational How is your diabetes managed: ☐ Tablets ☐ Diet ☐ Insulin ☐ Injectables

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Cura CMR8.0 1/4 v4.00 15/03/2024

PATIENT HEALTH HISTORY (ADULT) CMR8.0

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(Office use only – Affix identification label here)

URN:

Surname: Botterill

Given name(s): Bryan

Date of birth: 23/12/1988 Sex at birth: Male

Patient Health History
(Adult)

Musculoskeletal, mobility and falls			If *Yes*, provide further details:
Fainting, dizziness or fallen in the last 6 months	☒ No	☐ Yes	
Are you able to mobilise unassisted?	☐ No	☐ Yes	
Do you require a mobility aid?	☒ No	☐ Yes	☐ Wheelchair ☐ Walking frame ☐ Stick ☐ Other *(specify)*:
Arthritis (e.g. osteoarthritis, rheumatoid arthritis)	☒ No	☐ Yes	
Osteoporosis	☒ No	☐ Yes	
Back or neck injury or problems	☒ No	☐ Yes	
Previous back, neck or jaw surgery	☒ No	☐ Yes	

Gastrointestinal			If *Yes*, provide further details:
Reflux, heartburn, hiatus hernia, stomach ulcers	☒ No	☐ Yes	
Bowel problems (e.g. Crohn's, IBS, stoma, incontinence)	☒ No	☐ Yes	Specify:
Liver disease, jaundice, hepatitis	☒ No	☐ Yes	

Skin integrity			If *Yes*, provide further details:
Pre-existing wounds or breaks on your skin	☒ No	☐ Yes	Specify wound type and duration:
Eczema, dermatitis	☐ No	☒ Yes	Atopic Dermatitis

Anaesthetic risk and other conditions			If *Yes*, provide further details:
Have you had an adverse reaction to anaesthetics?	☒ No	☐ Yes	Type:
Has a close relative had an adverse reaction to anaesthetics?	☒ No	☐ Yes	
Have you ever had a difficult intubation?	☒ No	☐ Yes	
Do you have dentures, caps, crowns, loose teeth, implants or veneers?	☒ No	☐ Yes	
Can you lie flat for periods of time?	☐ No	☒ Yes	
Any other condition(s) we should be aware of?	☒ No	☐ Yes	Specify:
Have you or a relative ever been diagnosed with malignant hyperthermia?	☒ No	☐ Yes	
Have you had any previous operations or procedures?	☒ No	☐ Yes	Complete procedure and date performed below.

Procedure	Date performed	Procedure	Date performed
1.		4.	
2.		5.	
3.		6.	

General health and lifestyle			If *Yes*, provide further details:
Have you ever smoked?	☐ No	☒ Yes	If *current* smoker, daily amount: 2 If *former* smoker, year ceased:
Do you use recreational drugs?	☒ No	☐ Yes	Have you used recreational drugs in the last 24 hours? ☐ Yes ☐ No
Do you drink alcohol?	☒ No	☐ Yes	
What is your weight, height and BMI?			Weight (kg): 91 Height (cm): 153 BMI: 38.87
Have you unintentionally lost weight and/or had a decrease in appetite recently?	☒ No	☐ Yes	
Are you pregnant or breastfeeding?	☐ No	☐ Yes	If *pregnant*, number of weeks:
Do you live alone?	☒ No	☐ Yes	
Are you a carer for another person?	☒ No	☐ Yes	
Do you require assistance with day to day living?	☒ No	☐ Yes	Specify assistance required:
Do you have any cultural or religious needs?	☒ No	☐ Yes	Specify need(s):

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URN:

Surname: Botterill

Given name(s): Bryan

Date of birth: 23/12/1988 Sex at birth: Male

Patient Health History
(Adult)

General health and lifestyle *(continued)*			If *Yes*, provide further details:
Do you require a special diet?	☒ No	☐ Yes	☐ Diabetic ☐ Coeliac ☐ Vegetarian ☐ Vegan ☐ Lactose free ☐ Dairy free ☐ Kosher ☐ Other *(specify)*: ..... Please note any foods excluded from your diet (if applicable): .....

Prosthetics and aids			If *Yes*, provide further details:
Visual aids or visual impairment (e.g. glasses, contact lenses)	☒ No	☐ Yes	
Hearing aids or hearing impairment (e.g. hearing aid, cochlear implant)	☒ No	☐ Yes	
Implanted devices	☒ No	☐ Yes	☐ Metal plates or pins ☐ Artificial joint ☐ Lap band ☐ Intra-ocular lens ☐ Pacemaker ☐ Stent ☐ Defibrillator ☐ Other *(specify)*: .....

Allergies and adverse reactions (ADR)			If *Yes*, provide further details:
Do you have any allergies or adverse reactions to medication, tapes, latex, skin solutions or food??	☒ No	☐ Yes	Please enter details below.

Allergy	Reaction	Date/year of reaction

Medications: prescription and complementary			If *Yes*, provide further details:
Do you take any medications: prescription, over-the-counter medications, vitamins (e.g. ginko, fish/grapeseed oil, St John's Wort, weight loss medications)?	☐ No	☒ Yes	Please enter details below (one per line) or attach/upload a medication list.

Medication name	Dose	Frequency	Taking for
Promethazine 25mg	2 tablets	once per night	Sleep
Amitriptyline Viatris 25mg	1 tablet	Once per night	Sleep, Anti-depressant
Duloxetine 60mg	1 Tablet	once per day	Anti-Depressant
Montelukast	1 tablet	Once Daily	Allergy Medication

If you are taking any blood thinning or arthritis medication (e.g. Warfarin, Plavix, Aspirin) please ensure you have advised your doctor and have received advice on whether you will need to stop any medications prior to admission.

Infection risk and screening			If *Yes*, provide further details:
Have you tested positive to COVID in the last 4 weeks?	☒ No	☐ Yes	
Do you have a fever and/or respiratory symptoms (e.g. cough, sore throat, runny nose)?	☒ No	☐ Yes	
In the past 4–6 weeks have you or anyone close to you returned from overseas?	☐ No	☒ Yes	My partner and I return from Fiji 31 October 2024
Have you ever been infected with a multi-resistance colonized infection (MRSA/VRE/CRE/CPE)?	☒ No	☐ Yes	
Do you have any blood borne infections (e.g. hepatitis B or C, HIV)?	☒ No	☐ Yes	
Are you currently experiencing any type of infection, or have you been exposed to a person that is suffering an infectious disease in the past 2 weeks (e.g. chickenpox/shingles, measles, conjunctivitis)?	☒ No	☐ Yes	
Have you had vomiting or diarrhoea in the past 48 hours?	☒ No	☐ Yes	
Have you had an overnight stay at an overseas hospital or residential care facility in the past 12 months?	☒ No	☐ Yes	
Complete the additional question below if you are being admitted to a hospital in Western Australia.			
Have you been an inpatient in a hospital, resided in a residential care facility or worked in a hospital or residential care facility outside of Western Australia in the past 12 months?	☐ No	☐ Yes	

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URN:

Surname: Botterill

Given name(s): Bryan

Date of birth: 23/12/1988 Sex at birth: Male

Patient Health History
(Adult)

Creutzfeldt Jacob Disease (CJD) risk assessment			If *Yes*, provide further details: ☐ N/A
Complete these questions on CJD if you are having an operation on your eye, brain, spinal cord, pituitary gland or nerve root ganglia.			
Have you had brain or spinal cord surgery that included a dura mater graft prior to 1990?	☒ No	☐ Yes	
Have you taken human pituitary hormone (growth hormone/gonadotrophin) prior to 1986?	☒ No	☐ Yes	
Do you have a family history of CJD?	☒ No	☐ Yes	
Have you received a 'look back or medical in confidence' letter for CJD?	☒ No	☐ Yes	
Have you had an unexplained progressive neurological illness of less than 12 months?	☒ No	☐ Yes	

What matters

Is there anything that matters to you, specifically regarding your hospital stay that we need to know? ☒ No ☐ Yes

If *Yes*, specify:

Do you understand your healthcare rights (contact the hospital for further information)? ☐ No ☒ Yes

Legal documentation			If *Yes*, provide further details:
An Advance Care Directive is a set of written instructions that a person gives that specifies what actions should be taken for their health if they are no longer able to make decisions because of illness or capacity.			
Do you have a current Advance Care Directive?	☒ No	☐ Yes	
Does your Advance Care Directive include a Not for Resuscitation order?	☐ No	☐ Yes	Please attach a copy.
Name (please print):			Contact number:
Enduring Power of Attorney or legally appointed medical treatment decision-maker.			
Do you have an Enduring Power of Attorney or legally appointed medical treatment decision-maker?	☒ No	☐ Yes	Please complete details below and attach a copy.
Name (please print):			
Relationship to patient:			Contact number:
Details:			

Discharge planning

You must not engage in the following activities for 24 hours following your operation/procedure or as directed by your doctor:

- drive a motor vehicle, ride a bicycle or operate machinery or potentially dangerous appliances;
- make any important decisions or sign legal documents;
- drink alcoholic beverages.

You **must** arrange and advise the hospital of a responsible adult to drive you home and stay with you overnight. As this is important for your safety after receiving an anaesthetic, failure to do this may result in your procedure being cancelled or postponed.

Details of responsible adult collecting you/the patient:

Escort name (please print): Len Botterill

Relationship to patient: Father Contact number: 0413146217

Patient agreement

I certify that the information provided is true and accurate to the best of my knowledge and I have read and understood the discharge planning requirements as above.

Patient name (please print): Bryan Botterill

Signature: Date: 02/11/2024

Nurse use only

Comments/actions/outcomes:

Name (please print): Designation:

Signature: Date: ..... Time (24hr): ..... : .....

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Cura CMR8.0 4/4 v4.00 15/03/2024

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(Office use only – Affix identification label here)

URN:

Surname:

Given name(s):

Date of birth: Sex at birth: ☐ M ☐ F ☐ A

Privacy Collection Notice

Cura Day Hospitals Group Pty Ltd (ACN 125 245 409) (Cura) and its subsidiaries acknowledge the importance of patient privacy. We are committed to handling your information securely and to being open and transparent with you about our information handling processes.

Cura's privacy policy is available at www.curagroup.com.au. If you would prefer a printed version, please let us know by contacting us on (07) 3218 3700. Further details about how we deal with your personal information are provided below.

Who is collecting your personal information

Your personal information is being collected by Cura Day Hospitals Group Pty Ltd (ACN 125 245 409) (Cura) and its subsidiaries wherever located within Australia.

The contact details Cura Day Hospitals Group are:

Street address: Boundary Court 55 Little Edwards Street, Spring Hill QLD 4004

Telephone: (07) 3218 3700

Collection of your personal information

Your personal information is collected:

- from you when you provide personal information to us, including by completing admission forms, questionnaires and surveys; when observations are taken; when you report information to our staff about your health; and in some cases by way of photographs taken of you for a clinical purpose;
- from your relatives who may be able to provide us with information relevant to your healthcare where it is unreasonable or impracticable to collect information directly from you;
- from third party health service providers, including your doctors, diagnostic imaging and pathology companies;
- from Medicare, DVA and/or your health insurer;
- from your My Health Record.

Authority for collection

As a health service provider, we are required to collect and keep medical records of patients receiving services at our facilities.

Why does Cura collect your personal information?

We collect your personal information in order to provide health services to you at our facility. We also use the information for management of our services.

You may be asked to participate in research projects and/or feedback surveys which involve the collection of your personal information. Participation is entirely voluntary.

What would happen if Cura did not collect your personal information?

If Cura does not collect your personal information we may not be able to provide healthcare services to you. If we do not collect all of your relevant health information, this may pose a risk to your health as we will be using incomplete information to make care decisions. It may also impact on your ability to claim Medicare, DVA or private health insurance refunds.

Who can Cura disclose your personal information to?

By signing this Notice, you consent to Cura disclosing on a need-to-know basis only, your health information for the purposes of providing a health service to you and managing that service. This may include disclosing your personal information (including health information) to health service providers including; the surgeon performing the procedure, your GP, relevant clinical registries, allied health providers, pharmacy services, diagnostic imaging and pathology companies) and our staff involved in your care (e.g. nurses and allied health) or providing administrative support.

Sometimes your Surgeon will request that a surgical device representative be present during your procedure.

Cura supports nursing education, and at times student nurses will be involved in your care. Please let us know if you don't want a student involved in your care.

PRIVACY COLLECTION NOTICE CMR4.8

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day hospitals group

(Office use only – Affix identification label here)

URN:

Surname:

Given name(s):

Date of birth: Sex at birth: ☐ M ☐ F ☐ A

Privacy Collection Notice

Who can Cura disclose your personal information to? *(continued)*

By signing this Notice, and only where applicable, you consent to Cura or its subsidiary providing your Personal Information, excluding health related information to a debt recovery agency for the purposes of recovery any outstanding monies payable by you to Cura or its subsidiary for services provided by Cura or its subsidiary to you.

Cura may also disclose your personal information (without your consent) where it is authorised or required by law to do so.

Your Surgeon will ordinarily provide a discharge summary to your referring doctor. Please let your Surgeon know if you do not want this to occur. We may also provide discharge summaries to your treating Surgeon.

If you have received services at a Cura Hospital as a public patient under an arrangement with either a public hospital or a state or territory government arrangement, we will provide a discharge summary and a copy of your medical record to the public hospital or relevant government entity that referred you.

We will disclose information about your condition to your next-of-kin nominated on your admission paperwork if we need a decision to be made about your care and you do not have capacity to make the decision for yourself. We will let your contact person know when you are ready to be collected to go home.

We disclose your personal information to Medicare, DVA and your private health insurer for billing and regulatory purposes. We are required to provide certain data to State/Territory Health Departments about admissions to our facilities.

We will upload information to My Health Record unless you direct us not to.

Access to and correction of your personal information

Our privacy policy contains information about how you may access and seek correction of personal information about you that Cura holds.

Privacy complaints

Our privacy policy contains information about how you may complain about a breach of the Australian Privacy Principles and how Cura deals with complaints.

Overseas disclosure of your personal information

Should disclosure of personal information to entities outside Australia be required, Cura will, in all respects, comply with its obligations under the *Privacy Act 1988 (Cth)*.

Is there anyone to whom you do not want Cura to disclose your information to?

No

Declaration and consent

I have read and understood the information in this document and consent to the collections, uses and disclosures as described in this document.

Print name:	Signature:	Date:
Bryan Botterill		02/11/2024

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Cura CMR4.8 2/2 v2.00 05/07/2024