RAMSAY HEALTH CARE

ADMISSION REFERRAL FORM

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

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

AFFIX ID LABEL HERE

RHC100.20 Referral/Consent

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

Please Admit

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

Address: .....

Telephone: ..... (Home) ..... (Business) ..... (Mobile)

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

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: .....

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**

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 .....

❑ 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: ...../...../.....

ADMISSION REFERRAL FORM RHC003

Ver 1.2- 12/12

RAMSAY HEALTH CARE

CONSENT FOR TREATMENT

UR: .....

Surname: .....

Given Names: .....

AFFIX ID LABEL HERE

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

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

I have informed ..... and/or ..... / .....
Print name of patient / child *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 ❑ Both ❑ Not Applicable ❑

❑ Patient does ***NOT*** consent to having a blood or blood products transfusion.

❑ Interpreter used: Name of RHC accredited Interpreter: ..... Language: .....
Please print

Sight Translated ❑ (NSW) Verbally Interpreted ❑ (NSW)

Treating RHC Accredited Practitioner / Doctor

....
Signature *Print Name* *Contact Ph. No.* *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.
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 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) .....
Name of information sheet(s)

❑ Multimedia presentation(s) .....
Name of 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*

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

CONSENT FOR TREATMENT

RHC003

Ver 3.1 - 10/12

RAMSAY HEALTH CARE

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: .....

AFFIX ID LABEL HERE

RHC100.16 Preadmission Patient

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

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: .....
Item Numbers (if known): .....

PATIENT DETAILS

Is the person completing the form the patient: ☐ Yes ☐ No
If No, Your Name: ..... Your Phone No. .....

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) .....
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 to you that your admission form has been received and is NOT used for marketing purposes)
Date of Birth ..... / ..... / ..... Gender: ☐ Male ☐ Female ☐ Indeterminant

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: .....

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

CONTACT PREFERENCES (indicate your preferred contact option) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

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 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

RHC001

Ver 2 - 12/12

RAMSAY HEALTH CARE

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: .....

AFFIX ID LABEL HERE

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

ENDURING POWER OF ATTORNEY

Do you have a current Advance Health Directive? ☐ Yes ☐ No

Do you have enduring power of attorney – health and medical guardian? ☐ Yes ☐ No

Name:..... Relationship:..... Phone:.....

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) .....

MEDICARE DETAILS

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

Medicare Number: ..... Medicare Reference No: ..... Valid Until:.....

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

Public: Hospital Name:.....

Workers' Comp Fund Name:.....

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

Claim No: ..... Date of Accident: ..... / ..... / .....

Employer Name:..... Phone:.....

HR Manager:..... Fax No:.....

Third Party Name: ..... Details:..... Policy No.: .....

Serving Member of: ..... DVA No:..... DVA Card Colour: .....

Details of cover (white card only) .....

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 the following:

☐ Hospital Booklet ☐ Private Patient's Hospital Charter ☐ Your right to privacy under the Privacy Act

By signing below I declare that I am the person responsible for this account and ackowledge 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: ..... / ..... / .....

PATIENT ADMISSION DETAILS

RHC001

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

RAMSAY HEALTH CARE

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: .....

AFFIX ID LABEL HERE

Date of Birth: .....

RHC100.11 Patient Completed C

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

ADMISSION INFORMATION	NURSING NOTES
Is your admission to hospital for treatment of an injury? ☐ Yes ☐ No If Yes, please provide the date of injury: ____ / ____ / ____ How did the injury occur?: ☐ Car accident ☐ Work ☐ Sport ☐ Other Please specify: ..... Where did the injury occur?: ☐ Roadway ☐ Home ☐ Work ☐ Sports area ☐ Other Please specify:	
Could you be pregnant? ☐ Yes ☐ No Is the patient under the age of 18 years: ☐ Yes ☐ No If Yes, name of legal guardian of the child? Details: ..... Was the child born prematurely? ☐ Yes ☐ No Details: ..... Are the child's immunisations up to date: ☐ Yes ☐ No	

	YES	NO	COMMENTS	NURSING NOTES
Have you had Xrays taken for this admission?			Where:	
Have you had blood tests for this admission?			When: Where:	
Have you donated your own blood for the purposes of this operation?			Where:	
Have any other doctors been consulted recently eg. cardiologist, physician			If yes, please write details below	
Doctor consulted: ..... Specialty: ..... Doctor consulted: ..... Specialty: ..... Doctor consulted: ..... Specialty: ..... Doctor consulted: ..... Specialty:				

PREVIOUS HOSPITALISATIONS	YES	NO	COMMENTS	NURSING NOTES
Have you been admitted to this hospital before				
Have you been admitted to any hospital within the last 7 days				
Have you been admitted to any hospital within the last 28 days				
Have you been admitted to a hospital outside WA in last 12 months (For WA residents only)				*WA hospitals only*
Reason for Admission:			Hospital Name:	

PREVIOUS SURGERY / PROCEDURES *eg joint replacement, transplants, implants, colonoscopy*

OPERATION	APPROX YR	SURGEON	NURSING NOTES

MEDICATIONS *(including puffers, eye drops etc)*	YES	NO	COMMENTS	NURSING NOTES
Do you take anti-coagulant or blood thinning therapy (Warfarin, Coumadin, Plavix, Iscover, Aspirin)			Still take? ☐ Yes ☐ No Date to be ceased:	
Do you take steroids, anti-inflammatory drugs, cortisone tablets/injections				
Do you take herbal supplements or complementary therapies e.g. fish oil				
Have you received advice from your specialist rooms regarding taking/ceasing your medications prior to admission?				

NOTE: Please list all medications including those above in the following section

PATIENT HEALTH HISTORY – GENERAL RHC002

Ver 3 - 12/12

RAMSAY HEALTH CARE

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.

MEDICATION	FOR TREATMENT OF	FREQUENCY	DAILY DOSE	CESSATION INSTRUCTIONS	DATE CEASED	NURSING NOTES
						Patient own stock?
						☐ Pt med drawer
						☐ Schedule 8 store
						☐ Sent home

ALLERGIES / ALERTS	YES	NO	DETAILS / REACTIONS	☐ *Alert sticker*
Do you have adverse reactions to anaesthetic eg malignant hyperthermia				
Family member with adverse reaction to anaesthetic				
Foods excluded from diet				
Do you have allergies to medications, food, sticking plaster, latex / rubber (e.g. balloons, gloves) or other substances			If yes, please list details below.	
Do you have a medical dietary restriction? (e.g. diabetic, Coeliac Disease, Lactose Intolerance)				
Do you require a special diet? (e.g. Vegetarian, Vegan, Kosher etc)				

ALLERGY INCLUDING FOOD ALLERGIES	DETAILS / REACTIONS	☐ *Alert sticker*

LIFESTYLE	YES	NO	COMMENTS	NURSING NOTES
Height (cms): Weight:				*Check BMI>35*
Have you recently lost weight unintentionally				
Have you ever smoked			Daily Amount: Ceased:	
Do you drink alcohol			Daily Amount:	
Do you use recreational drugs			Daily Amount: Type:	
Do you exercise regularly eg 3 times per week				
Do you have chronic pain				

RHC002 PATIENT HEALTH HISTORY – GENERAL

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

RAMSAY HEALTH CARE

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: .....

AFFIX ID LABEL HERE

Date of Birth: .....

RHC100.11 Patient Completed C

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

CARDIOVASCULAR	YES	NO	COMMENTS	☐ *Cardiac risk*
Elevated cholesterol, triglycerides				
Blood pressure problems eg. low, hypertension				
Cardiac conditions eg. heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina				
Cardiac irregularities eg. palpitations, irregular heart beat, heart murmur, Atrial Fibrillation				
Cardiac surgery eg. pacemaker, implants/devices, prosthetic heart valve, grafts, stents, angioplasty, bypass or any other heart condition.				Year: Model:
Vascular disease eg. carotid disease, aortic aneurysm, peripheral vascular disease.				
Family history of cardiac disease				

ENDOCRINOLOGY	YES	NO	COMMENTS	NURSING NOTES
Diabetes			Type: Controlled by: ☐ Diet ☐ Insulin ☐ Tablets	
Blood glucose levels normally greater than 10 mmol/L				
Thyroid problems, hypothyroidism, goitre				

GASTROINTESTINAL	YES	NO	COMMENTS	NURSING NOTES
Hiatus hernia, gastrointestinal ulcers, reflux				
Liver disease, hepatitis (eg A, B, C), jaundice				
Bowel problems/habits, stoma or bowel disease eg Crohns, IBS				

GENITOURINARY	YES	NO	COMMENTS	NURSING NOTES
Kidney disease, dialysis, renal impairment				
Bladder problems or habits, stoma, incontinence, urinary retention				☐ *Falls risk screen*

HAEMATOLOGY & ONCOLOGY	YES	NO	COMMENTS	NURSING NOTES
Ever had a blood transfusion			Any reaction: Year Transfused:	
Blood Type:				
Diagnosed with cancer			Type: Body Site: Treatment: Date of Diagnosis:	
Blood clot in lung / legs (DVT / PE)				
Blood disorders eg anaemia				
Bleeding disorders or problems				

MUSCULOSKELETAL	YES	NO	COMMENTS	NURSING NOTES
Arthritis eg rheumatoid arthritis, osteoarthritis				
Back or neck injury or problems				

Ver 3 - 12/12

RAMSAY
HEALTH CARE

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.

NEUROLOGY	YES	NO	COMMENTS	NURSING NOTES
Neuromuscular diseases eg MS, myasthenia , dystrophies, parkinsons.				
Stroke, mini stroke, TIA			Date: Impairment:	
Speech problems or swallowing problems eg coughing when eating or drinking				
Limb paralysis or weakness			Left / right side or both	
Difficulties with attention span, understanding and/or problem solving				☐ *Falls risk screen*
Epilepsy, fits, blackouts, funny turns				
Other neurological problems eg migraine, polio, meningitis				
Short term memory loss or dementia				
Previous confusion in hospital				☐ *Falls risk screen*

PROSTHETICS / AIDS / OTHER	YES	NO	COMMENTS	☐ *Brought by Patient*
Visual aids - glasses, contact lenses, visual impairment				
Hearing aids, hearing appliance or hearing impairment, cochlear implant				
Dentures, caps, crowns, loose teeth, implants, veneers				
Other aids for daily living - e.g. artificial limbs				

RESPIRATORY	YES	NO	COMMENTS	NURSING NOTES
Asthma, Pneumonia, Hay Fever, Asbestosis, Chronic Obstructive Pulmonary disease (COPD) e.g. bronchitis, Emphysema.				
Shortness of breath eg walking more than 50m, climbing stairs/inclines				
Sleep Apnoea, disturbed sleep, snoring			Treatment	
Do you use a CPAP machine?			Please bring your CPAP	*Brought by patient*
Other lung problems eg tuberculosis				

OTHER	YES	NO	COMMENTS	NURSING NOTES
Depression, other mental illness				
Lymphoedema				
Any other medical conditions				

FALLS RISK	YES	NO	COMMENTS	☐ *Falls risk screen*
Do you have a fear of falling, are unsteady on feet or have fallen in last 6 months				
Do you use mobility aids eg walking stick, frame etc			Distance without aids	
Have you experienced fainting, dizziness in last 6 months				

RHC002 PATIENT HEALTH HISTORY – GENERAL

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

RAMSAY HEALTH CARE

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: .....

AFFIX ID LABEL HERE

Date of Birth: .....

INFECTION RISK	YES	NO	COMMENTS ☐ *Infection risk*
Have you travelled to a country with a health alert in last 7 days			
Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose			
Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms			
Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms			
Have you ever had MRSA, VRE or ESBL			
Do you have any wounds or breaks on your skin			
Do you have any other conditions or infections			
Have you had vomiting & diarrhoea in the past 48 hours?			
Are you having an operation on your: brain, pituitary gland, spinal cord, nerve root ganglia, retina, optic nerve or having facial maxillary surgery. If you are unsure please tick YES.			If yes, please answer the following 6 questions otherwise continue on to the next section
To find out more about cJD please go to the following URL - http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf			
1. Do you think you may have cCJD			
2. Do you have a first degree relative with cCJD			
3. Have you an unexplained progressive neurological illness of less than 12 mths			
4. Have you a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)			
5. Have you previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)			
6. Have you been involved in a look back for cCJD or have a "medical-in-confidence" letter regarding your risk for cCJD			

DISCHARGE PLANNING	YES	NO	COMMENTS ☐ *Discharge Planner*
Do you live alone			
Do you have someone to look after you after discharge or concerns after discharge			Name of person: Contact Number: Relationship:
Are you solely responsible for the care of another person at home			
Do you currently receive community support and/or nursing services			
Do you require assistance or have concerns with any aspects of day to day living			
Where do you plan to go after discharge			
Do you have escorted transport from hospital			

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

Signature _____

Patient Name _____ Date _____
(please print)

RHC100.11 Patient Completed C

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

Ver 3 - 12/12

RAMSAY
HEALTH CARE

PATIENT HEALTH HISTORY – GENERAL

TO BE COMPLETED BY THE NURSE.
Please PRINT clearly.

NURSE USE ONLY

RISK SCREENING	YES	NO	COMMENTS	NURSING NOTES
Fall risk screen required			Completed & attached ☐ Yes ☐ No	*Refer to Facility Policy*
Infection risk screen required			Completed & attached ☐ Yes ☐ No	*Refer to Facility Policy*
Pressure Ulcer risk screen required			Completed & attached ☐ Yes ☐ No	*Refer to Facility Policy*
Listeria risk screen required			Completed & attached ☐ Yes ☐ No	*Refer to Facility Policy* *Refer to Catering*

Patient history form reviewed by TPSU / PAC Staff ☐ Yes ☐ No		
Name of TPSU / PAC nurse:	Signature:	Date:
Designation:		Time:
Patient history form reviewed by Admitting Nurse ☐ Yes ☐ No		
Name of admitting nurse:	Signature:	Date:
Designation:		Time:
Patient history form reviewed by DSU / Ward Staff ☐ Yes ☐ No		
Name of DSU / Ward nurse:	Signature:	Date:
Designation:		Time:

CLINICAL / PRE-ADMISSION NOTES

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

RHC002 PATIENT HEALTH HISTORY – GENERAL