

Pre-admission Forms

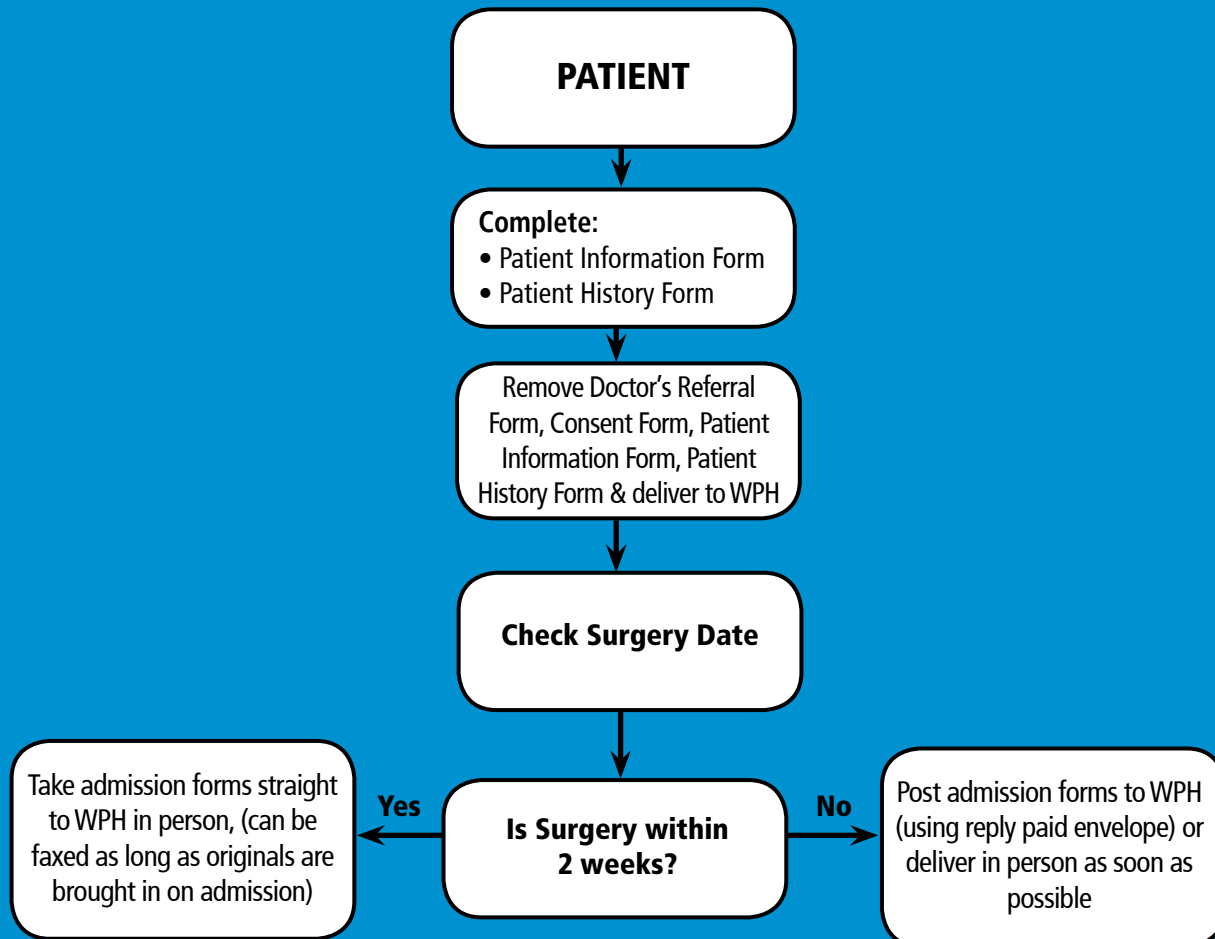


Please take the time to read and fill out the relevant documents as soon as possible

It is essential that the Hospital receives these forms following your visit to the doctor in order to confirm your admission

Date of Operation: _____

Attention Patient



The hospital must receive these forms to confirm your admission.

Please report to the front Reception Desk on arrival. To enable staff to prepare you may be a waiting time between

Patient Information (overnight & day only admissions)

Thank you for choosing Westmead Private Hospital. We hope your stay with us will be as comfortable and pleasant as possible.

PRE-ADMISSION INFORMATION

In order to confirm your admission **it is important that you:**

- Complete all the questions on the Pre-Admission form and the Patient Information form
- Ask your Doctor to complete the Doctor's Referral/Consent form
- Remove the completed forms from the booklet and forward immediately to the hospital in one of the following ways:

In person to Reception (preferably)

(Open 6am – 9pm Monday to Friday), (Open 6am – 8pm Saturday), (Open 8am – 8pm Sunday)

Faxing: (02 9687 9310) Please ensure you bring the original forms on the day of admission

Post: PO Box 161, Westmead 2145

(Please note that for Maternity admissions only original paperwork will be accepted)

It is essential that the hospital receives these forms as soon as possible to confirm your admission.

- If your stay is to be more than 1 night, you require assistance with discharge planning, or you have significant clinical needs, you may be contacted by the Hospital to conduct an assessment over the phone or to arrange a suitable appointment time to visit our pre-admission clinic

The day prior to admission

The Hospital will contact you after 3.30pm on the weekday prior to your admission to:

- confirm admission and fasting times
- discuss your hospital charges and health fund cover

If you have not been contacted by 7pm, please phone (02) 8837 9000 for details.

On the day of admission

Please Bring:

- Any current form of identification e.g. drivers licence
- Medicare Card
- Health fund book / card (if applicable)
- Pension and / or Veteran's Affairs card (if applicable)
- Worker's Compensation or Third Party claim details (if applicable)
- Pharmaceutical Safety Net Card and / or Health Care Card (if applicable)
- Any medications you are currently taking (in their original packets/container)
- Any current x-rays and pathology test results
- Original paperwork if not already supplied
- Mobility Aids, Reading Glasses and Hearing Aids and their cases
- Personal toiletries - (overnight patients only)
- If you have an Advanced Health Directive or an Enduring Power of Attorney for health matters, please bring a certified copy of these with you

Before Surgery

- Bathe or shower
- Wear loose, comfortable clothing
- DO NOT EAT, DRINK (even water), OR CHEW anything for at least 6 hours before the time of your operation (unless you are given specific instructions by your doctor or the pre admission nurse). If you are on regular

adequately for your procedure and to allow time for anaesthetic consultation, there your admission and procedure time.

medication please consult your doctor before taking your medication

- DO NOT smoke or drink alcohol 24 hours prior to admission
- DO NOT wear make-up, nail polish or jewellery (a wedding ring is permitted)
- DO NOT bring large amounts of luggage or valuables to hospital. We do not accept liability for any items brought into the hospital

ACCOUNTS / FEES

Insured patients

Please contact your private health fund to confirm your level of cover and whether you have an excess, co-payment or exclusion on your policy. In the event that you do have an excess or co-payment, these will be payable at the time of your admission.

Claims for hospitalisation will be made directly to your health fund by the hospital. Depending on your health fund, some ancillary items may appear separately on your hospital account. For items such as pathology, radiology, physiotherapy, ambulance, pharmacy, and doctors involved in your hospital care, such as surgeons, intensivists, surgeon's assistant, and anaesthetist, you will receive a separate account from the provider.

Self funded patients

Privately paying patients will be required to pay the estimated cost of hospitalisation on admission. Other costs which may be incurred during your stay will be payable when your invoice is finalised following discharge.

DISCHARGE

- Discharge time is 9am sharp (except day only patients who will be advised of their approximate discharge time on admission)
- Please stop at Reception in the main foyer to be discharged and to finalise your account
- If you have had a general anaesthetic or sedation you must NOT drive or drink alcohol for the first 24 hours, so please make arrangements for a responsible adult to drive you home. For overnight patients your doctor will advise when you are able to drive again
- Before you leave the hospital our staff will give you full instructions about dressings, medications and follow-up appointments. If you are taking regular medications you should discuss this with your doctor
- Collect any x-rays or medication you brought with you on admission

Day Only Patients

Day Surgery admissions have been specifically designed with a short stay in mind. However, if the need arises for you to remain in hospital overnight, you will be transferred to a suitable ward. We ask that you set aside the whole day for your admission. Due to limited space within the Day Surgery Unit, only ONE relative/person is to accompany you to this area. This person may stay with you until you go to the operating theatre. Once the Day Surgery Nurse has finished your admission, you will be taken to a shared waiting room and provided with a gown to put on. A bag will be provided for your clothes, you do not require sleepwear.

Post Surgery

After your procedure you will be taken to the recovery area. During this time, our nursing staff will continually monitor your progress and comfort.

Your length of stay in the recovery area will depend on your operative procedure. Usually patients are discharged between two and four hours after treatment.

After You Get Home

Depending on the surgery performed, some patients may experience certain sensations including: pain, nausea, sore throat, muscle pain, disturbed ability to concentrate. If you experience any other problems immediately following surgery please call the hospital on (02) 8837 9000. Should your symptoms persist beyond 24 hours, or you have any concerns please contact your doctor immediately, or the hospital after hours.

General Hospital Information

ACCOMMODATION

At Westmead Private Hospital our aim is to make your stay as pleasant and comfortable as possible. We offer a high standard of accommodation with both shared and private rooms. All rooms have ensuite facilities, specifically designed for maximum access.

While we will make every endeavour to provide you with your accommodation preference, please understand that in certain circumstances of high activity or emergency admissions, it may be necessary to offer you a shared room.

CHAPLAINCY SERVICE

Pastoral care volunteers can be organised to visit with you during your inpatient stay.

COFFEE SHOP

The coffee shop is located in the atrium and caters for a variety of needs. Offering delicious beverages, tortes and sandwiches.

COMPLIMENTS / FEEDBACK

We welcome compliments and feedback relating to your stay with us and we encourage all patients to complete a Customer Comment Card, located at the nurse's station or from Reception. This enables us to evaluate and improve our services to our patients. These comment cards are anonymous, however if you wish to write a specific and signed letter, your points will be acknowledged and dealt with appropriately.

If you are concerned about your care or the hospital services we encourage you to speak to the Nursing Unit Manager on the Ward, the Director of Clinical Services or the Chief Executive Officer during the day and the After Hours Co-ordinator out of hours. It is important that you endeavour to resolve any matter with the hospital whilst an inpatient. Should you feel that the matter requires independent hearing, please feel free to write to:

The Director General
NSW Department of Health
73 Miller Street
North Sydney NSW 2060

or

The Commissioner
Health Care Complaints Commission
Locked Mail Bag 18
Strawberry Hills NSW 2012

INTERPRETER SERVICE

If the services of an interpreter are required, contact the hospital prior to admission so that the necessary arrangements can be made. There may be a cost associated with this service.

MOBILE PHONES

Mobile phones are not permitted for use within the Hospital.

PARKING

For your convenience we have designated parking areas for visitors. Disabled parking is also available at the front entrance and both sides of the building. Please pay for parking at the booth located at the exit. Please observe restricted parking spaces for doctors and other designated areas.

PHYSIOTHERAPY

An independent physiotherapy practice provides comprehensive assessment and treatment to hospital inpatients. Physiotherapy is often a routine part of certain procedures or may be ordered by your treating doctor.

For certain physiotherapy services a separate account will be sent to you which you may be able to claim from your health fund. Where possible, all fees and charges will be discussed with you prior to the commencement of treatment.

PRIVACY

Westmead Private Hospital complies with the Commonwealth Privacy Act. Please refer to the Ramsay Privacy Policy on page 8.

SMOKING

Westmead Private Hospital is a no smoking facility.

SPECIAL DIETS

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

STAYING WITH CHILDREN IN HOSPITAL

We encourage a parent to stay with their child throughout their hospitalisation. We also encourage parents, where possible, to take an active role in the care of their child as this minimises their anxiety.

VALUABLES

Please do not bring jewellery or large amounts of money to hospital. The Hospital cannot accept responsibility for any valuables.

VISITING HOURS

Visiting hours must be strictly adhered to so that patients have adequate rest time.

- General 10am to 12 noon, 3pm to 8pm
- Maternity 11am to 12 noon, 6pm to 8pm (partners and siblings are welcome any time)

VISITORS (DAY SURGERY)

Please limit accompanying relatives to one per family.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS

WHAT THIS MEANS

Access

I have a right to health care.

I can access services to address my healthcare needs.

Safety

I have a right to receive safe and high quality care.

I receive safe and high quality health services, provided with professional care, skill and competence.

Respect

I have a right to be shown respect, dignity and consideration.

The care provided shows respect to me and my culture, beliefs, values and personal characteristics.

Communication

I have a right to be informed about services, treatment, options and costs in a clear and open way.

I receive open, timely and appropriate communication about my health care in a way I can understand.

Participation

I have a right to be included in decisions and choices about my care.

I may join in making decisions and choices about my care and about health service planning.

Privacy

I have a right to privacy and confidentiality of my personal information.

My personal privacy is maintained and proper handling of my personal health and other information is assured.

Comment

I have a right to comment on my care and to have my concerns addressed.

I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Privacy Policy

When you are admitted to hospital, you will be given a Privacy Statement which you will be asked to sign.

Ramsay Health Care is bound by the National Privacy Principles under the Privacy Act 1988 (Cth) and other laws about how private health service providers handle personal information. Ramsay Health Care complies with privacy laws in the way we collect, use, disclose and store your personal information.

The Privacy Statement below is a short version of how Ramsay Health Care will handle your personal information. For further information or to receive a copy of our full Privacy Policy, please ask a staff member, visit our website (www.ramsayhealth.com) or telephone the Hospital and ask to speak with our Privacy Officer. You can also write to our Privacy Officer to ask for more information.

Ramsay Health Care collects your personal information so that it can provide you with health care and for directly related purposes. For example, Ramsay Health Care may collect, use or disclose personal information:

- for use by a multidisciplinary treating team
- when working with health professionals, Medicare or your health fund
- in an emergency where your life is at risk and you cannot consent
- to manage our hospitals, including risk management, quality assurance and accreditation processes
- to teach health care workers
- to keep medical records as required under our policies and by law or
- for other purposes required or permitted by law.

Personal information may be shared between Ramsay Health Care facilities to coordinate your care. Some of our services are provided by outside organisations. This may mean that we share your personal information with third parties. For example, the contractor who conducts our patient satisfaction surveys may write to you for feedback about your experience with Ramsay Health Care. Your medical records may also be archived with an outside organisation. When we outsource our services, we make sure that their contracts with Ramsay Health Care comply with all laws about the privacy and confidentiality of your personal information.

Ramsay Health Care usually collects your personal information directly from you, but sometimes may need to collect it from someone else (for example, a relative or another health service provider). We will only do this if you have consented or where your life is at risk and we need to provide emergency treatment.

We will not use or disclose your personal information to any other persons or organisations for any other purpose unless:

- you have consented
- the use or disclosure is for a purpose directly related to providing you with health care and you would expect us to use or disclose your personal information in this way
- we have told you that we will disclose your personal information to other organisations or persons or
- we are permitted or required to do so by law.

You have the right to access your personal information in your health record. You can also ask for us to change your health record if you think that it is inaccurate.

Westmead Private Hospital

Doctor's Referral Form

To be completed by Doctor. Please PRINT clearly.

Please Admit

Mr, Ms, Mrs, Dr, Miss, Master: Surname Given Names

Address:

Telephone: Home Business Mobile

Date of Birth: / / Sex:

UR No.:	Admission No.:
Surname:	OFFICE USE ONLY
Given Names:	
Date of Birth:	Doctor:

Patient Details

Clinical Details

Presenting Symptoms:

Provisional Diagnosis:

Other conditions present:

History of Diabetes: Yes No Insulin injection Tablet Diet

Current medications:

ALLERGIES:

Admission Details

Proposed operation/treatment:

Date of Admission: / / **Expected length of stay:** Day Only Overnight or longer nights

Date of Operation: / / ICU request: Yes No Intubated: Yes No Image intensifier: Yes No

Estimated duration of operation: mins

Expected Item Number(s):

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Equipment Details:

Implantable device: Implanting Device
 Removing Device

Type:
Company: Contacted

Type:
Company: Contacted

Will the prosthesis used attract a gap payment? No Yes If so, gap estimate \$

Has informed financial consent been provided? Yes No

Patient Signature.....

Pre-operative instructions (including tests required):

Pre-admission clinic attendance required. **Please ensure your patients receive the pre-admission clinic Patient Information leaflet.**

Pathology tests:

Investigations: xray/ultrasound ECG Other.....

Drug Orders on Admission (drug order valid 24 hours only).....

Special Instructions:

Obstetric Details:

Parity: EDC: / / Blood Group: Rh: Hb:

Anti-D & agglut screen: Rubella HIA titre: HBs Ag:

*Consent (over page) to be completed and signed

Detach Along Perforation

Doctor's Referral Form

Consent Form

Request/Consent Form for Surgical Operation Procedure and/or Medical Treatment

UR No.: Admission No.:
Surname:
Given Names:
Date of Birth: Doctor:

OFFICE USE ONLY

Patient Details

Consent Form

Part A To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed and/or /
of his/her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risks of the following recommended operation/procedure(s).

Procedure/Reason for Admission:
(Please print)

- Procedure site
Procedure side of body: Right [] Left [] Both [] Not Applicable []
Patient does NOT consent to having a blood or blood products transfusion.
Interpreter used: Name of RHC accredited Interpreter: Language:
Sight Translated [] (NSW) Verbally Interpreted [] (NSW)

Treating RHC Accredited Practitioner / Doctor

Signature Print Name Date

Part B To be completed by the PATIENT / Person Responsible

I acknowledge that:

Doctor and I have discussed the treatment of my / patients condition.

- I have consented to the Operation / Procedure as described above.
Ramsay employees will administer care / treatment under my treating Doctors direction, or in an emergency, medical and nursing care will also be delivered as required.
I understand the explanation the Doctor gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) as discussed by my Doctor above.
I have had the opportunity to ask questions and these have been answered in a way I understand by my Doctor above.
I have read / seen / heard and understand the following where applicable.
Information sheet(s)
Multimedia presentation(s)

Where applicable which explains the operation / procedure(s) and the risks involved.

- I am able to withdraw this consent in writing at anytime prior to the commencement of treatment / procedures.

Patient / Responsible person(s) Signature Date

Print name of patient / person responsible
If person responsible signs, state relationship to patient eg: mother / father / husband

Detach Along Perforation

Westmead Private Hospital Patient Information Form

To be completed by Patient or complete online
at www.westmeadprivatehospital.com.au

Please PRINT clearly. Your responses are valuable in
planning your admission and caring for you during your stay.

UR No.: Admission No.:
Surname:
Given Names:
Date of Birth: Doctor:

OFFICE USE ONLY

Patient Details

Admission Details

Date of Admission: / / Date of Operation: / /
Admitting Doctor:
Reason for Admission:

Personal Details

Title: Surname: Previous Surname (if applicable):
Given Names: Preferred Name:
Address: Suburb: State:
Postcode: PO Box:
Telephone (Home): Mobile: (Business):
Date of Birth: / / Age: Sex: Male Female
Employment/Occupation: Child (not at school) Employed Home Duties Retired Other
Marital Status: Married or Defacto Never married Widowed Divorced Separated
Country of Birth: Are you a permanent resident of Australia? Yes No
Are you of Aboriginal/Torres Strait Islander (TSI) descent? No Yes, Aboriginal Yes, TSI Yes, both Aboriginal and TSI
Religion: Would you like a religious visit? No Yes
Main language spoken at home:

Person To Contact (Next of Kin)

Title: Name: Relationship to patient:
Address: Suburb: State:
Postcode: Telephone (Home): (Business): Mobile:

Person Responsible For Account

Is the Patient responsible for this account? Yes (Go to next section) No (Complete this section)
Title: Name: Relationship to patient:
Address: Suburb: State:
Postcode: Telephone (Home): (Business): Mobile:

Entitlements

Medicare Card No: [] [] [] [] [] [] [] [] [] [] Medicare Reference No*: Medicare Expiry Date:
Pension/Health Care Card No: [] [] [] [] [] [] [] [] [] [] Expiry Date: *No. to left of your name
Safety Net No: [] [] [] [] [] [] [] [] [] [] on Medicare Card
Repatriation No: [] [] [] [] [] [] [] [] [] [] Card colour: White Gold Other

Payment of Account is by:

Private Health Insurance Workcover/Third Party Repat/Veterans Affairs Workers Comp Fully by patient

Private Health Insurance

Fund Name: Membership No: Date Joined: / /

PLEASE TURN OVER AND COMPLETE BACK OF FORM

Detach Along Perforation

Patient Information Form

Previous Hospitalisation

Have you previously been a patient at this Hospital? No Yes Name admitted under: Year:
Have you been hospitalised within 7 days prior to this admission? No Yes
If yes, which Hospital? Admission date: Discharge date:
Were you a Private patient Public patient

Who is your GP / Local Doctor

Full name of GP:
GP Address:
GP Telephone: GP Facsimile: GP email:
Please list specialists, for example Cardiologist, Physician etc. that you have recently consulted.
.....
Do you have an Advanced Health Directive? (A document in which you give instructions about your future health care) Yes No

Preferred Accommodation (overnight patients only)

Whilst every effort is made to accommodate your request, we cannot always guarantee availability on the day of admission.
Please indicate your preferred accommodation: Shared Room Single Room

WorkCover / Third Party / Workers Comp

Workcover Third Party Workers Comp (Please tick one box)
▪ The **approval letter** for this admission (from your insurance company) must accompany this form.
Insurance Company Details: Name of Insurance Company:
Claim No: Authorised by:
Employer Details: Name of Employer:
Address Street: Suburb:
State: Postcode: Telephone: Date of Accident: / /
HR/Manager Contact: Fax:

Liability to be signed by patients (or guardians)

I certify that the above information is true, to the best of my knowledge and I also accept full responsibility for accounts rendered by Westmead Private Hospital including any shortfall in reimbursement by my health fund.
Signature of person responsible for account: Date / /

(Office Use Only)

Proposed operation/s: 1

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 2

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 3

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 4

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Diagnosis Description:
Admitting Doctor: Consent with split Yes No

Quoted	
Excess	
Co-payment	
TOTAL PAYABLE ON ADMISSION	\$

Comments:
.....
.....
.....
.....
.....

Paid \$

Receipt No.: Date:

Do you have or have you ever had any of the following conditions?	Circle as appropriate		Details
	NO	YES	
Have you any wounds or breaks on your skin?			
Have you ever had MRSA or VRE?			
Have you ever been involved in a "look back" for CJD or alternatively received an "In Medical Confidence" letter notifying you of a potential exposure to CJD?			
Do you have any other conditions or infections that may require further explanation?			

GENERAL PRACTITIONER AND OTHER DOCTORS

Who is your regular GP?

Please list any specialists, for example Cardiologist, Physician etc. that you have recently consulted.

	NO	YES	SPECIFY DETAILS
Have you or anyone in your immediate family ever had a reaction to an anaesthetic?			Details of reaction:
Have you ever had a reaction to a blood transfusion?			Details of reaction:

PROSTHESIS / AIDS / OTHERS	NO	YES	
Glasses / Contact Lenses			
Hearing Aid or other hearing appliance			
Dentures / Caps / Crowns / Loose teeth			

LIFESTYLE	NO	YES	
Have you ever smoked?			Daily amount: _____ or Date ceased: ____ / ____ / ____
Do you drink alcohol?			Daily amount: _____
Do you use recreational drugs?			Type: _____ Daily amount: _____
Do you require a special diet?			Type of diet: _____
Have you a fear of falling or have fallen within the last 12 months?			
Have you experienced fainting or dizziness in the last 12 months?			

Do you have an Advanced Health Directive? (A document in which you give instructions about your future health care) Yes

DISCHARGE PLANNING

Do you live alone?			
Do you have someone to look after you after discharge?			Name of person: Relationship: Contact No:
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			
Do you require assistance with any aspect of day to day living?			
Where do you plan to go after discharge?	<input type="checkbox"/> Home	<input type="checkbox"/> Rehabilitation	

If Rehabilitation, preferred location?

REHABILITATION INFORMATION

Information on the rehabilitation programs at Mt Wilga, Hunters Hill and Castlecrag Hospitals is available:

- On the internet...please visit <http://www.ramsayhealth.com.au>
- Alternatively, call our pre-admission clinic on 02 8837 9278 and we will post you information on the relevant rehabilitation hospital

NURSES USE ONLY

Name of admitting nurse: _____

Signature: _____ Designation: _____

Date: ____ / ____ / ____ Time: ____: ____

NB: IF 'YES', Discharge planning, Allergies or Falls questions: **PLEASE REFER TO RELEVANT POLICY**



If you have any questions about the admission process, completion of forms, costs or health insurance status, our pre-admission staff will be happy to assist you.

Ph: 02 8837 9000



Westmead Private Hospital
Corner Mons & Darcy Roads
Westmead NSW 2145

ph: 02 8837 9000 – fax: 02 9687 9095

Admission fax: 02 9687 9310

www.westmeadprivate.com.au