



Please read this booklet and return the completed forms to the Hospital as soon as possible after your appointment with your specialist.

For your convenience, you can also fill these forms in online. Visit the hospital website and click on the **online admission forms** link or visit **[www.yourhealthportal.com.au](http://www.yourhealthportal.com.au)**

Ramsay Health Care

# Admission Information Booklet

Patient information

WESTMEAD  
PRIVATE HOSPITAL



## Thank you for choosing our hospital

### Please ensure all forms are forwarded to the hospital promptly in order to confirm your admission.

In order to ensure your admission is streamlined, we request that you complete this hospital admission form prior to your admission date.

You will need approximately 30 minutes to fill in this form. It may be faster and easier for you to fill in the form online. Visit the hospital website and click on the online admission form or visit **[www.yourhealthportal.com.au](http://www.yourhealthportal.com.au)**. By completing your admission form online, some of this information will be retained for future admissions and will only require updating.

**We apologise for the length of these forms but much of the information required is dictated by Commonwealth or State legislation or is required by your health fund.**

### To assist you with this process, it is advisable that you have the following information at hand:

- Personal/Next of Kin details
- Medicare Card
- Funding details (eg DVA, Private health insurance, workcover or self funding)
- Benefit details (eg pharmacy benefit card or pension card)
- Item numbers if these were quoted by doctors' rooms
- Information your doctor supplied to you re implantable medical devices (eg prosthetic and disposables) – if applicable
- Medication information

*If you have private health cover, we recommend you contact your health fund prior to admission to check for any excess or waiting periods. We know that health and billing charges can be difficult to understand and we are happy to assist in any way we can, however we also advise that you seek clarification from your doctor and health fund.*

When you have completed filling in this admission form (and unless you have completed the forms online), please return it to the hospital in one of the following ways:

**a. Post to**

Westmead Private Hospital

PO Box 161, Westmead NSW 2145

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

**b. Fax to** (02) 9687 9310 if faxing, please bring the original forms on the day of admission; or

**c. Email to** [wmprecp@ramsayhealth.com.au](mailto:wmprecp@ramsayhealth.com.au)

**d. Hand deliver to hospital reception (open 6am – 9pm Monday to Sunday).**

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

### 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.

Westmead Private Hospital  
Cnr Mons & Darcy Roads, WESTMEAD NSW 2145

Tel: (02) 8837 9000

Fax: (02) 9687 9310

Web: [www.westmeadprivate.com.au](http://www.westmeadprivate.com.au)



## Booking online?

Head to **[www.westmeadprivate.com.au](http://www.westmeadprivate.com.au)**  
& follow the **Pre Admission Form** links!

# Preparing for your Admission

We are committed to providing patients with the highest standards of care. Throughout your stay, from pre-admission to discharge, you will be treated with the utmost respect and dignity.

After you have completed and returned the attached forms (or completed the online forms) you may be contacted by telephone prior to your day of admission by a preadmission nurse to get further details.

Your doctor will also explain your procedure or operation and complete the enclosed consent form with you.

## Preadmission

You may be asked to attend a preadmission clinic or contacted by the hospital preadmission nurse prior to your admission so we can speak with you about your hospital stay, your operation, previous surgical and medical history, what to bring to hospital, as well as allay any concerns you may have.

Discharge planning will also be addressed at this time (eg who will care for you at home on discharge, who will take you home etc). You are welcome to bring a relative or friend to this clinic.

## Day of Admission

### On the day of admission

You will be informed of the scheduled time for your surgery and subsequent 'nil by mouth' time by your doctor or the hospital.

#### Fasting Time

This is a period of time, prior to your operation, when you will have a restricted diet or not be allowed to eat or drink (including water). This time is determined by your Anaesthetist or Surgeon and is related to factors such as your age and the type of operation. It is imperative that fasting times be observed for your safety during your anaesthetic.

If you have any questions about your fasting times please check with your doctor or contact the hospital.

Please shower before your admission to hospital.

**Please bring with you into hospital anything applicable to your admission including:**

- doctor's admission letter
- consent form (if not already returned to the hospital)
- health fund number / details (if applicable)
- medicare card
- regular medications in original packaging
- pension health benefits card (if applicable)
- pharmaceutical benefits card (if applicable)
- relevant x-rays and / or test results
- for a child - favourite toy, formula, bottle and any special dietary needs (if applicable)
- Children may go to the procedure/theatre in their own pyjamas. These pyjamas must be cotton or cotton interlock with button through/loose fitting tops
- comfortable closed in shoes/slippers with non-slip soles
- night attire (if staying overnight)
- toiletries
- aides such as walking sticks, hearing aides or glasses
- personal articles i.e. sanitary pads (if applicable)
- method for settling your account
- certified copy of Advanced Health Directive or Enduring Power of Attorney (if available)
- please do not bring valuables as the hospital will not be liable for any loss

#### DO NOT:

- Smoke cigarettes or **chew gum**
- Wear jewellery. A wedding ring and watch are permitted
- Bring valuables ie. mobile phones and large amounts of cash. Mobile phones can interfere with some medical devices and may not be able to be used whilst in hospital.
- Wear make-up or nail polish

If you are feeling unwell (eg cold/flu) and are unsure if you are well enough for your procedure, please contact your treating doctor or GP for advice before admission.

## Day procedure patients (additional information)

- Please shower with soap on the day of admission before coming to the Day Procedure Unit and put on clean clothes
- Wear garments that are comfortable and easy to remove
- Check with your nurse before informing relatives / friends regarding the time that you should be picked up

## Day Patients

If you are coming into hospital as a day only patient (no overnight stay) then there are a couple of important things to note.

The major effects of your anaesthetic or sedation wear off quickly, however minor effects on memory, balance and muscle function may persist for some hours. These effects vary from person to person and are not individually predictable. Because of this please note the following:

### Important information

- **You are not permitted to drive for at least 24 hours after a general anaesthetic or sedation.**
- **A responsible person must be available to transport you home in a suitable vehicle. A train or bus is usually not suitable.**
- **A responsible person must be available to stay at least overnight following discharge from the Day Surgery Unit. This person must be physically and mentally able to make decisions for you if necessary.**
- **You must have ready access to a telephone in the post operative dwelling.**
- **You must remain within 1 hour of appropriate medical attention until the morning after discharge.**
- **You should not operate machinery or make any important decisions for at least 24 hours after your anaesthetic.**

## Overnight patients

For patients staying overnight at hospital, please check your hospital website for information regarding the services and facilities that are available to you during your stay such as internet access, telephones, televisions, visiting hours and other relevant information.

There is some important information that we would like to share with you here about keeping safe and well during your stay in our hospital:

### Infection Control

This hospital is committed to providing all patients with the highest quality of care by preventing the spread of infection.

Hand washing, high standards of housekeeping, and the use of sterile techniques and equipment are all part of our service to ensure your speedy recovery and to reduce the risk of infection.

Patients and visitors also have a role to play in reducing the risk of infection to themselves and other patients. Here are a few very simple guidelines:

- Hand hygiene is the most effective way to prevent the spread of infection. Alcohol based handrubs are a very effective form of hand hygiene and are located at strategic locations in the hospital. We encourage all patients and visitors to use these.
- We ask that people do not visit the hospital if they have gastroenteritis or other contagious diseases.



## Falls Prevention

The unfamiliar environment of a hospital combined with the fact that you may be on medication or fatigued can increase the likelihood of falls in hospital. Below are a few ways that you can reduce the risk of falling whilst in hospital:

- Take special care when walking or taking to your feet particularly if you are on pain-relieving drugs or other medications.
- Ensure you know the layout of your room and take care when moving around at night. Please use your call bell if you need assistance.
- Check the floors in your area to ensure they are not wet before walking. Avoid using talcum powder which makes floors slippery.
- Ask your nurses for assistance if you need to use the toilet and feel unsteady on your feet.
- Loose or full-length clothing can cause you to trip. Ensure your clothing is the right length for you.
- Check that your slippers or other footwear fit securely. If your doctor has requested you to wear pressure stockings then it is a good idea to also wear slippers over the top to reduce the risk that you may slip. Rubber soled slippers are ideal footwear whilst in hospital.

## Medication Safety

Please provide your nurse with any tablets or medicines (or prescriptions for these) that you have been taking before admission. These will be secured in a personal drug cabinet. Any additional medication you require while in hospital will be ordered by your doctor and supplied to you. When you are discharged, medications that you are required to take will be provided to you to take home.

## Pressure Injury Prevention

A pressure injury is an area that has been damaged due to unrelieved pressure. They may look minor, such as redness on the skin, but can hide more damage under the skin surface.

It is important that you relieve pressure by keeping active and changing your position frequently when you are lying in bed or sitting in a chair. If you are unable to move by yourself, the staff will help you change your position regularly. Special equipment such as air mattresses and booties may be used to reduce the pressure in particular places.

Tell staff if you have any tenderness, or soreness over a bony area or if you notice any reddened, blistered or broken skin.

## Blood Clot Prevention

Blood clotting is the body's natural way of stopping itself from bleeding. Clotting only becomes an issue when it is in the wrong place and blocks blood flow. Being immobile is a big risk in developing a clot and so blood clotting can increase when you are staying in hospital and spending a long time immobile.

In addition, there are a number of risk factors to blood clotting including previous strokes, inherited blood clotting abnormalities, lung disease, being overweight having had major surgery in the past or heart failure, smoking or contraception medications. If you have any of these risk factors, please alert your doctor or the staff.

While in hospital, staff will assess your risk of developing a clot and may ask you to wear compression stockings or sleeves, or they will provide you with blood thinning medication.

Staying mobile, taking any prescribed medications to reduce your risk of blood clotting, drinking plenty of fluid and avoid crossing your legs can reduce your risk of clotting.

If you have sudden increased pain or swelling in your legs; pain in your lungs or chest; difficulty in breathing, please alert your nurse as soon as possible. If these symptoms occur after discharge, seek emergency treatment.

## When You Leave

Before you leave hospital, please make sure you have the following:

- a discharge letter
- all personal belongings
- all personal x-rays
- all current medications
- follow-up appointment requirements

On your way out, please see staff at the Reception, to complete any discharge information.

If you have any excessive pain or are generally concerned about your condition after you leave hospital please contact your specialist, your GP or ring the hospital directly.

## Payment Information

It is very important that you approach your admission to hospital well informed of the financial consequences. Please read the following information and contact your hospital if you have any concerns or queries.

**Privately Insured Patients** - should confirm with your health fund prior to admission the following:

- Does my policy cover me for this procedure?
- Do I have an "excess" payment on my insurance policy?
- Are there any co-payments required for each night I will be in hospital?
- Does my policy exclude some treatments, for example cardiac, orthopaedic or rehabilitation?
- Are any prosthetic or disposable items used in the surgery not covered by my insurance?

Please note that if you have been a member of your health fund for less than 12 months your fund may not accept liability for the costs of this admission, eg if your condition or any symptoms of your condition existed prior to you joining your health fund. Any excess will be required to be paid on admission.

**Repatriation (DVA) Patients** – Gold card holders are covered for all care. White card holders are covered subject to approval by DVA.

**WorkCover Patients** – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed by your insurance company.

**Third Party Patients** – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed by your insurance company. Please bring full details of claim, including letter from insurance company with you.

**Uninsured Patients** – total payment (aside from any ancillary charges) must be made on admission. Please contact the hospital prior to admission for an estimate of fees and charges. As it is an estimate only, in the event of unforeseen complications or variations from the proposed treatment the cost may vary.

**Overseas Patients** – If you are insured with an overseas company, you will be asked to pay the estimated cost on admission. Please contact the hospital prior to admission for an estimate of fees and charges. As it is an estimate only, in the event of unforeseen complications or variations from the proposed treatment the cost may vary.

**What costs could I incur that will not be covered by my health fund?**

- Pharmacy (medicines required during your admission and discharge medications)
- Pathology (eg blood tests)
- Imaging or x-ray
- Medical and allied health practitioner's fees may be billed separately by the practitioner. Please discuss these with your doctor before your admission. You may receive separate accounts for:
  - Surgeon
  - Anaesthetist
  - Assisting Surgeon
  - Other consultants

- Emergency Centre attendance (if the hospital has an emergency centre and you received treatment in the centre prior to your admission a separate account will be rendered for these services)
- The following incidental items may not be covered by your health fund and will be payable on admission or discharge from the hospital\*:
  - STD telephone calls;
  - Standard **Fee for Incidentals** may apply during your admission.

This relates to Foxtel/Austar and wifi services or business centre access. Please check the hospital website before you are admitted for further information.

*\* Not all hospitals offer these services. Please check at time of admission.*

#### How do I pay?

For your convenience, payment may be made by cash, EFTPOS, Bank cheques, MasterCard or Visa. If you are wanting to pay by Amex or Diners, please check with your hospital if these cards are accepted.

If you have any further questions, please call the hospital's patient accounts department.

## Privacy Policy

Ramsay Health Care is bound by the Australian Privacy Principles under the Privacy Act 1988 (Cth) and other relevant laws about how private health service providers handle personal information. We are committed to complying with all applicable privacy laws which govern how Ramsay Health Care collects, uses, discloses and stores your personal information.

The Privacy Statement sets out in brief 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.au](http://www.ramsayhealth.com.au) or telephone the Hospital and ask to speak with our Privacy Officer. You can also write to our Privacy Officer to request more information.

Ramsay Health Care will collect your personal information for the purpose of providing 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;
- To liaise 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 for processes relating to risk management, safety and security activities and quality assurance and accreditation activities;
- For the education of health care workers;
- To maintain 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. We also outsource some of our services. This may involve us sharing your personal information with third parties. For example, we outsource the conduct of our patient satisfaction surveys to a contractor who may write to you seeking feedback about your experience with Ramsay Health Care. We may outsource information and data storage services (including archiving of medical records), which may involve storing that information outside of Australia. Where we outsource our services we take reasonable steps in the circumstances to ensure that third parties, including organisations outside of Australia, have obligations under their contracts with Ramsay Health Care to comply with all laws relating to the privacy (including security) and confidentiality of your personal information.

Ramsay Health Care will usually collect 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 request an amendment to your health record should you believe that it contains inaccurate information.

# 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](http://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.

## CONTACTS

It is always best to try to resolve your complaint with your local health service provider. If you have tried this and are still unsatisfied, you can make a complaint to the Health Care Complaints Commissioner in your state or territory. Some useful contact information is listed below:

- ACT Human Rights Commission, Health Services Commissioner - [www.hrc.act.gov.au](http://www.hrc.act.gov.au) - (02) 6205 2222
- NSW Health Care Complaints Commission - [www.hccc.nsw.gov.au](http://www.hccc.nsw.gov.au) - 1800 043 159
- NT Health and Community Services Complaints Commission - [www.hcsc.nt.gov.au](http://www.hcsc.nt.gov.au) - 1800 004 474
- QLD Office of the Health Ombudsman - [www.oho.qld.gov.au](http://www.oho.qld.gov.au) - 1800 077 308
- SA Health & Community Services Complaints Commissioner - [www.hcsc.sa.gov.au](http://www.hcsc.sa.gov.au) - 1800 232 007
- TAS Health Complaints Commissioner - [www.healthcomplaints.tas.gov.au](http://www.healthcomplaints.tas.gov.au) - 1800 001 170
- VIC Office of the Health Services Commissioner - [www.health.vic.gov.au/hsc](http://www.health.vic.gov.au/hsc) - 1800 136 066
- WA Health & Disability Services Complaints Office - [www.hadsc.wa.gov.au](http://www.hadsc.wa.gov.au) - 1800 813 583

# Important Information

**DOCTOR OR PATIENT TO RETURN THE FOLLOWING TWO PAGES [RHC003] TO THE HOSPITAL AS SOON AS POSSIBLE FOLLOWING CONSULTATION CONFIRMING ADMISSION. FORMS CAN BE RETURNED VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.**

**RAMSAY HEALTH CARE**

**ADMISSION REFERRAL FORM**  
TO BE COMPLETED BY DOCTOR  
Please PRINT clearly in block letters.

**Please Admit**  
Mr, Ms, Mrs, Dr, Miss, Master: \_\_\_\_\_ Surname \_\_\_\_\_ Given Names \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Home \_\_\_\_\_ Business \_\_\_\_\_ Mobile \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_

**Admission Details** Facility to be admitted to: \_\_\_\_\_  
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  
**Indication for ICU:** \_\_\_\_\_

**Estimated duration of operation:** \_\_\_\_\_ mins **Type of Anaesthetic:** ☐ General ☐ Local

**Clinical Details**  
Presenting Symptoms: \_\_\_\_\_  
Provisional Diagnosis: \_\_\_\_\_  
Other conditions present: \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

History of Diabetes: ☐ Yes ☐ No If yes, what type? ☐ Type 1 ☐ Type 2 Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

**ALLERGIES**  
**Expected Item Number(s):** \_\_\_\_\_

**Equipment Details:**  
Indemnitable device: ☐ Endoring Device ☐ Removable Device  
Type: Company: ☐ Contacted ☐ Company: ☐ Contacted  
Will the prosthesis used attract a gap payment? ☐ No ☐ Yes If so, gap estimate \$ \_\_\_\_\_ Patient Signature: \_\_\_\_\_  
Has informed financial consent been provided? ☐ Yes ☐ No

**Pre-operative instructions (including tests required):**  
☐ Pre-admission clinic attendance required.  
☐ Pathology tests ☐ x-ray/ultrasound ☐ ECG ☐ Other \_\_\_\_\_  
☐ Anaesthetic Consult  
☐ Drug Orders on Admission (drug order valid 24 hours only)  
☐ Special Instructions: \_\_\_\_\_

**Obstetric Details:**  
Parity: \_\_\_\_\_ EDC: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Blood Group: \_\_\_\_\_ Rh: \_\_\_\_\_ Hb: \_\_\_\_\_  
Antenatal & postnatal screening: \_\_\_\_\_ Rubella: \_\_\_\_\_ HPA: \_\_\_\_\_  
\*Consent (over page) to be completed and signed

**Admitting Doctor**  
Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

DO NOT WRITE IN THIS BINDING MARGIN

ADMISSION REFERRAL FORM

RHC003

Pg 1 of 2

**RAMSAY HEALTH CARE**

**CONSENT FOR TREATMENT (PRIVATE)**

**PART A - PROVISION OF INFORMATION TO THE PATIENT**  
To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed \_\_\_\_\_ PRINT NAME OF PATIENT \_\_\_\_\_ and/or \_\_\_\_\_  
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) / \_\_\_\_\_ RELATIONSHIP (FATHER, MOTHER, ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).  
Procedure/Treatment: \_\_\_\_\_

INJECT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS.  
Side of procedure/treatment: Left ☐ Right ☐ N/A ☐

SIGNATURE OF MEDICAL PRACTITIONER \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_  
Interpreter present SIGNATURE OF INTERPRETER \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

**PART B - PATIENT CONSENT**  
To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure/treatment as detailed above.  
• I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;  
• I understand the procedure/treatment carries some risk and complications may occur;  
• I understand additional procedure(s) may be needed if the doctor finds something unexpected;  
• I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);  
• I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;  
• I understand blood products/blood transfusions carry some risk and complications may occur, which have been explained to me;  
• I consent to\* / do not consent\* to blood products/blood transfusions, if needed;  
(\*PLEASE WRITE NOT APPLICABLE)

I request and consent to the procedure/treatment described above.

PATIENT / RESPONSIBLE PERSON(S) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PRINT NAME OF PATIENT / PERSON RESPONSIBLE \_\_\_\_\_ IF PERSON RESPONSIBLE SIGN, STATE RELATIONSHIP TO PATIENT (e.g. MOTHER / FATHER / HUSBAND)

DO NOT WRITE IN THIS BINDING MARGIN

CONSENT FOR TREATMENT (PRIVATE)

RHC003

Pg 2 of 2

**YOU CAN COMPLETE THE SUBSEQUENT 8 PAGES OF FORMS [RHC001 - PATIENT ADMISSION DETAILS & RHC002 - PATIENT HEALTH HISTORY - GENERAL] ONLINE. GO TO HOSPITAL WEBSITE LISTED ON PAGE 2 OF THIS BOOKLET AND FIND THE ONLINE ADMISSION FORM LINK. THESE DETAILS WILL BE SAVED FOR FUTURE ADMISSIONS.**

**ALTERNATIVELY, PLEASE RETURN THESE FORMS AT YOUR EARLIEST CONVENIENCE VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ALSO ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.**

**IF YOU HAVE ANY CONCERNS OR QUERIES THROUGH THE PROCESS PLEASE EMAIL OR PHONE THE DETAILS IN RED ON PAGE 2 OF THIS BOOKLET.**

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DO NOT WRITE IN THIS BINDING MARGIN

Ver 1.4- 04/13

# ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR  
Please PRINT clearly in block letters.

## Please Admit

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

Address: .....

Telephone: ..... Home ..... Business ..... Mobile .....

Date of Birth: ..... / ..... / ..... Sex: .....

**Admission Details** Facility to be admitted to: .....

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

**Indication for ICU:** .....

**Estimated duration of operation:** ..... mins **Type of Anaesthetic:** ☐ General ☐ Local

## Clinical Details

Presenting Symptoms: .....

Provisional Diagnosis: .....

Other conditions present: .....

Infection Risk: ☐ Yes ☐ No History of MRSA ☐ VRE ☐ Other: ..... VTE Risk: ☐ High ☐ Low

**CURRENT MEDICATIONS:** .....

**Is the patient taking any oral anticoagulants or antiplatelet medications?** ☐ Yes ☐ No **If Yes, date when ceasing:** .....

History of Diabetes: ☐ Yes ☐ No If yes, what type?: ☐ Type 1 ☐ Type 2 Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

**ALLERGIES:** .....

## Expected Item Number(s):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## 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.
- ☐ Pathology tests: .....
- ☐ Investigations: ☐ xray/ultrasound ☐ ECG ☐ Other: .....
- ☐ Anaesthetic Consult
- ☐ 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

## Admitting Doctor

Name: ..... Signature: ..... Date: ..... / ..... / .....



**RAMSAY**  
HEALTH CARE

## CONSENT FOR TREATMENT (PRIVATE)

UR: .....  
Surname: .....  
Given Names: .....  
Date of Birth: ..... Sex: .....

### PART A - PROVISION OF INFORMATION TO THE PATIENT

To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed .....and/or  
PRINT NAME OF PATIENT

..... / .....  
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) RELATIONSHIP (FATHER, MOTHER/WIFE ETC)

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

Procedure/Treatment: .....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

Side of procedure/treatment: Left ☐ Right ☐ N/A ☐

.....  
SIGNATURE OF MEDICAL PRACTITIONER

.....  
DATE

.....  
TIME

Interpreter present

.....  
SIGNATURE OF INTERPRETER

.....  
DATE

.....  
TIME

### PART B - PATIENT CONSENT

To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand blood products/blood transfusions carry some risk and complications may occur, which have been explained to me;
- I consent to\* / do not consent\* to blood products/blood transfusions, if needed;  
(\* DELETE WHERE NOT APPLICABLE)

I request and consent to the procedure/treatment described above.

.....  
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE

.....  
DATE

.....  
PRINT NAME OF PATIENT / PERSON RESPONSIBLE

.....  
IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT  
EG; MOTHER / FATHER / HUSBAND

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION



Preadmission Patient RHC100.16

# PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.  
Please PRINT clearly in block letters and return  
immediately to confirm your booking.

UR: .....  
Surname: .....  
Given Names: .....  
Date of Birth: ..... Sex: .....

## ADMISSION DETAILS

Specialist Surname: ..... Specialist First Name: .....  
Overnight: ☐ Yes ☐ No Do you know your admission date: ☐ Yes ☐ No Date of Admission: ..... / ..... / .....  
Procedure / Reason for Admission: ..... (If unsure leave blank)  
Item Numbers (if known): .....  
Is admission due to an injury? ☐ Yes ☐ No Date of injury: ..... / ..... / .....  
How did the injury occur?: ☐ Work ☐ Car accident ☐ Sport ☐ Other (please specify): .....  
Where did the injury occur?: ☐ Roadway ☐ Home ☐ Work ☐ Sports area ☐ Other (please specify): .....

Is the person completing the form the patient: ☐ Yes ☐ No

If No, Your Name: ..... Your Phone No. ....

## PATIENT DETAILS

Title: ..... Surname: ..... Maiden Name: .....  
Given Names: ..... Preferred Name: .....  
Residential Address: .....  
Suburb: ..... State: ..... Postcode: .....  
Postal Address: ☐ As above ☐ Different Details: .....  
Suburb: ..... State: ..... Postcode: .....  
Telephone (Wk/Day) ..... (Home/AH) ..... (Mobile/Other) .....

**Contact Preferences:** (indicate your preferred contact option) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

If there is a voice message service, may we leave a message? ☐ Yes ☐ No Allow SMS alert: ☐ Yes ☐ No

Email: .....

(Your email address is important as it is used to confirm your admission form has been received. It is NOT used for marketing purposes)

**Date of Birth** ..... / ..... / ..... Gender: ☐ Male ☐ Female

Marital Status: ☐ Single/Child ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Child (not at school) ☐ Employed ☐ Home Duties ☐ Other ☐ Retired ☐ Student ☐ Unemployed

Are you an Australian Resident? ☐ Yes ☐ No

Country / State of Birth: .....

Are you of Aboriginal / Torres Strait Islander (TSI) descent?

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown

Are you of Australian South Sea Islander (SSI) descent? ☐ No ☐ SSI ☐ Not Stated/Unknown

Religion: .....

**Do you consent to the Hospital disclosing your name to the following visiting officials (if they are available)?**

Chaplain Visit: ☐ Yes ☐ No Veteran Organisation Representative: ☐ Yes ☐ No

Language spoken at home: ..... Interpreter Required: ☐ Yes ☐ No

## MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ Yes ☐ No Medicare Number: 

--	--	--	--	--	--	--	--	--	--

Medicare Reference No: ..... (number in front of your name) Medicare Expiry date (MM/YYYY): .....

## NEXT OF KIN

Relationship to patient: .....

Title: ..... Surname: ..... Given Names: .....

Address: ☐ Same as patient ☐ Different from patient .....

Suburb: ..... State: ..... Postcode: .....

Telephone (Wk/Day) ..... (Home/AH) ..... (Mobile/Other) .....

## PERSON TO NOTIFY

☐ Same as next of kin Relationship to patient: .....

Title: ..... Surname: ..... Given Names: .....

Address: ☐ Same as patient ☐ Different from patient .....

Suburb: ..... State: ..... Postcode: .....

Telephone (Wk/Day) ..... (Home/AH) ..... (Mobile/Other) .....

## PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

Please PRINT clearly in block letters and return immediately to confirm your booking.

### PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

☐ Self ☐ Next of Kin ☐ Workers Compensation ☐ DVA ☐ Third Party ☐ Other: .....

Title: ..... Surname: ..... Given Names: .....

Address: ..... Suburb: ..... State: ..... Postcode: .....

Telephone (Wk/Day): ..... (Home/AH): ..... (Mobile/Other) .....

### PENSIONS / CONCESSIONS / HEALTH CARE CARD / SENIORS CARD / CONCESSIONAL PHARMACY BENEFITS

Do you have any type of pension/concessional benefits card?

☐ No ☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: ..... Benefit Card No: .....

Have you reached the Safety Net for Pharmaceuticals? ☐ Yes ☐ No Safety Net No: .....

### HEALTH INSURANCE DETAILS

Insurance Type: ☐ Private health fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ Self Funded ☐ Public

**Name of health fund:** ..... **Type of Cover:** .....

Membership No: ..... Do you have an excess? ☐ Yes ☐ No Amount: \$ .....

Have you changed your level of insurance cover in the last 12 months? ☐ Yes ☐ No

**DVA No:** ..... **DVA Card Colour:** ..... **Details of cover (white card only)** .....

**Workers' Comp Fund Name:** ..... **Claim No:** .....

**Employer:** ..... **HR Manager:** .....

**Phone:** ..... **Fax No:** .....

**Third Party Name:** ..... **Policy No.:** .....

**Referring Doctor Surname:** ..... **First Name:** .....  
(Specialist or GP who referred you to the admitting specialist)

**Address:** .....

**Suburb:** ..... **Postcode:** ..... **Phone No:** .....

**General Practitioner (GP) Surname:** ..... **First Name:** .....  
(If same as above write: "AS ABOVE")

**Address:** .....

**Suburb:** ..... **Postcode:** ..... **Phone No:** .....

### ACCOMMODATION PREFERENCE (whilst every effort will be made to meet your preference, we cannot guarantee availability)

Room preference: ☐ Private room ☐ Shared room

### HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within this booklet:

- ☐ Hospital Information  
☐ Charter of Healthcare Rights  
☐ Privacy Policy

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

- ☐ Informed Financial Consent  
☐ Payment Information

**Person responsible for payment of accounts** - Please provide your name, signature and today's date.

**Name:** ..... **Signature:** ..... **Date:** .....

**Patient's Signature**

**Signature:** ..... **Date:** ..... / ..... / .....

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION



# PATIENT HEALTH HISTORY – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
Please **PRINT** clearly in block letters and return  
immediately to confirm your booking.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....



RHC100.11  
Patient Completed C

PROCEDURE / ADMISSION	NO	YES	If yes, please answer these questions If no, please progress to the next question	NURSING NOTES
1. Could you be pregnant?				
2. Is the patient under the age of 18 years			Name of child's legal guardian: ..... Are the child's immunisations up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you had Xrays or blood tests taken for this admission			When: Where:	
4. Have any other doctors been consulted recently eg. cardiologist, physician			Doctor consulted: Specialty: ..... ..... .....	

PREVIOUS HOSPITALISATIONS	NO	YES	If yes, please answer these questions	NURSING NOTES
5. Have you been admitted to this hospital before				
6. Have you been admitted to any hospital within the last 28 days			<input type="checkbox"/> In the last 7 days <input type="checkbox"/> In the last 28 days Reason for Admission: ..... Hospital Name: .....	
7. For WA residents only - Have you been admitted to a hospital outside WA in last 12 months			Reason for Admission: ..... Hospital Name: .....	

PREVIOUS SURGERY / PROCEDURES	NO	YES	If yes, please complete table below	NURSING NOTES
8. Have you had any previous surgeries or procedures e.g. joint replacements, transplants, implants, colonoscopy				
OPERATION	APPROX YR	OPERATION	APPROX YR	NURSING NOTES

MEDICATIONS	NO	YES	If yes, please answer these questions	NURSING NOTES
9. Do you take any of the following: • anti-coagulant or blood thinning therapy e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaban, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor • cortisone tablets/injections, anti-inflammatory drugs • regularly take fish oil, krill oil, garlic or ginkgo supplements			Still take? <input type="checkbox"/> No <input type="checkbox"/> Yes Date to be ceased: .....  Still take? <input type="checkbox"/> No <input type="checkbox"/> Yes Date to be ceased: .....  Still take? <input type="checkbox"/> No <input type="checkbox"/> Yes Date to be ceased: .....	
10. Have you received advice from Specialist rooms regarding taking/ceasing medications prior to admission.			Details:	

**IMPORTANT:** Please either complete the medication table below or bring a profile OR list to hospital of all medications especially anti-coagulant or blood thinning therapy as well as other tablets, puffers, patches, injections, nebulisers, ointments, drops and including non-prescription medications and herbal supplements. IF STAYING OVERNIGHT: please bring medications in the original packaging

**NOTE:** Please list all medications including those mentioned previously in the following section

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY	NURSING NOTES
						Patient own stock?

☐ Pt med drawer  
☐ Schedule 8 store  
☐ Sent home

# PATIENT HEALTH HISTORY

## – GENERAL

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

Please **PRINT** clearly in block letters and return immediately to confirm your booking.

LIFESTYLE	NO	YES	If yes, please answer these questions	NURSING NOTES
11. Do you have a medical required or special diet e.g. diabetic, coeliac disease, lactose intolerance, vegetarian, vegan, kosher			Details:	
12. Have you ever smoked			Daily Amount: Ceased:	
13. Do you drink alcohol			Daily Amount:	
14. Do you use recreational drugs			Daily Amount: Type:	
15. What is your weight: kgs				
16. Have you lost weight unintentionally				<input type="checkbox"/> Malnutrition risk
17. What is your height: cm				
PROSTHETICS / AIDS	NO	YES	If yes, please answer these questions	NURSING NOTES
18. Do you use any prosthetics / aids e.g. aids for vision and hearing loss, walking sticks, other aids for daily living			Details:	<input type="checkbox"/> Falls risk screen
DISCHARGE PLANNING	NO	YES	Please answer these questions	NURSING NOTES
19. Where do you plan to go after discharge				
20. Do you live alone or are solely responsible for the care of another person at home			<input type="checkbox"/> I have someone to look after me after discharge <input type="checkbox"/> I currently receive community support and/or nursing services. <input type="checkbox"/> I require assistance with or have concerns with aspects of day to day living. <input type="checkbox"/> I have concerns after discharge	
21. Do you have escorted transport from hospital?			Name: Contact Number:	
ADVANCE HEALTH DIRECTIVE / POWER OF ATTORNEY	NO	YES	If yes, please answer these questions	NURSING NOTES
22. Do you have a current Advance Health Directive				
23. Do you have an enduring power of attorney - health & medical guardian			Name: Relationship: Phone:	
MEDICAL CONDITIONS				
24. Do you have any Allergies (see examples below) <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If No, go to question 25. If Yes, please tick the relevant conditions below.</i>				
If yes please tick relevant conditions following	DETAILS		NURSING NOTES	
<input type="checkbox"/> You or a family member has had an adverse reaction to anaesthetic eg malignant hyperthermia or post operative nausea and vomiting	<input type="checkbox"/> You <input type="checkbox"/> Family member Details:			
<input type="checkbox"/> Allergies or sensitivities including medications, latex, sticking plaster, iodine, xray dyes, food (e.g. seafood, nuts, gluten), food additives (e.g. salicylates, amines) or insects (e.g. bees, dust mites)	Please list details below			
ALLERGY INCLUDING FOOD ALLERGIES	DETAILS / REACTIONS		<input type="checkbox"/> Alert sticker	

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

# PATIENT HEALTH HISTORY – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
Please PRINT clearly in block letters and return  
immediately to confirm your booking.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

## MEDICAL CONDITIONS continued

**25. Do you have/had any Cardiovascular problems (see examples below)** ☐ No ☐ Yes  
*If No, go to question 26. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	DETAILS	NURSING NOTES
<input type="checkbox"/> Elevated cholesterol, triglycerides		
<input type="checkbox"/> Blood pressure problems eg. low, high, hypertension		
<input type="checkbox"/> Cardiac conditions eg. heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina		
<input type="checkbox"/> Cardiac irregularities eg. palpitations, irregular heart beat, heart murmur, Atrial Fibrillation		
<input type="checkbox"/> Cardiac surgery eg. pacemaker, implants/devices, prosthetic heart valve, grafts, stents.		Year: Model:
<input type="checkbox"/> Vascular disease eg. carotid disease, aortic aneurysm, peripheral vascular disease.		

**26. Do you have/had Diabetes or Thyroid conditions (see examples below)** ☐ No ☐ Yes  
*If No, go to question 27. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	DETAILS	NURSING NOTES
<input type="checkbox"/> Type 1 diabetes	Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets	
<input type="checkbox"/> Type 2 diabetes		
<input type="checkbox"/> Gestational diabetes		
<input type="checkbox"/> Unsure		

**27. Do you have/had any Gastroenterology or Urology problems (see examples below)** ☐ No ☐ Yes  
*If No, go to question 28. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	DETAILS	NURSING NOTES
<input type="checkbox"/> Hiatus hernia, gastrointestinal ulcers, reflux		
<input type="checkbox"/> Liver disease, hepatitis (eg A, B, C), jaundice, cirrhosis		
<input type="checkbox"/> Bowel problems/habits, stoma or bowel disease eg Crohns, IBS		
<input type="checkbox"/> Kidney disease, dialysis, renal impairment		
<input type="checkbox"/> Bladder problems or habits, stoma, incontinence, urinary retention		<input type="checkbox"/> Falls risk screen

**28. Do you have/had any Blood or Cancer problems (see examples below)** ☐ No ☐ Yes  
*If No, go to question 29. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	DETAILS	NURSING NOTES
<input type="checkbox"/> Ever had a blood transfusion	Any reaction: Year Transfused:	
<input type="checkbox"/> History of cancer	Type: Body Site: Treatment: Date of Diagnosis:	
<input type="checkbox"/> Blood clot in lung / legs (DVT / PE)		
<input type="checkbox"/> Blood or bleeding disorders eg anaemia		

**29. Do you have/had any Musculoskeletal conditions (see examples below)** ☐ No ☐ Yes  
*If No, go to question 30. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	DETAILS	NURSING NOTES
<input type="checkbox"/> Arthritis eg rheumatoid arthritis, osteoarthritis		
<input type="checkbox"/> Back or neck injury or problems		

# PATIENT HEALTH HISTORY

## – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**

Please **PRINT** clearly in block letters and return immediately to confirm your booking.

### MEDICAL CONDITIONS continued

**30. Do you have/had any Neurology problems (see examples below)**

☐ No ☐ Yes

*If No, go to question 31. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	<b>DETAILS</b>	<b>NURSING NOTES</b>
<input type="checkbox"/> Neuromuscular diseases eg MS, myasthenia , dystrophies, parkinsons.		
<input type="checkbox"/> Stroke, mini stroke, TIA	Date: Impairment:	
<input type="checkbox"/> Limb paralysis or weakness		<input type="checkbox"/> Falls risk screen
<input type="checkbox"/> Fear of falling, unsteady or fallen in last 6 months		<input type="checkbox"/> Falls risk screen
<input type="checkbox"/> Epilepsy/fits, faints, blackouts, dizziness		<input type="checkbox"/> Falls risk screen
<input type="checkbox"/> Speech or swallowing problems eg coughing when eating / drinking		
<input type="checkbox"/> Difficulties with problem solving, attention span, understanding, post surgery confusion		
<input type="checkbox"/> Other neurological problems e.g. meningitis, migraine, polio, short term memory loss, dementia, Alzheimers		

**31. Do you have/had any Breathing problems (see examples below)**

☐ No ☐ Yes

*If No, go to question 32. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	<b>DETAILS</b>	<b>NURSING NOTES</b>
<input type="checkbox"/> Asthma, pneumonia, hay fever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary disease (COPD)		
<input type="checkbox"/> Shortness of breath e.g. walking more than 50m, climbing stairs/inclines		
<input type="checkbox"/> Sleep apnoea, disturbed sleep, snoring		
<input type="checkbox"/> Use a CPAP machine	Please bring CPAP to hospital	
<input type="checkbox"/> Other lung problems eg tuberculosis		

**32. Do you have/had any Other conditions (see examples below)**

☐ No ☐ Yes

*If No, go to question 33. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	<b>DETAILS</b>	<b>NURSING NOTES</b>
<input type="checkbox"/> Chronic pain		
<input type="checkbox"/> Depression, other mental illness		
<input type="checkbox"/> Lymphoedema		
<input type="checkbox"/> Thyroid problems, hypothyroidism, goitre		
<input type="checkbox"/> Any other medical conditions		

**33. Are you susceptible to possible Infection Risk (see examples below)**

☐ No ☐ Yes

*If No, go to question 34. If Yes, please tick the relevant conditions below.*

<i>If yes please tick relevant conditions following</i>	<b>DETAILS</b>	<b>NURSING NOTES</b>
<input type="checkbox"/> Ever had MRSA, VRE, CRE or ESBL		
<input type="checkbox"/> Any wounds/ breaks on your skin		
<input type="checkbox"/> Other conditions or infections		
<input type="checkbox"/> If you are being admitted in the next 7 days, have you: * travelled to a country with a health alert * travelled to areas of high prevalence for acute respiratory infections or acute respiratory illness * had a fever and/or respiratory symptoms, eg cough, sore throat, runny nose * had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness * had vomiting and diarrhoea		

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION



DETACH ALONG PERFORATION



RHC100.11

Patient Completed C

DO NOT WRITE IN THIS BINDING MARGIN

Ver 4 - 09/14

## PATIENT HEALTH HISTORY – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
Please **PRINT** clearly in block letters and return  
immediately to confirm your booking.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

### MEDICAL CONDITIONS continued

**34. Are you having an operation on your brain, spinal cord, pituitary gland, nerve root ganglia, retina, optic nerve or having maxillary or dental surgery?**

☐ No ☐ Yes

*If No, please go to the next section. If Yes, please tick the relevant conditions below.*

***If yes please tick relevant questions following***

**DETAILS**

**NURSING NOTES**

☐ I think I may have CJD

☐ I have a first degree relative with CJD

☐ I have an unexplained progressive neurological illness of less than 12 mths

☐ I have a history or receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)

☐ I have previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)

☐ I have been involved in a look back for CJD or have a "medical-in-confidence" letter regarding your risk for CJD

☐ I am not sure

***To find out more about cCJD please go to the following URL - <http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf>***

I confirm that the information completed in this Patient Health History form is correct.

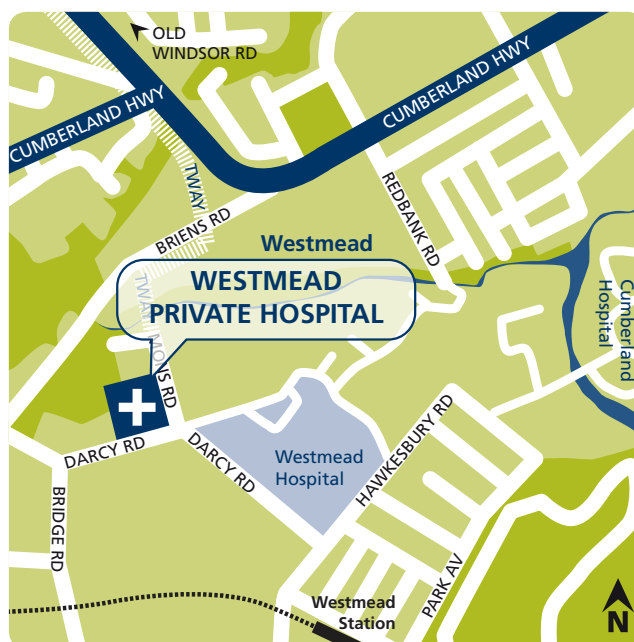
Signature .....

Patient Name ..... Date .....

(please print)







## Parking

For your convenience we have designated parking areas for visitors. Disabled parking is also available at the front entrance and side of the building. In addition we have free 30 minute drop off and pick up within the hospital. Please pay for parking at the pay machine located in the atrium.

## Visiting Hours

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

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



People caring for people

### Westmead Private Hospital

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Westmead NSW 2145  
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