Patient Admission Forms

It is essential that the hospital receives these forms as soon as possible following consultation with your doctor. This will help us to ensure you are well prepared for the day of admission. Please take the time to read and fill out all of the pages of this pack and return to the hospital.

168 Cudmore Terrace
Henley Beach SA 5022

P 08 8159 1200
F 08 8353 4051
E reception@westernhospital.com.au

www.westernhospital.com.au

Western Hospital SA

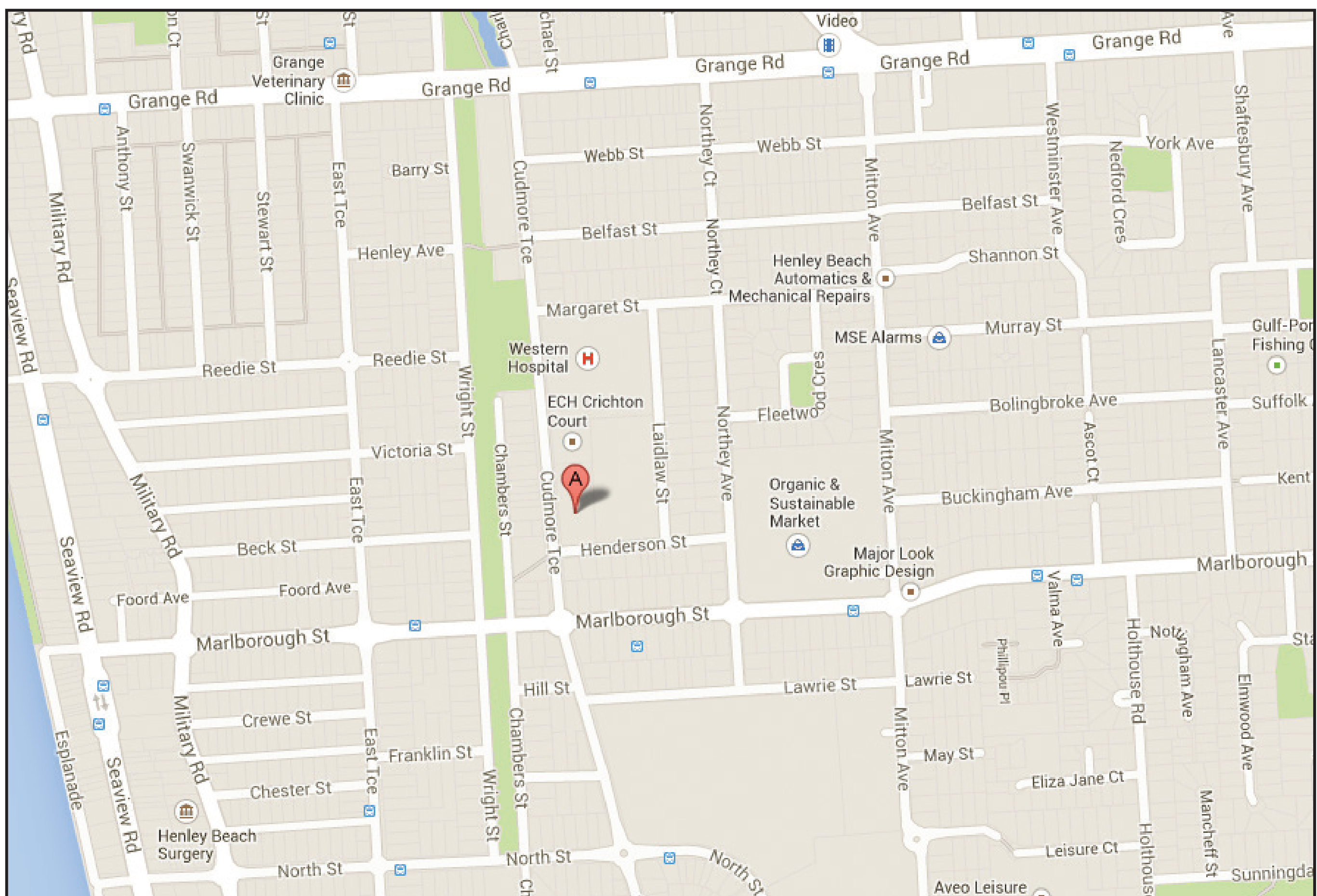
@WesternHospitSA

How to find us

Western Hospital is located at:

168 Cudmore Terrace Henley Beach SA 5022

P **08 8159 1200** F **08 8353 4051**



Map courtesy of Google Maps ©2013

Patient information

Information

Western Hospital is a health services hub, providing facilities for surgical and medical patients. It also provides a GP Practice and a Community Pharmacy on site, along with specialist consulting rooms.

The hospitals primary purpose is to care for you and your needs and the staff strive to maintain a high standard of patient care. The staff work as a team and will do their utmost to make your stay as comfortable as possible.

Accommodation

We pride ourselves on our single room accommodation and ensuite facilities. Every effort is made to provide patients with their choice of accommodation, either shared or private, but some circumstances may require us to provide alternative accommodation.

Admission

All admissions to the hospital are arranged by your doctor. Forms are generally provided by your doctor or you can download the forms from our website:
www.westernhospital.com.au

Please ensure that you have discussed your procedure with you doctor and you have signed a consent form.

The preadmission process is an important part of your hospital admission ensuring we can confirm the details of your admission, financial arrangements and any other needs you may have in the planning of your admission.

Please take the time to read and complete the attached pages of this admission document.

In order to minimise delays we request that you email, post, fax or personally hand in your completed admission forms at least five days prior to your admission.

Email to: bookings@westernhospital.com.au

Post to: PO Box 81 Henley Beach SA 5022

Fax to: 8353 5041

Or drop your admission forms in to our Reception staff Monday to Friday 7am -8pm and Saturday 8-4pm.

Preadmission service

A preadmission service for patients undergoing procedures is provided by the hospital.

Our preadmission nurses will review the medical history information you provide prior to your admission. Depending on the type of surgery and anaesthetic you will be having, you may be contacted by one of our nurses to further discuss the information you have provided us.

If you do need to be preadmitted by the preadmission nurse, you will be contacted prior to your admission date.

You may also need to visit the physio, or undergo blood or other tests, prior to your admission. Your doctor or the nurse will arrange these if required.

Discharge information

On the day of Discharge, patients are encouraged to vacate their rooms by 10am to enable us to prepare for incoming patients.

Where necessary, the planning of your discharge is commenced at the time of your admission and the following services may be planned and arranged:

- Equipment you may need at home
- Home support services (Community Nursing, MOW etc.)

Day patients should arrange a pick up time with the nursing staff upon admission.

Our objective is to ensure that your admission runs smoothly and that everything is ready and organised when you arrive at Reception on the day of your admission. If you have any queries about any aspect of your admission please do not hesitate to contact the hospital.

Patient information

What to bring

- Details of Health Insurance Membership, Workcover, Pension or Veterans Affairs cards, Pharmaceutical Benefits cards, Medicare card and Safety Net Entitlement card
- **SLEEP APNOEA PATIENTS** please bring in your CPAP machine with you to be checked by our maintenance department between 8am and 4pm Monday to Friday prior to admission day
- All relevant X-rays/scans
- All medication you are currently taking, in the original packaging. Bringing your medicines to hospital with you will assist staff to have a complete and accurate picture of your current treatment. It may also identify any issues you have with your medicines which can be referred to a pharmacist or your doctor.
- Nightwear, dressing gown, slippers (if staying overnight)
- Personal toiletries and soap
- Walking/mobiilty aids (including sturdy shoes)

What not to bring

- Cigarettes – **Western Hospital is a NO SMOKING environment and smoking is not permitted anywhere in the hospital or on hospital grounds.**
- Talcum powder is prohibited in the hospital
- Excess luggage
- Valuables – Western Hospital **strongly** recommends that you do not bring anything of value into the hospital (e.g. large amounts of money, credit cards if not required for payments or items of personal value). **THE HOSPITAL DOES NOT ACCEPT RESPONSIBILITY FOR LOST OR STOLEN ITEMS.**
- We request that in the interest of electrical safety, you do not bring in electrical items with you
- We also request that you remove jewellery, makeup and nail polish before your admission.

DAY OF ADMISSION: To enable staff to prepare you adequately for your procedure and to allow time for any anaesthetic consultation, there may be a waiting time between your admission and procedure time.

Guest Wi-Fi

Wi-Fi is available in all hospital areas. All patients can log on with no password for 20 minute sessions without any limits to the number of sessions during your stay.

TVs, radios & phones

Televisions and radios are provided at each bed. For overnight patients, a telephone is available in your room. Local calls are free of charge. Cordless phones are available for Day Procedure patients. The use of mobile phones is permitted in some areas of the hospital. Please follow signage and instructions from nursing staff.

Insured patients

Your account for hospitalisation will include accommodation, theatre fees and other chargeable items in accordance with Western Hospital's current arrangement with your health fund. For items and services such as pathology, radiology, physiotherapy, anaesthetists and other doctors involved in your care whilst in hospital, you will receive a separate account from the provider. **You should discuss these fees with your doctor prior to and during your hospitalisation.**

On receipt of your admission paperwork our staff will complete a health fund check, however it is also important that you contact your health fund to confirm your level of cover and whether you have an excess, co-payment or exclusion on your policy. **All excesses and co-payments for all patients (including Day patients) are payable on admission. If these payments are not received prior to or on the day, your procedure will be cancelled. Payments can be made over the phone with your credit card.**

In the event that your health fund rejects your reimbursement claim for any reason, the hospital will seek to recover any amounts outstanding from you.

In this admission pack you will find a financial consent declaration. Please read this information carefully as it details your financial obligations.

Self-insured patients

If you are self-insured (i.e. you do not have private health cover) you will be required to pay an estimated amount of the total account on or prior to your admission. Other costs which may be incurred during your stay will be payable when your account is finalised on discharge.

Patient information

WorkCover/Third Party Insurance Patients

If you are a WorkCover or Third Party Insurance patient, Western Hospital will require written approval for your admission from the relevant insurance company on or prior to your admission day.

Pharmacy

Western Pharmacy is located onsite and can fill all of your prescriptions. It serves the community of the western suburbs and provides professional medication advice.

A Clinical Pharmacist is available whilst you are in hospital for advice and counselling as required.

You will be required to pay for any discharge medications on your day of discharge.

Visitors

Normal visiting hours are 11am – 8pm. Please speak to the nursing staff about visiting outside of these hours. We ask you be mindful of other patients comfort when visitors come in to see you.

Mail

Mail will be delivered to you daily, the correct address to inform your relatives is:

c/- Western Hospital
168 Cudmore Terrace, Henley Beach SA 5022

Or they can email to:
reception@westernhospital.com.au

Children in hospital

Parents may visit their children at any time. Arrangements can be made for one parent to be accommodated with their child. If your child has a special toy etc. please bring it with him/her.

Special diets

If you require a special diet please inform us as soon as possible so we can meet your needs.

Free parking

Ample parking space is provided on the hospital grounds. Please ensure your vehicle is not parked in unauthorised areas.

Interpreter service

If the services of an interpreter are required, please contact the hospital prior to admission so that the necessary arrangements can be made.

Courtside café

Our café located on the ground floor, is open Monday to Friday, 8am – 5pm. There is a wide range of food and beverages available for purchase.

Further information

If you require any further information or you would like to talk to someone about your planned hospital stay, please contact us on 8159 1200 and ask to speak to our Patient Services Coordinator or Pre-admission Nurse.

You can find out more information about Western Hospital and its services by visiting our website:

www.westernhospital.com.au

Log onto our Facebook page:
Western Hospital SA

or follow us on Twitter:
@WesternHospitSA

Your privacy

Respecting your privacy

The privacy of your personal information is important to us at Western Hospital and we are committed to ensuring it is protected. Western Hospital complies with the National Privacy Principles under the Commonwealth Privacy Act 1988 and all other state/territory legislative requirements in relation to the management of personal information.

Collecting of personal information

In order to provide you with the health care services that you have requested when you become a patient with us, we need to collect and use your personal health information. If you provide us incomplete or inaccurate information we may not be able to provide you with the services you are seeking.

When you become a patient of Western Hospital, a medical record is created and it includes personal information such as your name and contact details, as well as information about your health problems and the treatment you received.

Each time you attend the hospital, we will update your medical record, collecting information necessary for the provision of healthcare and services for you.

Our staff will always endeavour to be sensitive to your needs when obtaining personal health information. However, they are also committed to acting in your best interests by making a thorough assessment of your condition and medical history.

Protecting your personal information

In addition to complying with all relevant privacy and confidentiality legislation, Western Hospital has strict policies and protocols with respect to the collection, use, disclosure and storage of patient information. We have taken measures to ensure both paper based and electronic information on our computer system are stored securely. Only authorised personnel have access to your information.

Using and disclosing your personal information

During your hospitalisation there may be occasions when we may be obliged to or authorised under law to disclose patient information, regardless of your consent, including subpoena of records for legal action, mandatory reporting to government authorities (such as registration of births, deaths, diseases and treatments) or reporting information about care provided as required by the SA Department of Health.

In order for us to provide care and services for you, we may also use your information where necessary for the management of our hospital, to liaise with your health fund, and Medicare as necessary, and for activities such as quality assurance processes, accreditation, audits, risk and claims management and education of health professionals involved in your care and treatment.

Accessing your personal information

You have a right to have access to the health information that we hold in your health record, subject to some exceptions allowed by law. You can also request an amendment to your health record should you believe that it contains inaccurate information. For more information about accessing your records, please contact our Privacy Officer.

If you have a complaint about privacy issues

If you have a complaint about our information handling practices, you are encouraged to speak directly to our staff.

If after this you feel the matter has not been addressed, please contact the Office of the Australian Information Commissioner (OAIC) who have complaint handling responsibilities under the Privacy Act 1988 (Cth).

Contact them on 1300 363 992, post to GPO Box 5218 Sydney NSW 2001 or visit their website www.oaic.gov.au

Included in this pack is a Privacy Consent Form, which we ask you to read, sign and return with your paperwork. If you have any further questions please contact us and will be happy to answer them for you.

Rights and responsibilities

As a consumer of healthcare services at Western hospital you have specific rights and responsibilities regarding your care and treatment.

Western Hospital's Rights and Responsibilities Charter recognises that people receiving Care and people providing care all have important parts to play in achieving healthcare rights. These rights and responsibilities are essential to make sure that care provided is of a high quality and is safe.

You have the right to

- Have access to the best and most appropriate care available for your needs
- Be shown respect, dignity and consideration
- Be informed of all aspects of services, options, treatments and costs in an open and clear way
- Be included in decisions and choices about your care
- Privacy and confidentiality of your personal and health information
- Ask the identity, professional status and qualifications of any healthcare worker providing care and services
- Express your concerns or provide feedback by making suggestions or complaints and you have the right to have these addressed.

You have the responsibility to

- Answer questions about your health openly and completely
- Comply with prescribed treatments, seeking clarification if you are unsure
- Inform staff and your doctor if you have any concerns about your conditions
- Discuss with your healthcare professionals if you wish to refuse treatment
- Respect the dignity and rights of other patients, visitors and hospital staff
- Contact the hospital should you wish to postpone or cancel your admission or if you are unable to arrive at the scheduled time
- Respect hospital property, policies and regulations
- Finalise your accounts pertaining to your hospitalisation
- Direct any complaint to a staff member so that appropriate steps can be taken to address your concerns.

Look for our Patient Feedback Survey Forms, we would love to hear what you think of the care and service you received. We welcome any opportunity to hear from you so that we can continue to improve the quality and safety of the care we provide.

Complaints, compliments and feedback

We welcome any feedback relating to any aspect of the care and services you receive at Western Hospital, and we encourage you to complete the Patient Feedback Surveys available in all areas.

If you have particular concerns we encourage you to speak to our staff directly whilst you are in hospital or contact our Chief Executive Officer:

Western Hospital
168 Cudmore Terrace, Henley Beach SA 5022
P 8159 1200 F 8353 4051

We will endeavour to resolve your concerns with you and we welcome the opportunity to improve the safety and quality of our care and services.

Should you feel that the matter needs independent review, we encourage you to contact the Healthcare & Community Services Complaints Commission: call 1800 232 007 or visit their website www.hcscc.sa.gov.au

The brochure '10 Tips for Safer Healthcare' is available in compendiums in your room. If you would like further information you can access it at The Australian Commission for Safety and Quality in Health Care website at: www.safetyandquality.gov.au/publications/10-tips-for-safer-health-care/

Patient notes

If you have any questions at all please do not hesitate in contacting your doctor, our hospital reception staff or preadmission nursing staff.

Patient Admission Form

OFFICE USE ONLY
UR No:

Please complete and return Admission Form and Patient History to Western Hospital promptly prior to your admission. You can do this by post, in person to our reception, or by emailing to: bookings@westernhospital.com.au

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS OF THE FORMS. YOUR RESPONSES ARE VALUABLE IN PLANNING YOUR ADMISSION AND CARING FOR YOU DURING YOUR STAY.

ADMISSION DETAILS	
DATE OF ADMISSION	DATE OF OPERATION/PROCEDURE
ADMITTING DOCTOR	
REASON FOR ADMISSION	
HOSPITAL STAY ☐ OVERNIGHT ☐ DAY	

PERSONAL DETAILS		
TITLE	SURNAME	
PREVIOUS SURNAME (IF APPLICABLE)		
GIVEN NAMES	PREFERRED NAME	
ADDRESS	SUBURB	STATE
P/CODE	EMAIL	
POSTAL ADDRESS (IF DIFFERENT FROM ABOVE)		
PHONE – HOME	WORK	MOBILE
DATE OF BIRTH	AGE	SEX: ☐ MALE ☐ FEMALE
COUNTRY OF BIRTH	ARE YOU A PERMANENT RESIDENT OF AUSTRALIA? ☐ YES ☐ NO	
MAIN LANGUAGE SPOKEN AT HOME?	DO YOU REQUIRE AN INTERPRETER? ☐ YES ☐ NO	
OCCUPATION	RELIGION	
WOULD YOU LIKE A RELIGIOUS/PASTORAL VISIT WHILST IN HOSPITAL? ☐ YES ☐ NO		
MARITAL STATUS: ☐ SINGLE ☐ MARRIED OR DEFACTO ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED		
RACE (REQUIRED BY SA HEALTH): ☐ CAUCASIAN ☐ ABORIGINAL ☐ TSI ☐ ASIAN ☐ OTHER		

PERSON TO CONTACT (NEXT OF KIN)			
TITLE	SURNAME	GIVEN NAME	
RELATIONSHIP TO PATIENT			
ADDRESS	SUBURB	STATE	P/CODE
PHONE – HOME	WORK	MOBILE	
ALTERNATIVE CONTACT PERSON –	PHONE	RELATIONSHIP	

WHO IS YOUR GP/LOCAL DOCTOR		
FULL NAME OF DOCTOR		
ADDRESS		
TELEPHONE	FAX	EMAIL

WESTERN
YOUR HOSPITAL THAT CARES

Patient Admission Form

ENTITLEMENTS		
MEDICARE NO.	NO. PREFIXING NAME	VALID TO
PENSION NUMBER		EXPIRY DATE
PBS SAFETY NET CARD NO		EXPIRY DATE
DEPARTMENT OF VETERAN AFFAIRS FILE NO	EXPIRY DATE	GOLD / WHITE / OTHER

PREVIOUS HOSPITALISATION	
HAVE YOU BEEN A PATIENT AT WESTERN HOSPITAL SINCE AUGUST 2003? ☐ YES ☐ NO	IF YES, WHAT YEAR?
HAVE YOU BEEN A PATIENT AT ANY HOSPITAL WITHIN THE PAST SEVEN (7) DAYS? ☐ YES ☐ NO	
IF YES, PLEASE STATE WHICH HOSPITAL	
DATES OF HOSPITALISATION FROM	TO
WERE YOU A PRIVATE PATIENT? ☐ YES ☐ NO	PUBLIC PATIENT ? ☐ YES ☐ NO

PERSON RESPONSIBLE FOR THIS ACCOUNT		
IS THE PATIENT RESPONSIBLE FOR THIS ACCOUNT? **YES** (GO TO NEXT SECTION) **NO** (COMPLETE THIS SECTION)		
TITLE	SURNAME	GIVEN NAME
RELATIONSHIP TO PATIENT		
ADDRESS	SUBURB	STATE
PHONE – HOME	WORK	MOBILE

HEALTH INSURANCE DETAILS

INSURED PATIENTS: it is recommended that you contact your health fund prior to completing this section to check your level of cover, particularly if you have been a member for less than 12 months or have changed your cover in the same period. Please be aware of the PRE-EXISTING CONDITION RULE. It is important that you are aware of all financial costs relating to your stay in hospital. Please note payment methods accepted are: cash, eftpos, credit card, bank cheque and direct deposit. Direct deposits must be made three days prior to admission. We DO NOT accept personal cheques, AMEX or Diners cards.

HEALTH FUND NAME	MEMBERSHIP NO.	TABLE
CURRENT TABLE MEMBERSHIP: OVER 12 MONTHS? ☐ YES ☐ NO	LESS THAN 12 MONTHS? ☐ YES ☐ NO	
DO YOU HAVE AN EXCESS OR CO-PAYMENT TO PAY? ☐ YES ☐ NO	IF YES, HOW MUCH? **$**	

ANY EXCESS OR CO-PAYMENT MUST BE PAID PRIOR TO YOUR ADMISSION

OUT OF POCKET EXPENSES

HAS YOUR ADMITTING DOCTOR/SPECIALIST/ANAESTHETIST EXPLAINED TO YOU HIS HER ACCOUNT DETAILS IN RELATION TO YOUR ADMISSION AND TREATMENT? ☐ YES ☐ NO

IF YOU ANSWERED NO, IT IS RECOMMENDED YOU TALK TO YOUR ADMITTING DOCTOR/SPECIALIST/ANAETHETIST PRIOR TO YOUR ADMISSION TO OBTAIN INFORMATION ABOUT ANY OUT OF POCKET EXPENSES THAT MAY APPLY

SELF FUNDED PATIENTS

Please obtain information regarding item number(s) for planned procedure from your doctors' rooms , and then contact the hospital for an estimate of costs.

ALL COSTS FOR UNISURED PATIENTS ARE PAYABLE PRIOR TO ADMISSION AND ARE NOT COVERED BY MEDICARE

COMPENSABLE ADMISSIONS

WORKCOVER ☐ THIRD PARTY ☐ PUBLIC LIABILITY ☐

THE APPROVAL LETTER FOR THIS ADMISSION (FROM YOUR INSURANCE COMPANY) MUST ACCOMPANY THIS FORM

INSURANCE COMPANY DETAILS:	NAME OF INSURANCE COMPANY	
CLAIM NUMBER	DATE OF ACCIDENT	
CONTACT PERSON	PH	FAX
EMPLOYER DETAILS:	NAME OF EMPLOYER	
ADDRESS		
CONTACT PERSON	PH	FAX

Financial & Privacy Consent Form

The Federal Privacy Act (1988) (Cwlth) with amendements, states that your consent needs to be obtained prior to our collecting personal and health information about you. Please read carefully the Privacy Policy Information, which provides details related to the management of your Personal Health Information, prior to signing this consent form.

UR: ______________________

SURNAME: ______________________

GIVEN NAME: ______________________

D.O.B ______________ SEX: ______________

PHONE NUMBER ______________________

FINANCIAL CONSENT AND INFORMATION

1. **I certify that the above information is true and to the best of my knowledge. I accept full responsibility for accounts rendered by Western Hospital, including any shortfall in reimbursement by my health fund or any insurance company gap following settlement by the health fund and/or insurance company.**
2. **I have had the financial costs of my hospitalisation clearly explained to me and understand that:**
   - **total costs cannot be quoted, but only estimated in advance;**
   - **my obligation to pay for my hospitalisation is independent of any benefits I may be able to claim for my private health insurance and that I will be liable for any debt collection and or solicitors fees incurred in the collection of these accounts.**
3. **I understand that any excess payable under my private health insurance fund will be paid on admission.**
4. **I understand that I may be required to pay for some items used in theatre that may not be covered by my health fund.**

SIGNATURE OF PERSON RESPONSIBLE FOR THE ACCOUNT

PRIVACY CONSENT

1. **I have read the information provided and am aware of the Western Hospital Policy for the management of personal health information.**
2. **I understand I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the healthcare and treatment given to me.**
3. **I am aware of my right to access the information collected about me, except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.**
4. **I understand that if my personal and health information is to be used for any other purpose than set out in the information provided, my further consent will be obtained.**
5. **I understand that I may notify the hospital of specific limitations on access or disclosure which will be documented in my health record.**
6. **I consent to the handling of my personal health information by Western Hospital for the purposes set out in the information provided, subject to any limitations on access or disclosure that I notify the hospital of.**

SIGNATURE OF PERSON RESPONSIBLE*

PRINT FULL NAME	DATE

*A “person responsible” means a person defined as a “person responsible” under the Privacy Act 1988 (Cwlth) with amendements including the patient’s partner, family member, carer, guardian, close friend and a person exercising power under an enduring power of attorney.

IN ADDITION: I consent to Western Hospital providing my name and religion/denomination to chaplains registered with the facility so that I may be provided with pastoral care ☐ YES ☐ NO

Should you require any assistance completing this form, please do not hesitate to contact our reception staff.

This page has been left blank intentionally

Patient Questionnaire

WESTERN
YOUR HOSPITAL THAT CARES

We depend on you to provide accurate health screening information. To help us, you are requested to complete this Questionnaire and return with your Admission Form to the hospital at least FIVE days prior to admission. Please complete all three (3) pages If you have any queries, do not hesitate to contact the hospital and the Admissions Officer will be able to assist you. The information you provide will assist us to streamline your hospital admission and discharge, and allow nursing care to be planned to meet your individual needs.	UR: ____________ DRS NAME ____________ SURNAME: ____________ GIVEN NAME: ____________ D.O.B ____________ SEX: ____________ PHONE NUMBER ____________

Please remember to bring with you all your current medication (in original labelled containers) and relevant x-rays to hospital. It is advisable that you do not bring any valuable items into hospital. The hospital cannot take any responsibility for any valuables.

WHAT IS YOUR EXPECTED LENGTH OF STAY? ☐ DAY SURGERY ☐ OVERNIGHT	NUMBER OF DAYS
WHAT IS YOUR ADMISSION DATE?	WHAT IS YOUR PLANNED ADMISSION TIME?
WHAT IS YOUR PLANNED DISCHARGE DATE? (For overnight patients, Day of Discharge – time 1000)	
WHAT HEALTH PROBLEMS ARE YOU BEING ADMITTED FOR?	
WHAT NAME WOULD YOU PREFER TO BE CALLED?	
DO YOU REQUIRE AN INTERPRETER? ☐ YES ☐ NO	SPECIFY LANGUAGE

DISCHARGE PLANNING – please discuss any concerns you may have about your discharge with the Admitting Nurse

DO YOU LIVE ALONE? IF NO, WITH WHOM?	☐ YES	☐ NO
DO YOU RESIDE IN A HOSTEL OR NURSING HOME? (Name & contact number)	☐ YES	☐ NO
DO YOU REQUIRE DVA TRANSPORT TO BE BOOKED?	☐ YES	☐ NO
DO YOU REQUIRE ASSISTANCE WITH ANY ASPECTS OF DAY TO DAY LIVING?	☐ YES	☐ NO
IF **YES**, PLEASE PROVIDE DETAILS:		
DO YOU CURRENTLY RECEIVE ANY HOME SERVICES? (circle) Nursing / Home Help / MOW / Other:	☐ YES	☐ NO
DO YOU ANTICIPATE NEEDING ANY OF THESE HOME SERVICES ON DISCHARGE?	☐ YES	☐ NO
HAVE YOU EVER HAD AN AGED CARE ASSESSMENT? (ACAT)	☐ YES	☐ NO
IF **YES**, PLEASE PROVIDE DETAILS IF YOU HAVE BEEN APPROVED FOR ANY CARE:		

HAVE YOU COMPLETED ANY OF THE FOLLOWING? (tick)

- ☐ Enduring Power of Attorney (Financial Decisions)
- ☐ Enduring Power of Guardianship (Personal Decisions)
- ☐ Medical Power of Attorney (Medical Decisions)
- ☐ Anticipatory Directive

IF YES TO ANY OF THE ABOVE PLEASE PROVIDE A COPY TO THE HOSPITAL

DAY SURGERY PATIENTS – if you are an overnight patient please go to the next section

You must have a responsible adult take you home and stay with you for 24 hours. Nursing staff will contact you 24-72 hours following your procedure. If you have any concerns within this time, please ring Western Hospital on 8159 1200.

WHAT IS THE BEST PHONE NUMBER TO CONTACT YOU ON?		
HAVE YOU ORGANISED HOME SUPPORT OVERNIGHT?	☐ YES	☐ NO
HAVE YOU ORGANISED AN ESCORT AND TRANSPORT FOR DISCHARGE?	☐ YES	☐ NO
NAME OF THE PERSON TAKING YOU HOME?	WHAT IS THEIR PHONE NUMBER?	
RELATIONSHIP TO PATIENT?		

DAY SURGERY PATIENT/CARER DECLARATION:

I, ______________________________ have organised a responsible adult to care for me for the 24 hours following my surgery/procedure and will abide by the instructions that will be given to me by the nursing staff and/or medical officer.

SIGNATURE	DATE

WESTERN
YOUR HOSPITAL THAT CARES

Patient Questionnaire

MEDICATION HISTORY – please ensure you provide details of your allergies or sensitivities	
ALLERGIES/SENSITIVITIES **Nil Known** ☐	**ADVERSE REACTION**
EXAMPLE: Penicillin / Tapes / Food	EXAMPLE: Rash / Nausea / Vomiting / Anaphylaxis

DO YOU HAVE A LATEX (RUBBER) ALLERGY?	☐ YES ☐ NO
IF **YES**, WHAT TYPE OF REACTION DO YOU HAVE?	
DO YOU TAKE ANY ANTI-COAGULANT OR BLOOD THINNING MEDICATIONS? (e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin etc)	☐ YES ☐ NO
HAVE THESE BEEN STOPPED PRIOR TO SURGERY? IF **YES**, DATE STOPPED: / /	☐ YES ☐ NO
DO YOU TAKE ANY STEROIDS, ANTI-INFLAMMATORY DRUGS OR CORTISONE/PREDNISOLONE TABLETS/INJECTIONS? IF **YES**, NAME OF MEDICATION:	☐ YES ☐ NO
HAVE THESE BEEN STOPPED PRIOR TO SURGERY? IF **YES**, DATE STOPPED: / /	☐ YES ☐ NO
DO YOU TAKE SLEEPING TABLETS OR TABLETS FOR ANXIETY, NERVES OR DEPRESSION?	☐ YES ☐ NO
ARE YOU TAKING AN ORAL CONTRACEPTIVE PILL?	☐ YES ☐ NO
ARE YOU BREASTFEEDING?	☐ YES ☐ NO
ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS?	☐ YES ☐ NO
DO YOU SMOKE OR HAVE YOU SMOKED IN THE PAST? IF **YES**, HOW MANY CIGARETTES PER DAY: NUMBER OF YEARS A SMOKER: YEAR CEASED:	☐ YES ☐ NO
DO YOU USE RECREATIONAL DRUGS? IF **YES**, WHAT TYPE AND HOW MUCH?:	☐ YES ☐ NO
DO YOU DRINK ALCOHOL? IF **YES**, HOW MANY STANDARD DRINKS EACH DAY (AVERAGE):	☐ YES ☐ NO

LIST OF CURRENT MEDICATIONS

Please list all medications you are currently taking (prescribed, over the counter, vitamins, complementary).
Please bring in original containers, no dosettes please. Supply a list if more medications are taken.

MEDICATION	DOSE	DIRECTIONS	MEDICATION	DOSE	DIRECTIONS

MEDICATIONS USUALLY ADMINISTERED BY: ☐ SELF ☐ CARER

HAVE YOU HAD ANY RECENT CHANGES TO YOUR MEDICATION?	☐ YES ☐ NO
DO YOU TAKE MORE THAN 5 MEDICATIONS OR TAKE MORE THAN 12 DOSES PER DAY?	☐ YES ☐ NO
DO YOU USUALLY USE A DOSE ADMINISTRATION AID (WEBSTER PACK OR DOSETTE)?	☐ YES ☐ NO
DO YOU HAVE A LOCAL COMMUNITY PHARMACY?	☐ YES ☐ NO
IF **YES**, WHAT IS THE NAME AND CONTACT NUMBER OF THE PHARMACY?	

Patient Questionnaire

WESTERN
YOUR HOSPITAL THAT CARES

SURGICAL HISTORY

What operations or major illnesses do you have or have you had in the past? List any past operations (including any implants e.g. pacemaker, infusaport, epidural steroids etc.) and any major illnesses.

OPERATION AND/OR ILLNESS	YEAR	OPERATION AND/OR ILLNESS	YEAR

QUESTION			STAFF USE ONLY
HAVE YOU EVER HAD AN ANAESTHETIC BEFORE?	☐ YES	☐ NO	
HAVE YOU EVER HAD A SPINAL OR EPIDURAL ANAESTHETIC BEFORE?	☐ YES	☐ NO	
HAVE YOU EVER HAD ANY PROBLEMS WITH ANAESTHETICS?	☐ YES	☐ NO	
IF **YES**, DESCRIBE:			
HAS ANY FAMILY MEMBER EVER HAD ANY PROBLEMS WITH ANAESTHETICS?	☐ YES	☐ NO	
IF **YES**, DESCRIBE:			
IS YOUR ADMISSION THE RESULT OF INJURY DUE TO AN ACCIDENT? (eg sports, fall, car)	☐ YES	☐ NO	
IF **YES**, GIVE DETAILS OF HOW ACCIDENT HAPPENED:			

MEDICAL HISTORY

WEIGHT: KG	**HEIGHT:** CM	**BMI:**

	QUESTION			STAFF USE ONLY
CVS	DO YOU HAVE ANY **HEART PROBLEMS**? (Irregular heart rate, murmur etc)	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU EVER HAD A **HEART ATTACK**? IF **YES**, WHEN:	☐ YES	☐ NO	
	HAVE YOU EVER HAD BYPASS SURGERY? (bypass, valve replacement, stent)	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	DO YOU HAVE A **PACEMAKER** OR **IMPLANTED DIFIBRILLATOR**? (circle)	☐ YES	☐ NO	
	DO YOU HAVE **ANGINA**? DO YOU USE GTN PATCH / SUBLINGUAL SPRAY / TABLETS? (circle)	☐ YES	☐ NO	
	IF **YES**, HOW OFTEN AND DATE LAST USED:			
	DO YOU GET **SHORT OF BREATH**, **CHEST PAIN** OR **PALPATATIONS** AFTER EXERCISE OR CLIMBING STAIRS?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU EVER HAD **HIGH** / **LOW BLOOD PRESSURE**? (circle applicable)	☐ YES	☐ NO	
	HAVE YOU EVER HAD A **CVA** / **STROKE**? IF **YES**, WHEN:	☐ YES	☐ NO	
	IF **YES**, DESCRIBE ANY ON-GOING PROBLEMS:			
	DO YOU HAVE ANY **BLEEDING** / **CLOTTING** / **BLOOD DISORDERS**?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU EVER HAD A **BLOOD TRANSFUSION**?	☐ YES	☐ NO	
	HAVE YOUR EVER HAD ANY REACTIONS TO A **BLOOD TRANSFUSION?**	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			

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Patient Questionnaire

MEDICAL HISTORY

			STAFF USE ONLY
CVS	DO YOU HAVE A HISTORY OF BLOOD CLOTS IN YOUR LUNG? (**Pulmonary Embolism** (PE))	☐ YES ☐ NO	
	IF **YES**, WHICH YEAR:		
	DO YOU HAVE A HISTORY OF BLOOD CLOTS IN YOUR LEG OR ARM? (**Deep Vein Thrombosis** (DVT))	☐ YES ☐ NO	
	IF **YES**, WHICH YEAR:		
	HAVE YOU EVER BEEN DIAGNOSED WITH CANCER?	☐ YES ☐ NO	
	IF **YES**, WHICH TYPE: YEAR DIAGNOSED:		
RESP	DO YOU HAVE **SLEEP APNOEA**?	☐ YES ☐ NO	
	HAVE YOU EVER HAD **SLEEP STUDIES**?	☐ YES ☐ NO	
	DO YOU USE A **CPAP MACHINE**? (For overnight stays please bring your CPAP with you)	☐ YES ☐ NO	
	HAVE YOU EVER HAD **THROAT**, **NOSE** OR **LUNG SURGERY**?	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **LUNG** OR **CHEST CONDITIONS**? (asthma, bronchitis, emphysema)	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	HAVE YOU HAD A **COLD** OR **FLU** IN THE PAST 2 WEEKS?	☐ YES ☐ NO	
MET	DO YOU HAVE **DIABETES**? ☐ INSULIN ☐ TABLET ☐ DIET CONTROLLED *Please check with your doctor regarding your diabetes care before & after surgery*	☐ YES ☐ NO	
	DO YOU HAVE **THYROID PROBLEMS**?	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE **JAUNDICE**, **HEPATITIS** (specify type A, B, C) OR **LIVER DISEASE**?	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **GASTRIC PROBLEMS**? (hiatus hernia, stomach ulcers, reflux)	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **BOWEL PROBLEMS**? (diarrhoea, constipation, incontinence, diverticulitis/stomas)	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **KIDNEY PROBLEMS**?	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **BLADDER PROBLEMS**? (incontinence, frequency, catheter, urgency, burning)	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		
	HAVE YOU HAD ANY RECENT **UNINTENTIONAL WEIGHT LOSS**?	☐ YES ☐ NO	**IF YES, COMPLETE MALNUTRITION HIGH RISK ASSESSMENT**
	IF **YES**, DESCRIBE:		
	DO YOU HAVE ANY **SPECIAL DIETARY REQUIREMENTS**?	☐ YES ☐ NO	
	IF **YES**, DESCRIBE:		

Patient Questionnaire

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MEDICAL HISTORY				
				STAFF USE ONLY
GENERAL	DO YOU HAVE ANY **JAW** OR **NECK STIFFNESS**?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	DO YOU HAVE **DIFFICULTY OPENING YOUR MOUTH WIDE** OR HAVE **LIMITED NECK MOVEMENT**?	☐ YES	☐ NO	
	DO YOU HAVE ANY **BROKEN**, CHIPPED, **LOOSE** OR **WOBBLY TEETH**?	☐ YES	☐ NO	
	DO YOU HAVE ANY **CAPS**, **CROWNS**, **DENTURES** OR **PLATES**?	☐ YES	☐ NO	
	ARE YOU, OR COULD YOU BE, **PREGNANT**?	☐ YES	☐ NO	
FALLS RISK	DO YOU HAVE ANY **MOBILITY PROBLEMS**? (arthritis, back pain, leg weakness)	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	CAN YOU EASILY, WITHOUT STOPPING (PLEASE TICK ONE) ☐ Walk around the house ☐ Walk up one flight of stairs ☐ Walk up two flights of stairs (one floor) ☐ Walk up two flights of stairs (two floors)			
	WHAT PREVENTS YOU FROM WALKING FURTHER?			
	DO YOU USE ANY **MOBILITY AIDS**? FRAME / STICK / CRUTCHES / WHEELCHAIR (please circle)	☐ YES	☐ NO	
	DO YOU SUFFER FROM **DEPRESSION** OR AN **ANXIETY RELATED ILLNESS, SHORT TERM MEMORY LOSS OR OTHER MEMORY PROBLEM**?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	DO YOU HAVE ANY **CIRCULATORY PROBLEMS**? (numbness, tingling, cold hands/feet)	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU EXPERIENCED **FAINTING** OR **DIZZINESS** IN THE PAST 12 MONTHS?	☐ YES	☐ NO	
	HAVE YOU HAD ANY **FITS, CONVULSIONS OR BLACKOUTS**? (epilepsy)	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU HAD ANY **FALLS** IN THE PAST 12 MONTHS?	☐ YES	☐ NO	
	IF **YES**, WHEN AND DESCRIBE:			
	DO YOU HAVE ANY PROBLEMS WITH YOUR **VISION**? (limited, cataracts, glaucoma)	☐ YES	☐ NO	
	DO YOU WEAR GLASSES / CONTACT LENSES ? (please circle)	☐ YES	☐ NO	
	DO YOU REQUIRE **ASSISTANCE** TO SHOWER, DRESS, GET IN/OUT OF BED/CHAIR?	☐ YES	☐ NO	
	DO YOU HAVE ANY **HEARING PROBLEMS**? HEARING AIDS? ☐ LEFT ☐ RIGHT	☐ YES	☐ NO	
	DO YOU TAKE **REGULAR PAIN RELIEF**?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			

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Patient Questionnaire

MEDICAL HISTORY				
				STAFF USE ONLY
INTEG	DO YOU HAVE ANY **OPEN WOUNDS, SKIN BREAKS, FISTULAS OR STOMAS**?	☐ YES	☐ NO	
	IF **YES**, DESCRIBE:			
	HAVE YOU EVER HAD A **MULTI-RESISTANT ORGANISM INFECTION**? (MRSA, Golden Staph, VRE) ***If you are unsure of this please speak to your admission nurse.***	☐ YES	☐ NO	
	DO YOU HAVE OR HAVE YOU HAD ANY OTHER **INFECTIONS** OR **INFECTIOUS DISEASES**?	☐ YES	☐ NO	
	DO YOU HAVE ANY OTHER **CONDITION** OR **INFECTIONS** THAT MAY REQUIRE FURTHER EXPLANATION?	☐ YES	☐ NO	

PATIENT DECLARATION

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT.

PATIENT (OR PARENT/GUARDIAN) NAME: ______________________________ DATE ____ / ____ / ____

PATIENT (OR PARENT/GUARDIAN) SIGNATURE: ______________________________

Thank you for completing this questionnaire. Please return with all of your paper work to Western Hospital as soon as possible.

Note: If you do not have an electronic signature, please submit the form and you will be able to sign the form at the hospital upon admission.

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THIS SECTION IS TO BE COMPLETED BY THE PRE-ADMISSION NURSE
PRE-ADMISSION ASSESSMENT

	DATE OF PRE-ADMISSION?		☐ IN PERSON ☐ TELEPHONE	
	DISCHARGE PLANNING COMMENCED?			☐ YES ☐ NO
	COMMENTS:			
EDUCATION	PRE OP CARE DISCUSSED	☐ YES ☐ NO	TRIFLOW PROVIDED & DISCUSSED	☐ YES ☐ NO
	POST OP CARE DISCUSSED	☐ YES ☐ NO	TED STOCKINGS PROVIDED & DISCUSSED	☐ YES ☐ NO
	PAIN RELIEF DISCUSSED (Analgesia/PCA etc)	☐ YES ☐ NO	ADVISED TO TAKE X-RAYS TO HOSPITAL ON DAY OF ADMISSION	☐ YES ☐ NO
	INFORMATION BOOKLETS PROVIDED (Pain Management, medications etc)	☐ YES ☐ NO	PRE OP PHYSIO REVIEW ARRANGED? DATE ________ / ________ / ________	☐ YES ☐ NO
EQUIPMENT	CRUTCHES	☐ YES ☐ NO	SHOWER CHAIR	☐ YES ☐ NO
	WALKING STICK	☐ YES ☐ NO	HIP CHAIR	☐ YES ☐ NO
	FRAME	☐ YES ☐ NO	REACHING AID	☐ YES ☐ NO
	TOILET RAISER	☐ YES ☐ NO	OTHER	☐ YES ☐ NO
PATHOLOGY	AUTOLOGOUS BLOOD. PATHOLOGY GROUP ______________	☐ YES ☐ NO	ECG DATE ________ / ________ / ________	☐ YES ☐ NO
	GROUP AND SAVE SERUM	☐ YES ☐ NO	MRSA/VRE/MRO SWABS ARRANGED/TAKEN	☐ YES ☐ NO
	BLOODS: CBP E/LFT	☐ YES ☐ NO ☐ YES ☐ NO	RESULTS RETURNED DATE ________ / ________ / ________	☐ YES ☐ NO
	URINE MC&S	☐ YES ☐ NO	PATIENT ADVISED OF COMPLAINTS AND FEEDBACK PROCESS	☐ YES ☐ NO

PRE ADMISSION NURSE SIGNATURE, PRINTED NAME & DESIGNATION ________________________________

THIS SECTION IS TO BE COMPLETED BY THE ADMISSION NURSE
ON ADMISSION DOSA/WARD

DATE OF ADMISSION: / /	TIME: :	NAME BAND WITH CORRECT DETAILS INSITU:	☐ YES	☐ NO
LIST OF PROSTHESIS BROUGHT IN:				
VALUABLES: HAVE THEY BEEN TAKEN HOME?		☐ YES	☐ NO	☐ N/A
LOCKED AWAY SECURELY?		☐ YES	☐ NO	☐ N/A
IF LOCKED AWAY, CUPBOARD/ROOM NO: ________________	LOCKED IN HOSPITAL SAFE?	☐ YES	☐ NO	☐ N/A
MRSA/VRE/MRO SCREEN INDICATED? (HIGH RISK PATIENT)		☐ YES	☐ NO	☐ N/A
SWABS TAKEN? (ON ADMISSION OR IN PRE-ADMISSION)		☐ YES	☐ NO	☐ N/A
PRE-ADMISSION RESULTS REVIEWED?		☐ YES	☐ NO	☐ N/A
MEDICATIONS BROUGHT IN & PRE-ADMISSION DOCUMENTATION FOR MEDICATIONS CONFIRMED?			☐ YES	☐ NO
PATIENT HISTORY FORM CHECKED AND DISCUSSED WITH PATIENT OR CARER?			☐ YES	☐ NO
NEXT OF KIN DETAILS CONFIRMED?			☐ YES	☐ NO

ADMISSION NURSE SIGNATURE, PRINTED NAME & DESIGNATION ________________________________

ORIENTATION BY WARD NURSE FOR OVERNIGHT PATIENTS ONLY

USE OF FACILITY & SERVICES EXPLAINED (INC. TV, CALL BELLS, CUPBOARDS, BATHROOM ETC)	☐ YES	☐ NO
PATIENT HAS BEEN SHOWN THE BEDSIDE COMPENDIUM IN THE BEDSIDE DRAWER?	☐ YES	☐ NO

PHONES, VISITING HOURS, USE OF KITCHEN FACILITIES FOR PATIENTS/VISITORS & DISCHARGE INFORMATION EXPLAINED? ☐ YES ☐ NO

ADMISSION NURSE SIGNATURE,
PRINTED NAME & DESIGNATION ________________________________

DATE: / /
TIME: :

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