Dr Anthony J Oliver
Oral & Maxillofacial Surgeon

Same Day Consult/Surgery Form

THIS FORM MUST BE COMPLETED IN FULL

INSTRUCTIONS:

To enable your surgeon to assess if you are a suitable candidate for Same Day Consult and Surgery you are required to complete this form and forward to our office with your Referral and X-ray. Please ensure you provide a home number and mobile number on this form.

Once received, Dr. Oliver will review your referral and x-ray and determine whether your surgery needs to be performed in a private hospital or under local anesthetic. You will then be contacted by a Patient Liaison Officer to advise you of the preferred treatment plan and an estimate of fees.

Fees	***Surgeon's fees*** are payable the day before surgery. ***Anaesthetist fees*** are payable a few days prior to your surgery. ***Hospital fees*** are payable on the day of surgery.
Carer	You must attend with a carer as you will not be able to drive after your surgery.
Fasting	Our team will give you fasting instructions when your surgery is booked.
Treatment Plan	We will schedule either a telephone conference or video conference (Skype/ Zoom/FaceTime) with Dr. Oliver.

PATIENT INFORMATION	
Title	
Given Names	
(Preferred Name)	
Surname	
Date of Birth	
Street Address	
Suburb	
Post Code	
Occupation	
Home Phone	
Work Phone	
Mobile	
Email	
REFERRAL INFORMATION	
Referred by	
Usual Medical GP	

CARD INFORMATION	
MEDICARE NO.	__ __ __ __ / __ __ __ __ __ / __
No. next to your name	
Expiry Date	__ __ / __ __ __ __
VETERAN NO.	☐ White Card ☐ Gold Card

HEALTH INSURANCE INFORMATION	
NAME OF HEALTH FUND:	
HEALTH FUND MEMBERSHIP NO:	
Have you been with this Fund for more than 12 months:	**YES/NO**
Do You Have Hospital Insurance?	**YES/NO**
Do You Have Dental Extras?	**YES/NO**
If 'YES' are your Dental Extras with the same fund?	**YES/NO**

As I am seeking private treatment, I understand that the payment of the account is my sole responsibility. I undertake to pay any additional expenses incurred in recovery of overdue accounts. In the case of a minor this responsibility transfers to the person responsible for the account.
This Practice has a Privacy Policy on handling patient information. You are not obliged to provide any information requested of you, but that failure to do so might compromise the quality of your care. I consent to the handling of my information for the purposes required for my treatment subject to any limitations on access or disclosure, that I notify this Practice of in writing.

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NAME:	**DOB:**	
PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	**NO**	**YES**
Have you or any member of your family had or been exposed to infectious/ communicable disease in the last 2 weeks? (Eg. Flu, shingles, measles)		
Do you require assistance with walking?		
Have you ever smoked? If yes, what is your daily amount?		
Do your drink alcohol? If yes, what is your daily amount?		
Have you had any serious illness?		
Any further comments?		
List names/doses of all TABLETS/MEDICINES you are currently taking (including non-prescription medications and herbal medicines):		
How do you plan to get home when you are discharged?		
Where will you be staying the night of your surgery?		

For patients who will have intravenous sedation at our Burwood Practice:

Following surgery, I will have a responsible adult drive me home. I realize that mental impairment may persist for several hours following the administration of anaesthesia. I will avoid making decisions or taking part in activities which may depend upon full concentration of judgement for 24 hours.

For all patients:

I will follow discharge instructions and attend appointments as advised. The answers I have given to all questions are true to the best of my knowledge.

Signed _____ *Date* _____