People caring for people

RAMSAY HEALTH CARE

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**

Ramsay Health Care

Admission Information Booklet

Patient information

Admission Date: .....

Please call the day prior to your admission between 11:30am and 1:00pm to obtain your admission time and fasting details on (02) 6361 6784 or (02) 6362 8122. Monday admissions please call the previous Friday for your admission time and fasting details.

DUDLEY 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.** 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. Hand deliver to hospital reception - (Open 7am - 5pm, Monday to Friday).

b. Post to

Dudley Private Hospital
261 March Street
ORANGE NSW 2800

or

c. Fax to (02) 6363 1977

Please call the day prior to your admission between 11:30am and 1:00pm to obtain your admission time and fasting details on (02) 6361 6784 or (02) 6362 8122. Monday admissions please call the previous Friday for your admission time and fasting details.

Dudley Private Hospital
261 March Street, ORANGE NSW 2800

Tel: (02) 6362 8122
Fax: (02) 6363 1977

Web: www.dudleyprivate.com.au

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. 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.

For healthy adults having an elective procedure, limited solid food may be given up to 6 hours prior to anaesthesia and clear fluids totalling **not more than 200mls per hour** may be taken **up to 2 hours prior to anaesthesia.** (see Australian and new Zealand College of Anaesthetists -'Recommendations for Perioperative Care of Patients Selected for Day Care Surgery') For children and others, your doctor will advise.

Please shower before admission.

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

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

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

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

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

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

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

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

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

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

People caring for people

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

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

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

Guiding Principles

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

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

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

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

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

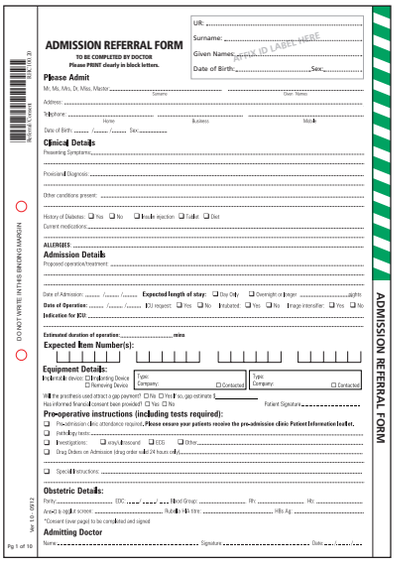
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Important Information

DOCTOR OR PATIENT TO RETURN THE FOLLOWING TWO PAGES 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.



ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR

Please PRINT clearly in block letters.

UR:

Surname:

Given Names:

Date of Birth: Sex:

PREFIX ID LABEL HERE

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:

History of Diabetes: ☐ Yes ☐ No ☐ Insulin injection ☐ Tablet ☐ Diet

Current medications:

ALLERGIES

Admission Details

Proposed operation/treatment

Date of Admission: ____/____/____ Expected length of stay: ☐ Day Only ☐ Overnight stay(s) ..... night/s

Date of Operation: ____/____/____ ICU required: ☐ 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 ☐ Pioneering Device

Type: Company: ☐ Contacted

Type: Company: ☐ Contacted

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

Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature

Pre-operative instructions (including tests required):

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

☐ Fasting (hrs/mins):

☐ Investigations: ☐ xrays/ultrasound ☐ ECG ☐ Other

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

☐ Special Instructions:

Obstetric Details:

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

Any Ab's applied for: Rubella Hb titre: Hbs Ag:

*Consent form page 6 to be completed and signed

Admitting Doctor

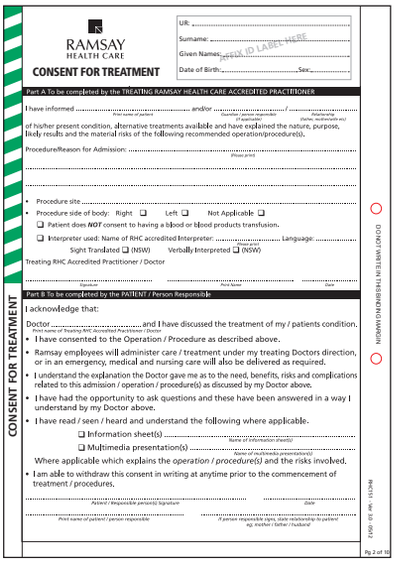
Name: Signature: Date: ____/____/____

DO NOT WRITE IN THIS BINDING MARGIN

ADMISSION REFERRAL FORM

Ver 1.0 - 09/12

Pg 1 of 10



RAMSAY HEALTH CARE

CONSENT FOR TREATMENT

UR:

Surname:

Given Names:

Date of Birth: Sex:

PREFIX ID LABEL HERE

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

I have informed ..... and/or ..... / .....

Name of patient / 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)

Sight Translated ☐ (NSW) Verbally Interpreted ☐ (NSW)

Treating RHC Accredited Practitioner / Doctor

Signature Print Name Date

Part B To be completed by the PATIENT / Person Responsible

I acknowledge that:

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

CONSENT FOR TREATMENT

DO NOT WRITE IN THIS BINDING MARGIN

RHC151 - Ver 1.0 - 09/12

Pg 2 of 10

YOU CAN COMPLETE THE FOLLOWING FORMS (PAGES 3 THROUGH TO 10) 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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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

Welcome and thank you for choosing Dudley Private Hospital. We hope that your stay with us will be as comfortable and pleasant as possible.

Visiting Hours

General Wards / Rehabilitation Unit
10:00am to 8:00pm daily

High Dependency Unit
10:00am to 8:00pm daily, with rest period between 1:00pm to 3:00pm. During rest period we request no visitors or patient phone calls during this time. Please limit visitors to 2 whilst patient is in the High Dependency Unit.

Dudley Clinic
Weekdays: 12:00pm – 1:30pm, 2:30pm-3:30pm, 4:30-8:00pm

Weekends: 10:00am – 8:00pm

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.

If you have indicated that you would like a Chaplain or Veteran Organisation Representative visit, Dudley Private Hospital will make every attempt to facilitate this.

Discharge Information

Discharge time is 10:00am - excluding Day Procedure patients who will be informed of their approximate discharge time on admission. You may be asked to wait in the Reception area on your day of discharge if you are unable to be collected by 10:00am.

Additional Information

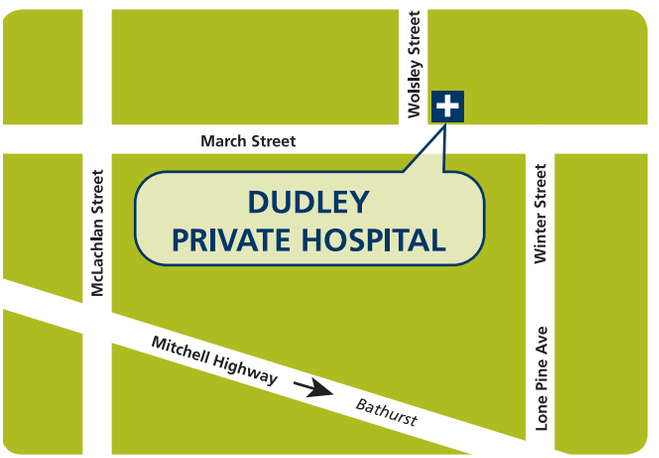
Accounts / Fees
A fund check will be performed by the Hospital prior to your admission and you will receive an Estimate of Expenses / Financial Consent information prior to admission either by mail or telephone. To expedite your admission process we encourage you to pay any outstanding amounts prior to admission by contacting our Patients Account Co-ordinator on 6361 6771.

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 prior permission.

Internet Access
Dudley Private Hospital is able to provide wireless internet access. If your personal electronic device is wireless compatible and you wish to access this service, please request an access card from Reception or Nurses Station after office hours.

Newspapers
A selection of complimentary daily newspapers are available for your convenience.

Customer / Carer Feedback
We value customer and carer feedback. If you have any comments with regard to your stay please complete a feedback card which are available throughout our facility, or respond via our website contact option.



RAMSAY HEALTH CARE

People caring for people

Dudley Private Hospital
261 March Street
Orange NSW 2800
ph: 02 6362 8122 – fax: 02 6363 1977
www.dudleyprivate.com.au

Dudley Private Hospital - Pre-Admission Booklet / ver. 1 - Nov 2012