ADVANCED DENTAL
ANAESTHESIA SOLUTIONS

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IMPORTANT INFORMATION ABOUT YOUR PROCEDURE

ADAS will confirm your admission time 24 hours prior to the procedure.

PRESCRIPTION MEDICATION:
If you take prescription medication and you are required to do so within the fasting period, please ensure you only use a small sip of water and do not consume anything at all for at least 1 hour prior to the procedure.
When you arrive for your procedure, please inform your surgeon and anaesthetist of the time of your last dosage.

Please note, if you are taking blood thinners (E.g. Aspirin, Warfarin) you will be required to stop taking the medication for at least one week prior to your procedure. Please consult your doctor before discontinuing any prescribed medication.

On the day of your procedure, please bring with you ALL your prescription medications, including inhalers such as Ventolin.

NON-PRESCRIPTION PRODUCTS:
Please stop taking any vitamins of herbal products effective immediately and until after your procedure.

SMOKING & ALCOHOL:
Smokers may have delayed recovery or 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 risks. Do NOT consume any alcoholic beverages within 24 hours of your procedure.

GETTING HOME:
It is essential that you make arrangements for a reliable person to take you home and stay with you for the first 24 hours after your procedure. *It is both a legal & medical requirement*.
At home please follow the post-operative instructions provided to you and limit your physical activities. Do not drive or operate machinery for 24 hours following your procedure, and avoid making any legal or financial decisions.

In some instances, prescription medication will need to be collected on discharge or by your carer/driver whilst they wait for you. Please make arrangements for this to occur.

Medical and Carer's certificates can be provided on the day if required.

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PREPARING FOR YOUR PROCEDURE

WHAT TO WEAR/BRING:

- Clothing: Please wear a loose dark t-shirt/top (no long sleeves), comfortable pants and enclosed flat shoes with socks. Bring a warm jumper.
- Remove all jewellery.
- Do not wear any moisturiser/foundation/make-up.

- Men should shave the day of the appointment (except men with full beards or moustache need not shave).
- Please bring a blanket for Recovery.
- Children may also bring a comforting item (soft toy/blanket).

FASTING INSTRUCTIONS:

For your safety under general anaesthesia, you are required to fast. Fasting means: No food, No drink, No chewing gum/Breath Mints etc.

- Morning Patients: Fast from **12:00AM Midnight the night before** your procedure.
- Afternoon Patients: Fast from **06:00 AM the morning of** your procedure.

FEEDBACK:

ADAS strives to ensure a safe and comfortable experience before, during and after your treatment. 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

If you wish to make a suggestion to better improve our delivery of care, or if we have failed to meet your expectation 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 via phone or email conversation to your satisfaction, ADAS has 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 guided by AHPRA.

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 might 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, that 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 of our records or a written summary, our usual feels apply to 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 utmost confidentiality. 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 training and 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 objection, you must let us know in writing.

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

Signature _____

Print Name _____

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:

Dental Clinic: _____ Treating Practitioner: _____

Family Name: _____ Given Name: _____

Date of Birth: _____ Sex: _____

Address: _____

_____

Phone: Mobile: _____ Landline: _____

Email: _____

Medicare Number: _____Expiry: _____

Interpreter Required: _____ If Yes, what language? _____

Do you have a medical power of Attorney? Yes ☐ No ☐

Name: _____ Contact Number: _____

If you have an advanced care directive, please provide written details:

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 no, provide details below.

Name: _____ Relationship: _____
Mobile: _____ Other (work/landline): _____

Address where you are staying after surgery:

_____
_____

Family/Local Doctor's Name:
Name: _____Phone: _____
Name of Clinic: _____
Address:_____
_____

***HEALTH INFORMATION**:*

Age:	yrs	Height:	cm	Weight:	kg

***ALLERGIES**: Do you have any allergies? Specify Allergy and Reaction:*

Latex/Rubber?
Medication/Lotions-Solutions?
Tape/Food/Other?

**Please attach a separate page if more room is required

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

List any operations or procedures including dates:

PREVIOUS ANAESTHETIC DETAILS:

Have you or a family member had a reaction to Anaesthetic? Please specify:
Do you or your family have a history of Malignant Hyperthermia? YES ☐ NO ☐
Do you have any questions relating to the Anaesthetic? Please specify:

REGULAR MEDICATIONS:

Do you take any Medications? This includes: Tablets, Puffers, Eye Drops, Vitamins, Herbal Medicine
Please list below: (Please attach a separate page if more room is required)

Name of medication	**How much (Dose)**	**How often (Frequency)**

BLOOD THINNING MEDICATIONS:

Do you take any of the following blood thinning medications?

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

Any other blood thinners_____

BISPHOSPHONATE MEDICATION FOR BONE DISEASE OR METASTATIC DISEASE:

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

☐ Osteoporosis ☐ Paget's Disease ☐ Bone Cancer, Cancer Spread to Bones ☐ Multiple Myeloma ☐ Other

If you have previously taken any Bisphosponates:
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:

_____

_____

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/Fractured Nose: YES ☐ NO ☐

Any complications with previous dental treatment? YES ☐ NO ☐

If yes, please provide details:

_____

_____

GENERAL MEDICAL CONDITION:

Have you ever had or do you have any of the following? Please tick Yes or No	***NO***	***YES***	***If yes, please add comments/details***
High Blood Pressure (Managed by)	☐	☐	
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 Replaced/Stents	☐	☐	
Respiratory problems Asthma/Bronchitis	☐	☐	Nebulisers ☐ Puffers ☐ Home oxygen ☐
Shortness of Breath	☐	☐	
Tuberculosis	☐	☐	
Obstructive Sleep Apnoea (OSA) Has your OSA been diagnosed with a sleep study?	☐	☐	CPAP used?
Diabetes	☐	☐	Type 1 ☐ Type2 ☐ Unsure ☐ Insulin ☐ Tablets ☐ Diet ☐
Speech/Swallowing problems	☐	☐	
Any recent weight loss of more than 5KG	☐	☐	How Much?
Any recent decrease in appetite	☐	☐	
Epilepsy/Fits/Seizures/Migraines/Blackouts/ Fainting	☐	☐	Last Seizure?
Strokes/Mini Strokes (TIA'S)	☐	☐	Weakness/Symptoms?
Infectious Diseases: HIV/Hepatitis/STI's	☐	☐	
Hospital acquired Infections (VRE/MRSA)	☐	☐	
Creutzfeldt Jakob Disease (CJD)	☐	☐	
Blood Clots/Bleeding disorders/Anaemia Blood Transfusions	☐	☐	
Elimination Issues: Bowel/Bladder problems	☐	☐	
Kidney Condition	☐	☐	
Liver Disease	☐	☐	
Reflux/Indigestion/Hiatus Hernia/Ulcers	☐	☐	
Mental Health Problems: Depression/Anxiety etc	☐	☐	
Short Term Memory Loss/ Dementia Previous confusion/Delirium/Wandering	☐	☐	
Skin Conditions/Existing Wounds/ Broken Skin	☐	☐	

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? PLEASE TICK YES OR NO	***NO***	***YES***	***If yes, please add comments/details***
Have you taken any Prednisolone, Cortisone, or Steroids in the last 6months	☐	☐	
Chronic or acute pain	☐	☐	Location: Severity:
Cancer	☐	☐	Details: Date Diagnosed:
Female Patients: Are you pregnant? Are you breasting feeding?	☐	☐	
Other Medical Conditions?	☐	☐	

LIFESTYLE:

DO YOU:	***NO***	***YES***	
Drink Alcohol?	☐	☐	Amount: How often?:
Smoke tobacco?	☐	☐	Cigarettes per day: Year started? Date Ceased (if applicable):
Use recreational drugs?	☐	☐	Type: Amount: How often?:
Have vision or hearing impairment?	☐	☐	Details: Aids Used:
Do you have assistance with: Mobility Hygiene Meals Medication	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	 Stick ☐ Frame ☐ Crutches ☐ Wheelchair ☐ Council ☐ Other ☐ Council ☐ Other ☐ Dosette ☐ Webster ☐ Family/other ☐
How many stairs can you walk up without stopping			Two flights or more /One flight/ Half a flight ☐ ☐ ☐

SOCIAL:

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

RESPONSIBILITY & CONSENT STATEMENT:

I have completed this questionnaire to my best knowledge and understand that failure to make a full disclosure may place me (or the above-mentioned patient) at undue medical risk. I also give my consent to procedures, medications or anaesthetics to be administered for diagnostic purposes or dental treatment.

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 a cancellation fee of $500 per hour (maximum of 5 hours) if less than 48 hours' notice for cancellation is provided. **I also understand that any legal and debt collection fees associated with an unpaid account will be at my expense**.

Signed_____ Date _____

Print name:_____

CONSENT TO COSTS:

Costs will be explained to you when booking your procedure. Informed financial consent will be obtained you prior to your procedure being undertaken. If you have any questions regarding the fees, please don't hesitate to contact us on (03) 8362 7007 or info@adas.net.au

ANAESTHETIC PAYMENT AUTHORISATION:

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

Payment Type: ☐ Visa ☐ Master Card

Card Number:

Expiry: (MM/YY)

Security Code (VISA/MasterCard - three-digit code on the back of your card):

Name on Card:_____

Signed: _____ Date: _____

Please note that these details must be completed prior to your paperwork being processed. Failure to complete the above details may mean that your surgery is delayed or cancelled. If you wish to discuss the anaesthesia billing further, please contact ADAS – info@adas.net.au

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ANAESTHESIA SOLUTIONS

Transfer Details

Ambulance Cover: Yes ☐ **OR** No ☐

Ambulance Membership Number: (If applicable)

Member # _____

In case of Emergency:

Would you like to be transferred to -

Private ☐ **or** Public Hospital ☐

Private Health Insurance Details:

Fund: _____

Member Number: _____

Emergency Family Contact

Name: _____

Relationship to Patient: _____

Mobile: _____

Home: _____

Work: _____

Blood Group (If Known) _____

Allergies/Sensitivities: _____

***Signature*:** _____ ***Date*:** _____

Name: _____