Bathurst Private Hospital

REFERRAL FOR ADMISSION

REFERRING DOCTOR

PLEASE **COMPLETE** PAGES 2 & 3 OF FORM
THANK YOU

PATIENT OR GUARDIAN

PLEASE **COMPLETE** PAGES 1,4,5,6 & 7 OF THE FORM
plus **Patient Details and date at bottom of page 1**

Please see your G.P. if you are unsure of anything about your medical history.

Once complete please forward to **Bathurst Private Hospital**
as soon as possible either **in person, by fax or email:**

Deliver to: Main Entrance (Reception)
51 Gormans Hill Road Bathurst NSW 2795

Email: admin@bathurstprivate.com.au
Fax: (02) 6332 9147

YOU ARE NOT BOOKED IN FOR YOUR SURGERY UNTIL YOUR BOOKING FORM IS RECEIVED BY BATHURST PRIVATE HOSPITAL

IF YOU HAVE ANY QUESTIONS RELATING TO YOUR ADMISSION PLEASE CONTACT BATHURST PRIVATE HOSPITAL ON **02 6331 7766** DURING OFFICE HOURS OR YOUR DOCTORS SURGERY.

Bathurst Private Hospital

MRN

SURNAME .....

OTHER NAMES .....

SEX ..... DOB .....

DOCTOR .....

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ Male ☐ Female

Surname: Previous Name:

Given Name: Date of Birth: Age:

Address:

Town: State:

Mailing Address: Town: State:

Email (Compulsory):

Telephone (H): (W): Mob:

☐ Married ☐ Defacto ☐ Single ☐ Widowed ☐ Divorced Religion:

Country of Birth:

Aboriginal or Torres Strait Islander? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Both ☐ No, Neither

Employment Status: ☐ Child ☐ Student ☐ Employed ☐ Unemployed ☐ Retired ☐ Home Duties

Language/s spoken at home: Interpreter required: ☐ Yes ☐ No

Have you been a patient in Bathurst Private Hospital before?: ☐ Yes ☐ No

NEXT OF KIN Allow hospital to contact? ☐ Yes ☐ No

Name: Relation to patient:

Telephone (H): (W): Mob:

Address: State

Medicare Number: M/Care Ref. No.: Exp. Date:

Person responsible for hospital account? ☐ Self ☐ Workers Comp ☐ Travel Insurance

DVA ☐ White ☐ Gold Number: Other?:

Private Health Fund?: Member No:

COMPLETE THIS SECTION FOR WORKERS COMPENSATION/TRAVEL INSURANCE OR OTHER

Name Employer: Phone:

Address:

Insurance Company: Phone:

Third Party Company: Phone:

Overseas Visitor - Travel Insurance Company: Phone:

DOCTOR NOTIFICATION

I do/do not consent to the notification of my local GP Dr. _____

Medical Practice Name: _____ Telephone _____

of my admission to hospital and the exchange of information relevant to my case.

Signed: Date:

VMO ADMISSION

Admitting Medical Officer: .....

Pre-Admission Medical Assessment required

☐ Yes ☐ No

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OPERATING PROCEDURE

ITEM No(s):

PRESENTING PROBLEM:

Infection Status (e.g. VRE or MRSA)?

Yes / No Date: .....

Patient is diabetic? Yes / No
If Yes, is N.I.D.D.M. or I.D.D.M (Circle)

Patient's HEIGHT ..... WEIGHT..... BMI .....

If BMI is over 40, has patient been approved by Anaesthetist? ..... ☐ Yes ☐ No

Admission Type:

☐ **Day Surgery only**

☐ **Admit day prior to surgery**

☐ **Admit day of surgery (i.e. overnight/s stay)**

Date of Admission: ...../...../.....

Date of Procedure: ...../...../.....

Length of stay: (Specify) .....

Approximate duration of theatre: .....

Type of Anaesthetic:

☐ General ☐ Local ☐ Block ☐ Sedation ☐ Spinal ☐ Epidural

Requirements:

X-Rays: ☐ Yes ☐ No ☐ Mobile X-Ray

Surgical Assistant Required: ☐ Yes ☐ No

Name: .....

Prosthesis required: ☐ Yes ☐ No .....

.....

.....

Company Name: .....

Special Requirements:

☐ Image Intensifier

☐ Operating microscope

☐ Frozen Section

☐ Bone Bank

☐ Gamma Probe

☐ Ultrasound

Investigations to be completed prior to admission

FBC	☐	Fe Studies	☐
EUC	☐	Coags	☐
LFT's	☐	MSU	☐
TFT's	☐	MRSA screen	☐
G&H	☐	X-Rays	☐
ECG	☐	CT Scans	☐

Other: .....

Are there any medication to be ceased prior to surgery?

☐ Yes ☐ No

Which medication? .....

Days prior to Surgery? .....

Patient informed of Bowel Prep? ☐ Yes ☐ No ☐ N/A

Clinical Requirements: (✓)

☐ TED's

☐ Anticoag Therapy Specify: .....

☐ Preps (including bowel) Specify: .....

☐ Shave / Clip

☐ Antibiotics Specify: .....

Other Investigations / Requirements:

.....

CLINICAL URGENCY

Category 1 ☐ within 30 Days

Category 2 ☐ within 90 Days

Category 3 ☐ within 365 Days

Category 4 ☐ not ready for care

Surgery Due Date: ...../...../.....
(HOSPITAL USE ONLY)

OFFICE USE ONLY: To Ward / Day Surgery

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PROVISION OF INFORMATION TO PATIENT **To be completed by Medical Practitioner**

I, Dr ..... have informed this Patient / Parent / Guardian* of the nature, likely results and material risks of ..... and of any financial interest I have in Bathurst Private Hospital.

(insert name of procedure or treatment)

If Interpreter Present*

..... Signature of Interpreter

..... Signature of Medical Practitioner

PATIENT CONSENT **TO BE COMPLETED BY PATIENT**

Dr ..... and I have discussed .....'s / my* present condition and the various ways in which it might be treated. The doctor has recommended

.....

.....

(insert name of procedure or treatment)

The doctor has told me that:

- The procedure/treatment carries some risk and that complications may occur;
- An anaesthetic, medications or blood transfusion may be needed and they may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care;

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanations and the answers to my questions.
I understand that I may withdraw my consent anytime prior to the procedure/treatment.
I consent to BPH contacting my health fund or insurance provider to assess/confirm my coverage.
I also consent to anaesthetics, medicines or other treatments which could be related to the procedure/treatment.
I consent / do not consent* to a blood transfusion if needed,
I request and consent to the procedure / treatment described above for: .....

(insert "me" or name of child)

I note that the Children (Care and Protection) Act 1987 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

* DELETE THIS SECTION IF NOT REQUIRED

While I consent to the above procedure / treatment, after discussing this matter with the doctor, I **REFUSE CONSENT** (for myself/my child)* to the following aspects of the recommended procedure or treatment:

..... INSERT OBJECTION

..... (This part must be countersigned by the Doctor if retained)

..... SIGNATURE OF PATIENT/PARENT OR GUARDIAN*

..... PRINT NAME OF PATIENT, PARENT OR GUARDIAN

..... DATE

..... ADDRESS

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IF YES, please give details to any questions

What is your: Weight ..... kg **Height:** ..... cm/ft inches		
Any CURRENT or PAST MEDICAL CONDITIONS, PHYSICAL / DEVELOPMENTAL ILLNESS OR DISABILITY (eg Cancer, Autism, sight/hearing impaired)		☐ No
Have you ever been treated for: : ☐ anxiety ☐ depression ☐ bipolar disease ☐ psychosis ☐ obsessive compulsive disorder ☐ PTSD ☐ schizophrenia ☐ personality disorder ☐ other mental health problem or addiction:		☐ No
Are you currently being treated for any of the above mental health illnesses or addictions? If Yes, give details:		☐ No
Are you a diabetic? If Yes: How is it managed? ☐ Diet ☐ Tablet ☐ Insulin		☐ No
Do you have thyroid disease? If yes: ☐ hypothyroidism ☐ hyperthyroidism		☐ No

Surgical History

Have you had any previous surgery? If Yes, give details:		☐ No
Surgery **Year** .... ATTACH SEPARATE SHEET, IF REQUIRED		
Have you had any problems with anaesthesia? ☐ malignant hyperthermia ☐ nausea/vomiting ☐ pseudocholinesterase deficiency ☐ difficulty with insertion of the anaesthesia breathing tube ('difficult intubation') ☐ other If Yes: Describe:		☐ No
Do you have a blood relative who has had problems with anaesthesia? ☐ malignant hyperthermia (high fever) ☐ pseudocholinesterase deficiency ☐ other If Yes, give details:		☐ No
Are you allergic to latex? If Yes: Describe: ..... Have you been tested for latex allergy? ☐ Yes ☐ No		☐ No
Do you have any allergies to any medication? If Yes, please list: name: ..... reaction: ..... name: ..... reaction: ..... name: ..... reaction: ..... name: ..... reaction:		☐ No
Do you have any allergies to food, tapes or other allergies? If Yes, list:		☐ No

Respiratory

Have you ever been diagnosed with: ☐ asthma ☐ tuberculosis ☐ emphysema ☐ COPD ☐ Any other breathing or lung problems		☐ No
Do you see a Respiratory Specialist? Name ..... Last Visit:		☐ No
Do you use oxygen at home? If Yes, how much? ☐ Mask ☐ nasal prongs ☐ ..... Litres/min		☐ No

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Respiratory (cont'd)

Do you have sleep apnoea? If Yes, do you: ☐ use CPAP ☐ use BiPAP ☐ don't use CPAP	☐ Yes	☐ No
Do you snore loudly enough to be heard through closed doors?	☐ Yes	☐ No
Do you often feel tired, sleepy or fatigued during the day?	☐ Yes	☐ No
Has anyone observed you stop breathing or choking/gasping during your sleep?	☐ Yes	☐ No
Do you have a cough with sputum?	☐ Yes	☐ No
Do you have any problems with breathing? Describe:	☐ Yes	☐ No
Do you have any problems with your jaw or mouth opening? Describe:	☐ Yes	☐ No

Cardiovascular

Have you ever had: ☐ high blood pressure ☐ heart attack ☐ heart murmur ☐ angina ☐ heart failure ☐ irregular heart beat ☐ heart valve problem ☐ other heart problems		☐ No
Do you have a Cardiologist? If Yes: Name ..... Last visit		☐ No
Do you have a : ☐ pacemaker ☐ defibrillator (ICD) ☐ stents ☐ artificial heart valve		☐ No
Have you needed: ☐ heart surgery ☐ carotid surgery ☐ surgery on major arteries or veins If Yes: Details ..... Hospital ..... Year		☐ No
Have you had a: ☐ stress test ☐ anglogram ☐ echo cardiogram (heart ultrasound) If Yes: Details ..... Hospital ..... Year		☐ No

Gastrointestinal

Have you ever had liver problems such as ☐ hepatitis ☐ cirrhosis? Details		☐ No
Do you have a frequent ☐ heartburn (GORD) ☐ ulcer(s) or ☐ hiatus hernia? Details		☐ No
Have you ever had : ☐ jaundice ☐ hepatitis Details		☐ No

Haematological

Have you ever been diagnosed with: ☐ bleeding disorder ☐ Anaemia ☐ Sickle cell disease ☐ low blood iron ☐ Thalasemia ☐ low platelets ☐ Other		☐ No
Have you ever had a blood clot in your ☐ legs or ☐ lungs? If yes, when? ..... Treatment? .....Has it resolved?		☐ No
Have you taken any blood thinner medication in the last month? If Yes: Name		☐ No
Have you recently stopped taking a blood thinner? If Yes: When did you stop:		☐ No
Do you bruise easily, get nosebleeds, or bleed excessively after brushing teeth? Details		☐ No
Have you ever had a blood transfusion? Year: ..... Reason (eg. after childbirth/accident) ..... Year: ..... Reason ..... Year: ..... Reason		☐ No

Neurological/Musculoskeletal

Have you ever had: ☐ Stroke (CVA) ☐ Mini-Stroke (TIA) ☐ Seizures If yes: When was your last episode?		☐ No
Any ongoing muscle weakness, speech or memory concerns? Describe:		☐ No
Do you have: ☐ Multiple Sclerosis ☐ Parkinsons ☐ Alzheimers ☐ memory problems ☐ Other neurologic or muscle disorder		☐ No
Do you get: ☐ numbness ☐ tingling or ☐ weakness of your arms (☐ L, ☐ R) or Legs (☐ L, ☐ R)		☐ No
Do you have arthritis? If yes: ☐ osteoarthritis ☐ rheumatoid arthritis ☐ Other:		☐ No
Do you have difficulty with any of the following activities? If yes: ☐ bathing yourself ☐ dressing yourself ☐ feeding yourself ☐ grooming yourself		☐ No

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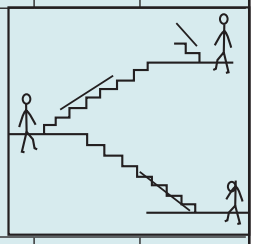
Neurological/Musculoskeletal (cont'd)

Do you have any weakness in your arms/hands? If yes: ☐ Left ☐ Right ☐ Both		☐ No
Do you have any weakness in your legs? If yes: ☐ Left ☐ Right ☐ Both		☐ No
Do you use any assistive devices? If Yes: Check all that apply: ☐ cane ☐ walker ☐ wheelchair ☐ crutches ☐ bed lift ☐ commode ☐ Other		☐ No
Do you have limited neck or jaw movement? Yes: Please specify		☐ No

Can you normally walk without stopping?
If no, please state why? (e.g. knee pain, shortness of breath)



more than 2 flight of stairs? ☐ Yes ☐ No .....
one flight of stairs? ☐ Yes ☐ No .....
around the house? ☐ Yes ☐ No .....
Can you lie flat for 1 hour? ☐ Yes ☐ No .....

Have you ever had : ☐ jaundice ☐ hepatitis	☐ Yes	☐ No

Renal

Have you ever had kidney disease? Describe:		☐ No
Are you a dialysis patient? ☐ peritoneal ☐ hemodialysis		☐ No

Hearing

Do you have or need Hearing Aids? If Yes: ☐ left hearing aid ☐ right hearing aid		☐ No

Vision

Do you need to wear glasses or use contact lenses? If Yes: ☐ wear glasses/lenses all the time ☐ wear glasses/lenses just for reading		☐ No

Other

Do you get motion sickness? If Yes, give details:		☐ No
Do you smoke or have you ever smoked? If yes # of cigarettes a day: ..... # of years smoked: ..... Year stopped:		☐ No
Do you use recreational drugs, street drugs or marijuana/cannabis? If Yes: Type: ..... Amount: ..... How often: ..... Type: ..... Amount: ..... How often:		☐ No
Do you drink alcohol such as beer, wine and/or liquor? If Yes: # of drinks a week:		☐ No

Medications and Supplements

Include prescription **AND** non-prescription medication you take including tablets, injections, inhalers, creams, patches, drops, insulin, pain relief, vitamin supplements etc. **LIST ALL.** Attach a separate sheet, if required.

DRUG NAME & STRENGTH **REASON FOR TAKING?** **TIME OF DAY / WEEK?** **YOUR DOSE** (e.g. 2 tablets)

.....

.....

.....

.....

ATTACH SEPARATE SHEET, IF REQUIRED

.....

.....

Name of local prescribing doctor ..... Town .....

Name of your local pharmacy ..... Town .....

(contined over page)

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Have you had any tests done for your GP / Specialist in the last 6 months? (eg. blood tests, rays/echo/stress tests) If yes, please list: .... Specialists Name and contact Number:		☐ No
Do you have a responsible adult to stay with you the night after you leave hospital? Name:	☐ Yes	☐ No
Do you have someone to collect you from hospital? Contact name:	☐ Yes Contact No:	☐ No
Are you the primary carer for someone? If Yes, Specify	☐ Yes	☐ No
Do you have:		
Steps / Stairs	☐ Yes How many	☐ No
Hand rails in your bathroom / toilet?	☐ Yes Specify	☐ No
A shower over the bath?	☐ No ☐ Yes	
Do you currently need assistance?		
to ☐ Stand ☐ Mobilise If Yes, give details:		☐ No
to ☐ Transfer into bed or Chair If Yes, give details:		☐ No
Do you require a special diet? (e.g. Diabetic, Vegetarian, etc.) ☐ Yes, Specify		☐ No
Do you currently use any services listed below?		
Home Help ☐ | Meals on Wheels ☐ | District Nurse ☐ | Other ☐ (Please outline)		☐ No
Do you have an Advanced Care Directive? If yes please attach or bring a copy with you to the hospital.	☐ Yes Copy attached? ☐	☐ No
Have you had any brain surgery between 1972-1989?	☐ Yes	☐ No
Do you have a family history or relatives with CJD? (known as Mad Cow disease)	☐ Yes	☐ No
Have you received any growth hormones prior to 1985?	☐ Yes	☐ No
Have you suffered from a recent progressive dementia, (physical or mental) the cause of which has not been diagnosed?	☐ Yes	☐ No
What are your goals of care for this admission?		
Do you have anything further your wish to add to this booking form?		☐ No

PLEASE COMPLETE IF THE PATIENT IS A CHILD

Was the child born prematurely? If so, how many weeks? ..... weeks	
Does your child have any problems with his/her HEART OR LUNGS OR ANY OTHER MEDICAL PROBLEMS? If Yes, please give details	☐ No
HAVE YOU ANSWERED EVERY QUESTION AND GIVEN DETAILS WHERE REQUIRED? ☐ Yes	☐ No

/ /

REVIEWED BY PRE-ADMISSION NURSE FOR SURGICAL ADMISSIONS ..... **(Signature & Date)**