Obesity Surgery WA
Email: reception@oswa.com.au
Tel: 9332 0066
Fax: 9312 1619

CRESTON

Medical History

Name:______________________________ Date:____________________

CURRENT MEDICAL PROBLEMS:

____

____

____

CURRENT MEDICATION:

____

____

____

PAST MEDICAL PROBLEMS:

____

____

____

PAST SURGERY:

____

____

____

ALLERGIES TO MEDICATIONS/DRESSING:

____

____

HOW MUCH DO YOU SMOKE/ VAPE? __________ **HOW MUCH ALCOHOL DO YOU DRINK?** __________

Have you ever had? (Please circle)

Cancer? Abdominal or Pelvic Surgery? Heart Attack or Heart disease? DVT, Clot or Embolism?

Any issue with PAST Anaesthesia?

____

Do you have a family history of? (Please circle)

Colon Cancer Ovarian cancer Breast Cancer Bleeding or Clotting (Thombosis)

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Please complete the following (please tick box and specify where necessary).

Yes	No		Specify
☐	☐	Medication allergy	______
☐	☐	Other allergies (including latex, dressings, food)	______
☐	☐	Blood pressure problems	______
☐	☐	Bleeding/clotting problems	______
☐	☐	Diabetes	______
☐	☐	Breathing problems	______
☐	☐	Asthma/lung disease	______
☐	☐	Sleep apnoea	______
☐	☐	Current skin infection	______
☐	☐	Epilepsy/fits	______
☐	☐	Hepatitis	______
☐	☐	Kidney problems	______
☐	☐	Back or neck problems	______
☐	☐	Psychiatric problems (anxiety, depression)	______
☐	☐	Do you have a pace maker?	______
☐	☐	Cortisone/steroids?	______
☐	☐	Problems with anaesthetic in the past?	______
☐	☐	Other history/conditions	______
☐	☐	Have you ever been diagnosed with a gastric ulcer or Helicobacter pylori infection?	

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Name: ______________________________________ Date:___________

Please complete the following questionnaire if you are considering Weight Loss Surgery.

This questionnaire is to assess your sleep health.

Epworth Sleepiness Scale (ESS)		**OSA-50 Sleep Apnoea Questionnaire**	
How likely is the patient to doze/fall asleep in the following situations? Choose most appropriate number for each situation. 0 = would never fall asleep 1 = slight chance of falling asleep 2 = moderate chance of falling asleep 3 = high chance of falling asleep		Waist Circumference (at belly button): Males >102cm, Females >88cm. **(If YES score 3)**	**/3**
		Has your snoring ever bothered other people? **(if YES score 3)**	**/3**
		Has anyone noticed that you stop breathing during your sleep? **(If YES score 2)**	**/2**
Sitting and reading	**/3**	Are you over 50 years of age? **(If YES score 2)**	**/2**
Watching TV	**/3**	**A score greater than or equal to 5 indicates high risk of OSA.** **A score less than 5 indicates low risk of OSA.**	
Sitting, inactive in a public place (theatre, meeting etc).	**/3**		
As a passenger in a car for an hour without a break	**/3**		
In a car, while stopped for a few minutes in traffic	**/3**		
Lying down to rest in the afternoon when opportunity permits	**/3**		
Sitting quietly after lunch without alcohol	**/3**		
Sitting and talking to someone	**/3**		
Total **A score of 8 or more represents someone who is symptomatic**	**/24**	**Total**	**/10**

STOP-Bang Questionnaire Please answer the following questions by circling "yes" or "no" for each one.	
Snoring – Do you snore loudly?	YES / NO
Tiredness – Do you often feel tired, fatigues, or sleepy during the daytime?	YES / NO
Observed Apnoea – Has anyone observed that you stop breathing, or choke, or gasp during your sleep?	YES / NO
High Blood Pressure – Do you have or are you being treated for high blood pressure?	YES / NO
BMI – Is your Body Mass Index more than 35kg per m^2?	YES / NO
Age – Are you older than 50 years?	YES / NO
Neck Circumference – Is your neck circumference greater than 40cm?	YES / NO
Gender – Are you male?	YES / NO
Score 1 point for each positive response. Scoring interpretation: 0-2 = low risk, 3-4 = intermediate risk, ≥5 = high risk. **Total**	**/7**

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Patient Information Form

Mr, Dr, Mrs, Ms, Miss (Please circle)

Surname:___________________________________ Given Names:____

Date of Birth: _________________________________ Marital Status:____

Address:____

Phone No (Home):_______________________(Work):___________________ (Mobile):____________________________

Email Address:____

Occupation:_______________________________________ Employer:_______________________________________

Referring Doctor:____

GP Name & Address (if different from referring Doctor):

____

Other health care professionals involved in your care (e.g. Specialists, Psychologist, Physiotherapist)

____

____

Do you have Gold Hospital Cover for *Bariatric/Weight Loss Surgery? ☐YES ☐NO ☐UNKNOWN

*(For Bariatric Surgery you need to be on Gold Cover or have chosen weight loss surgery as part of your cover - please check with your Private Health Insurance to confirm your level of cover)

Private Health Fund:___________________________________ Member Number: ________________________________

Have you been with your private health fund for longer than 12 months? ☐YES ☐NO

Medicare No: ___________________________________ Ref No: ______

DVA Card No:___________________________________ DVA Card Colour:__________________

Disability Covered (White Card):____

Person responsible for Account: ____

Next of Kin (name in full):____

Relationship:___________________________ Phone No (Home):__________________(Mobile):_____________________

Is this consultation and Workers Compensation Claim? ☐YES* ☐NO

*If yes, please provide approval documentation and Claim Number: ____

Please note that private patients seen in these rooms will be charged a fee above the Schedule Fee. This will require payment of a gap not covered by Medicare or your Private Health Fund.

<u>*A FEE IS INCURRED IF 24HRS NOTICE IS NOT GIVEN TO CHANGE/CANCEL APPOINTMENT*</u>

I am aware that I am liable for any Debt Collection Fees associated with any overdue payments on my account.

Signature:____ Date: ______________________________

Assoc. Prof. Harsha Chandraratna Consulting Surgeon/Medical Director

Dr Stephen Watson General Surgeon

Dr Leon Cohen General Surgeon

Murdoch - St John of God Medical Centre, Suite 27, *1st Floor, 100 Murdoch Drive, Murdoch WA 6140*

Booragoon - Garden City Specialist Centre, *537 Marmion Street, Booragoon WA 6154*

Subiaco - Surgeons House, 162 Cambridge *Street, West Leederville WA 6007*

Mandurah – Sessional Suite *Address to be advised*

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COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. (This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you).
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge me fees to cover

- Time spent by administrative staff to provide access at the employee's hourly rate of pay
- Time necessarily spent by a medical practitioner to provide access at the practitioner's ordinary sessional rate and
- For photocopying and other disbursements at cost

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed: .... **Patient Full Name:** .... **Date:** ....

Patient feedback and social media policy

At OSWA we strive to provide the best care and support to our patients through continuous education activities for all staff and by assessing patient feedback to make changes to processes and care where appropriate.

We ask our patients to use social media in a kind and respectful manner and respect the privacy of other patients that are attending our clinic. Social Media community forums are meant to be used as a supplementary support tool not as a replacement for the information and advice provided by our trained clinicians and our practice staff. Any concerning posts which include inappropriate behaviour toward forum members or staff will be reported and requested to be removed. Serious breaches of the social media policy with regards to bullying and harassment could result in your being banned from our practice.
If you have any concerns with regards to your treatment or our service, please direct your feedback in writing:
Attention: Business Manager, OSWA, 537 Marmion Street, BOORAGOON WA 6154

Or Via Email: reception@oswa.com.au

I understand the above patient feedback and social media policy:

Signed: .... **Patient Full Name:** .... **Date:** ....