

<h1>DUDLEY</h1> <h2>PRIVATE HOSPITAL</h2>	PLEASE PRINT
	Patient Name: _____ D.O.B. _____
	<i>Insert Patient Label</i>
	Admission Date (Required): _____ Procedure Date (Required): _____
	Treating Accredited Practitioner: _____
Referring General Practitioner: _____ (optional)	

PART A 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 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 Not Applicable
- Patient does NOT consent to having a blood or blood products transfusion
- Interpreter used: Name of RHC accredited Interpreter: _____ Language: _____
Please print Please print
- 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 treatment of my/patients condition.
Print name of Treating RHC Accredited Practitioner / Doctor

- I have consented to the Operation/Procedure as described above.
- Ramsay employees will administer care/treatment under my treating Doctor's 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 which explains the operation/procedure(s) and the risks involved.
 - Information sheet(s) _____
Name of information sheet(s)
 - Multimedia presentation(s) _____
Name of multimedia presentation(s)
- 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

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Dudley Private Hospital

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

Patient Details

Admission Form

To be completed by Patient.
 Please *PRINT* clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Details

Date of Admission: _____/_____/_____ Date of Operation: _____/_____/_____ Estimated Date of Discharge: _____/_____/_____

ADMISSION TYPE:
 Inpatient Day Patient Outpatient

Admitting Doctor: _____
 Admission Diagnosis/Procedure: _____

Personal Details

Title: _____ Surname: _____ Previous Surname (if applicable): _____
 Given Names: _____ Preferred Name: _____
 Address: _____ Suburb: _____ State: _____
 Postcode: _____ Telephone (Home): _____ (Business): _____ Mobile: _____

Sex: Male Female Date of Birth: _____/_____/_____ Age: _____

Marital Status: Single Married De facto Separated Divorced Widowed

Occupation: _____ **Are you an Australian Resident?** Yes No

Are you of Aboriginal/Torres Strait Islander (TSI) descent? No Yes, Aboriginal Yes, TSI Yes, both Aboriginal and TSI

Country of Birth: _____ Preferred Language: English Other _____

Religion: _____ **Would you like a religious visit?** No Yes

Person Responsible For Account

Is the Patient responsible for this account? Yes (Go to next section) No (Complete this section)

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

Private Health Insurance Details

Fund Name: _____ **Membership No:** _____ **Date Joined:** _____/_____/_____

Type of cover: Single Family Other _____ **Level of cover (if known):** _____

Has this level of cover changed in the last 12 months? No Yes

Do you have an excess: No Yes Amount \$ _____ Have you paid an excess this year? No Yes Amount \$ _____

Person To Contact (Next of Kin)

Name: _____ **Relationship to patient:** _____
 Address: _____ Suburb: _____ State: _____
 Postcode: _____ Telephone (Home): _____ (Business): _____ Mobile: _____
 Second Contact/Power of Attorney: _____ Telephone: _____

Preferred Accommodation

Whilst every effort is made to accommodate your request, we cannot always guarantee availability on the day of admission. Overnight Patients only - please indicate your preferred accommodation below. Note: Veterans Affairs, Workcover and Third Party Patients are covered for shared Room Accommodation only - a separate charge may apply for a single room.

Shared Room Single Room **Please check level of health insurance cover if requesting a single room**

Privacy Policy

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, 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 also outsource the archiving of our medical records to a contractor. Where we outsource our services we ensure that third parties have obligations under their contracts with Ramsay Health Care to comply with all laws relating to the privacy 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.

If you consent to Ramsay Health Care using or disclosing your personal information for the following purpose, please tick the box and sign the consent below:

- to receive a visit from a pastor or chaplain;
- to receive an informal visit from a member of the local veteran community.

Consent

I hereby authorise the Hospital to collect, use and disclose my information as described above, and confirm that I have read and understand my Rights and Responsibilities as a patient.

Signature of patient or authorised representative

Printed Name Date

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Surname:

Given Names:

Date of Birth: Doctor:

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

Patient History Form

PLEASE ANSWER ALL QUESTIONS

Please specify the reason for your admission (If being admitted for treatment of an injury, please also state how and where the injury occurred).

Admission Date:

What is your Weight kg/stone Height cm/ft. inches

1. ARE you ALLERGIC to any medicines, tapes antiseptics, latex, rubber or foods? (Please outline) No YES If Yes please give details

2. Have pathology/blood tests/autologous blood/ECG/X-rays been ordered for this admission No Yes If Yes please give details

3. Have you or a blood relative ever had a problem With ANAESTHETICS? No YES If Yes please give details

3a. Have you had a recent anaesthetic? No Yes Where/when

4. Any PREVIOUS OPERATIONS No Yes If Yes please give details

5. Any MAJOR ILLNESS eg diabetes, cancer, thyroid disease, kidney disease, rheumatoid arthritis, other No YES If Yes please give details

5a. If DIABETIC please specify type and management Managed By Type 1 Type 2 Unsure Diet Tablets Insulin

6. Any history of DEPRESSION/DEMENTIA/OTHER MENTAL ILLNESS No Yes If Yes please give details

7. Do you have any BREATHING/RESPIRATORY PROBLEMS? (COPD/CAL, Asthma, Pneumonia, Emphysema, Sleep Apnoea, Shortness of Breath, Other) No Yes If Yes please give details

7a. Have you been hospitalised for your respiratory condition within the last 6 months No Yes If Yes please give details

7b. Do you use home oxygen No Yes

8. Do you have or have you ever had in the past problems with your HEART? (High blood pressure, chest pain, angina, heart attack, rheumatic fever, murmurs, prosthetic heart valve, bypass, stent) No Yes If Yes please give details

If yes has your condition become worse in the last 3 months No Yes

8a. Do you have a Pacemaker/Defibrillator? No YES where last checked / / date

9. Do you have any heartburn, indigestion, hiatus hernia, reflux, bowel disorder, faecal incontinence or urinary incontinence? No Yes If Yes please give details

10. Do you have any BLEEDING PROBLEMS? (Easy bruising, excessive bleeding after dental extractions) No Yes If Yes please give details

11. Have you ever had BLOOD CLOTS in the legs or lungs? No Yes when / why

12. Have you ever had a blood transfusion? No Yes where / when

13. Have you ever had a problem with epilepsy, stroke or leg or arm weakness? No Yes If Yes please give details

13a. Have you had any fits, faints or "funny turns", or have you fallen within the last 12 months? No YES If Yes please give details

14. Have you ever had jaundice or hepatitis? No Yes which / when

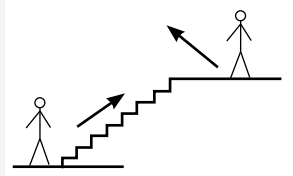
15. Do you have limited neck or jaw movement? No Yes why

16. Could you possibly be pregnant? No Yes If Yes number of weeks

Patient Name: _____

IF THIS ADMISSION RELATES TO A CHILD please complete

17. Was the child born prematurely?. If so, how many weeks No Yes _____ Weeks
18. Does your child have any problems with his/her HEART No Yes
OR LUNGS OR ANY OTHER MEDICAL PROBLEMS? Please give details _____
19. Has your child been immunised? No Yes
20. Do you have any major disabilities (e.g. blindness, deafness, intellectual) No Yes If Yes please give details _____
21. **PROSTHESIS/AIDS/OTHERS**
- Glasses/Contact Lenses No Yes
- Hearing Aid or other hearing appliance No Yes
- Body Piercing No Yes Site _____
- Caps/Crowns/Loose Teeth No Yes
- Dentures No Yes Part Full Upper Lower
- Artificial joints or limbs No Yes Site _____
- Metal plates/pins No Yes Site _____
22. Do you smoke? If yes how many per day? No Yes _____ per day
- 22a. Have you ever smoked? If yes when did you stop? No Yes _____
23. Do you have more than 3 alcoholic drinks most days? No Yes how many? _____
24. Have you ever injected yourself or used a substance not prescribed by a doctor? No Yes type _____
25. Can you normally walk without stopping
- A) More than 2 flights of stairs? No Yes
- B) One flight of stairs? No Yes
- C) Greater than 50 metres? No Yes
- D) Around the house? No Yes
26. Can you lie flat for 1 hour No Yes
27. Do you require a special diet/ (e.g. Diabetic, Vegetarian, Kosher, etc) No Yes Please specify _____



28. ARE YOU TAKING ANY MEDICINES, STEROIDS, INHALERS, TABLETS OR DRUGS, (INCLUDING HORMONES, CONTRACEPTIVES OR ASPIRIN) FOR ANY REASON? (PLEASE LIST)
- DRUG NAME AND STRENGTH HOW MANY? HOW OFTEN? FOR TREATMENT OF:**
- _____
- _____
- _____
- _____
- _____

PLEASE BRING ALL MEDICATIONS YOU ARE CURRENTLY TAKING WITH YOU ON ADMISSION IN THEIR ORIGINAL PACKAGING

29. Have you recently taken blood thinning/arthritis medication (including Aspirin based or Anti-inflammatory medication)? No YES Name of Medication _____
30. Have you been instructed to cease this medication No YES Date stopped or to be stopped ____/____/____

31. It is the Hospital's policy to notify your nominated Local Doctor of your admission to Hospital Please indicate if you DO/DO NOT want this to occur. (Please circle)
- I DO/DO NOT consent to the exchange of information relevant to my case.
- NAME OF LOCAL DOCTOR _____ PHONE _____
- NAME OF CARDIOLOGIST (if applicable) _____ PHONE _____
- NAME OF PHARMACY _____

DETACH ALONG PERFORATION

Dudley Private Hospital

The Australian Charter of Healthcare Rights

Ramsay Health Care and Dudley Private Hospital abide by the Australian Charter of Healthcare Rights produced by the Australian Commission on Safety & Quality in Healthcare. The seven Charter rights are detailed below. For further information please obtain a brochure available from reception.

Access

A right to health care.

You have a fundamental right to adequate and timely health care. Sometimes this may not be at the healthcare facility you first attend as not all services are necessarily available everywhere.

You can contribute to the right of access by trying to meet your appointments and telling the facility when you cannot.

Safety

A right to safe and high quality care.

If you are unsure about what is happening to you or if you think something has been missed in your care, alert your healthcare provider. Let your provider know any circumstances that might make your health care riskier.

Respect

A right to be shown respect, dignity and consideration.

You are entitled to receive care in a way that is respectful of your culture, beliefs, values and characteristics like age and gender. It is important to tell your healthcare provider of any changes in your circumstances.

Respect also includes being mindful of healthcare staff and other patients.

Communication

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

Healthcare providers will tell you about the care you are receiving and help you understand what is happenig to you.

You can contribute to communication by being as open and honest as you can be. To understand the instructions given to you, you can ask questions if you would like more information.

You can use interpreters if English is not your first language. Interpreter services are free and can be provided in person or by phone.

Participation

A right to be included in decisions and choices about care.

You are encouraged to participate in decisions about your care. Ask questions if you are unsure about what is happening to you. Involve your family or carer if this makes you more comfortable and sure.

Privacy

A right to privacy and confidentiality of provided information.

You are able to see your records and ask for information to be corrected if it is wrong. In some situations your health information will need to be shared between healthcare providers.

You can also contribute by respecting the privacy and confidentiality of others.

Comment

A right to comment on care and having concerns addressed.

Healthcare providers want to solve problems quickly, but they need to be told about the problem first. If you have any suggestions about how services could be improved please let staff know.

The procedures used by the health service organisation to comment about your care should be made available to you. You can provide verbal or written comments about the procedures and your experiences.

To commend health workers, to complain about your health care and / or to be advised of the procedure of expressing concern about your care please contact your health service provider's patient liaison representative.

Dudley Private Hospital

Patient Information

Accounts/Fees

If you are a member of a health fund it is important prior to your admission to check with them regarding the following:

- That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation outlined in the Pre-Admission Form.
- If an excess is payable for this admission.
- 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 your joining. If there is a question regarding pre-existing symptoms your health fund has the option to obtain details in this regard from your GP or specialist.**

You will receive an Estimate of Expenses / Financial Consent information prior to admission. To expedite your admission process we encourage you to pay any outstanding amounts prior to admission by contacting our Patients Account Co-ordinator on 6361 6771.

Pharmacy and pathology, imaging and x-ray may attract an additional charge. Sundry item charges eg. crutch hire are payable on discharge. Please note that medical, surgeon, assistant surgeon, anaesthetist and allied health practitioner's fees will be billed separately by the practitioner.

Payment Procedure

- Private patients - the portion of your estimated hospital account not covered by your health fund, eg. an excess, must be paid on admission. Any additional costs incurred during your stay are payable prior to discharge. eg. Discharge Pharmacy Costs and some investigations.
- Repatriation (DVA) patients - the hospital will lodge a claim on your behalf. Any additional costs incurred during your stay are payable prior to discharge. eg. private room.
- Work Cover patients - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.
- Third Party patients - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.
- Uninsured patients - total payment (aside from any ancillary charges) must be made on admission.
- Other costs which may be incurred during your stay are payable on discharge. Please bring provision for payment of these fees on admission to hospital.

Payment may be made by cash, cheque, credit card (Diners Card not accepted) or eftpos.

Meals

Dudley Private Hospital aims to provide a choice of meals and to supply special diets where it is in the interest of your medical care. Food or alcoholic drinks should not be brought to you by visitors without the permission of your nurse.

Valuables

It is strongly recommended that you do not bring jewellery or large amounts of money to Hospital as provision for safe custody is limited. However, if it is unavoidable, please arrange with the Reception Staff or Nurse to have it put into safe custody. Dudley Private Hospital does not accept liability for any items brought into the Hospital.

Visiting

- Hospital visiting hours are 10am to 8pm daily.
- For High Dependency Ward please ask at Nurses Station prior to visiting
- Arrangements for visiting outside of usual visiting hours can be made in consultation with the Nursing staff
- Relatives may stay with critically ill patients for extended periods, as may a parent with their child
- Day procedure patients - please check with admission nurse
- If you have indicated that you would like a Religious or Returned Service League visit, Dudley Private Hospital will make every attempt to facilitate this.

Medical Records and Privacy

Records will be kept of your illness and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law. You are entitled to view your medical record please consult with your health care professional. Dudley Private Hospital complies with the Privacy Act 1988 and all National Privacy Principles, including the way we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our Hospital (eg. to your health funder, DVA, the supplier/manufacturer of your prosthesis, to our insurer, to an external company contracted by Dudley Private Hospital to evaluate customer satisfaction).

Discharge Information

- DISCHARGE TIME IS 10am** (Excluding Day Procedure patients who will be informed of their approximate discharge time on admission)
- You should arrange for someone to escort you home
- You must not drive a car until the day following your operation/procedure or anaesthesia (your motor vehicle insurance may not cover you)**
- Before you leave the hospital, make sure that you or your relatives/friends know how to care for you at home
- Check with your Nurse/Doctor about continuing medication, follow-up appointments, etc.
- Please do not forget to collect any x-rays or medications brought with you on admission

Please contact your Nurse if you have any concerns, problems or suggestions during your stay.

Patient Name: _____

32 QUESTIONS RELATED TO CREUTZFELDT-JAKOB DISEASE (CJD) (MAD COW DISEASE)

- 32a. Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990? No YES
- 32b. Have you had two or more first-degree relatives who have been diagnosed with Creutzfeldt-Jakob Disease (cCJD) or other Prion Disease, where a genetic cause has not been excluded? No YES
- 32c. Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been diagnosed? No YES
- 32d. Have you received human pituitary hormone treatment for infertility or human growth hormone for short stature prior to 1986? No YES
- 32e. Have you been involved in a "Look Back" study for cCJD or are you in possession of a "Medical in Confidence Letter" regarding the risk of cCJD? No YES

33 QUESTIONS RELATED TO SARS/AVIAN INFLUENZA/UNDIAGNOSED RELATED RESPIRATORY INFECTION

In order to ensure the safety of all our patients, visitors and staff, it is essential that you complete the following questions regarding recent travel history and your current state of health. This vigilance is a recommendation of the Australian Government Department of Health and Ageing.

- 33a. Have you travelled overseas recently? No YES
- 33b. Have you been back in Australia for 14 days or less prior to admission? No YES
- 33c. Do you have signs and symptoms of a respiratory infection or fever? (Significant only if patient answers yes to previous questions) No YES

N.B.: If a patient answers YES to all 3 questions contact Infection Control Consultant and CEO immediately.

DISCHARGE PLANNING

34. Do you live in a Nursing Home/Hostel, etc? No Yes
35. Do you have a responsible adult to stay with you the night after you leave hospital? No Yes
36. Do you have someone to collect you from hospital? No Yes If Yes please give details
Contact Name _____ Relationship _____ Contact Number _____
37. Where do you plan to go on discharge? _____
38. How will you travel to your destination? _____ day/s
39. How long do you expect to stay in hospital? _____ day/s
40. Are you over 75 years of age? No YES
41. Do you live alone? No YES
42. Are you a primary carer for someone? No YES
Have arrangements been made for their care? No Yes _____
43. Do you receive any help at home? No YES If yes please complete A to D
A) Home Help _____ Service Provider _____ Contact Phone Number _____
B) Meals on Wheels _____ Service Provider _____ Contact Phone Number _____
C) District Nurse _____ Service Provider _____ Contact Phone Number _____
D) Other (please outline) _____
44. Do you feel you will require any additional assistance when you go home? No YES If Yes please give detail
e.g. bathing, dressing, catheter/colostomy care _____
45. Do you have: No Yes If yes where and how many
A) Step/stairs? No Yes _____
B) Handrails in your bathroom? No Yes _____
C) Hand rails in your toilet? No Yes _____
D) A shower over the bath No Yes _____
E) An outside toilet No Yes _____
46. Do you use/require: No Yes
A) Walking stick/frame? No Yes _____
B) Wheelchair? No Yes _____
C) Assistance of one person? No Yes _____

Preadmission

Nurse: _____
Signature _____ Designation _____ Print _____ Initials _____ Date _____ Time (Hrs) _____

Admission

Nurse: _____
Signature _____ Designation _____ Print _____ Initials _____ Date _____ Time (Hrs) _____

DETACH ALONG PERFORATION

PATIENT HISTORY FORM

ADMISSION FORMS

Admission Date: _____

PATIENTS OR GUARDIANS

Please complete the blue coloured sections of this booklet, or alternatively an online Admission Form is available by visiting our website: www.dudleyprivate.com.au and following the prompts for Online Admission Form.

If you choose to complete this booklet, in order to confirm your admission, it is essential that the Hospital receives these detachable pages as soon as possible following your visit to the Doctor.

Admission Information

Please call the **afternoon prior** to your admission between 2pm and 4pm to obtain your admission and fasting details.

(02) 6361 6784 or (02) 6362 8122

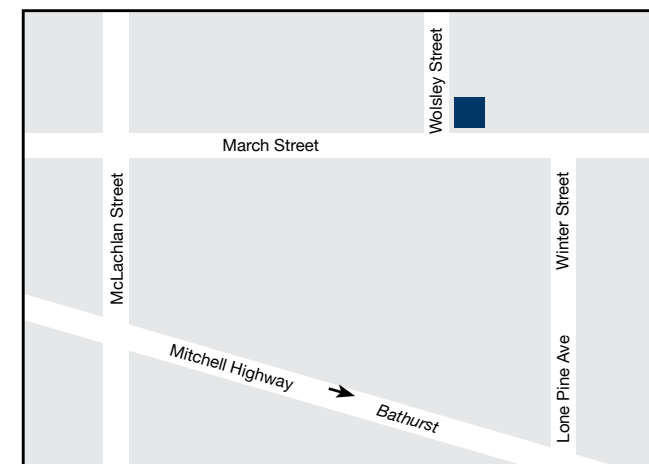
Visiting Hours

Hospital visiting hours are 10am to 8pm daily.

Discharge Information

Discharge time is 10am (excluding Day Procedures).

You may be asked to wait in the Patient Lounge area on your day of Discharge if you are unable to be collected by 10am.



Postal Address: 261 March Street
ORANGE NSW 2800

Telephone: (02) 6362 8122