Bathurst Private Hospital

MRN:

SURNAME

OTHER NAMES

DOB / SEX

WARD / DOCTOR

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 ..... (insert name of procedure or treatment) and of any financial interest I have in Bathurst Private Hospital.

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

SURNAME: **FIRST NAME:** **DOB:** **MRN:**

20. Are you taking **ANY** medications/vitamins - over the counter, prescribed and/or herbs/supplements?
☐ Yes ☐ No **If yes please specify:**

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 .....

21.	Do you have a responsible adult to stay with you the night after you leave hospital?	☐ No ☐ Yes
22.	Do you have someone to collect you from hospital? Contact name:	☐ No ☐ Yes Contact number .....
23.	Are you the primary carer for someone? If Yes, Specify	☐ No ☐ Yes
24.	Do you have:	
a)	Steps / Stairs	☐ No ☐ Yes If Yes, how many .....
b)	Hand rails in your bathroom / toilet?	☐ No ☐ Yes Specify .....
c)	A shower over the bath?	☐ No ☐ Yes
25.	Do you currently use / require?	
a)	Walking stick / Frame	☐ No ☐ Yes
b)	Wheelchair	☐ No ☐ Yes
c)	Assistance of one person	☐ No ☐ Yes
26.	Do you require a special diet? (e.g. Diabetic, Vegetarian, etc.)	☐ No ☐ Yes Specify .....
27.	Do you currently use any services listed below?	
a)	Home Help	☐ No ☐ Yes
b)	Meals on Wheels	☐ No ☐ Yes
c)	District Nurse	☐ No ☐ Yes
d)	Other (Please outline)	.....
28.	Do you have an Advanced Care Directive? If yes please attach or bring a copy with you to the hospital.	☐ No ☐ Yes If Yes, copy attached? ☐
29.	Have you had any brain surgery between 1972-1989?	☐ No ☐ Yes
30.	Do you have a family history or relatives with CJD? (known as Mad Cow disease)	☐ No ☐ Yes
31.	Have you received any growth hormones prior to 1985?	☐ No ☐ Yes
32.	Have you suffered from a recent progressive dementia, (physical or mental) the cause of which has not been diagnosed?	☐ No ☐ Yes
33	What are your goals of care for this admission?	.....
	PLEASE COMPLETE IF THE PATIENT IS A CHILD	
34.	Was the child born prematurely? If so, how many weeks?	☐ No ☐ Yes ..... weeks
35.	Does your child have any problems with his/her HEART OR LUNGS OR ANY OTHER MEDICAL PROBLEMS? Please give details	☐ No ☐ Yes
36.	**HAVE YOU ANSWERED EVERY QUESTION AND GIVEN DETAILS WHERE REQUIRED?**	☐ No ☐ Yes

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

Bathurst Private Hospital

REFERRING DOCTOR

PLEASE **COMPLETE** PAGES 3 & 4 OF FORM
THANK YOU

PATIENT OR GUARDIAN

PLEASE **COMPLETE** PAGES 1,2 & 5 OF THE FORM
plus **Patient Details and date at bottom of page 4**

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 Front Office @ 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.

REFERRAL FOR ADMISSION

MRN:

☐ 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:

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

Have you reached your **Pharmacy Safety Net** this year? ☐ Yes ☐ No If yes, Number is?

Pensioner Number: DVA Card: Gold/White:

Health Fund Name: M/Ship No.: Excess $:

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

Country of Birth: Aboriginal or Torres Strait Islander - ***Please circle:***

1. Yes Aboriginal 2. Yes Torres Strait Islander 3. Yes Both 4. 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

CONTACT PERSON

Name: Relation to patient:

Telephone (H): (W): Mob:

Address: State

COMPLETE THIS SECTION IF UNDER WORKERS COMPENSATION

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.

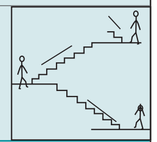
Signed: Date:

SURNAME: **FIRST NAME:** **DOB:** **MRN:**

TICK THE APPROPRIATE BOXES **IF YES, please give details to any questions**

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

1.	Any CURRENT or PAST MEDICAL CONDITIONS, PHYSICAL/MENTAL ILLNESS OR DISABILITY? (e.g. Cancer, Autism, Depression, PTSD, sight/hearing impaired)	☐ No ☐ Yes **If yes, please give details**
1a.	Are you diabetic?	☐ No ☐ Yes
1b.	**If Diabetic, do you manage with:**	☐ **Diet** ☐ **Tablet** ☐ **Insulin**
2.	ALL PREVIOUS OPERATIONS?	☐ No ☐ Yes **If yes, please give details**
3.	Have you, or a blood relative, ever had a problem with ANAESTHETICS?	☐ No ☐ Yes **If yes, please give details**
4.	Are you ALLERGIC to ANY medicines, tapes, antiseptics, latex, rubber or foods? *(Please list)*	☐ No ☐ Yes
5.	Do you have any BREATHING/RESPIRATORY PROBLEMS (shortness of breath, cough, pneumonia, TB, asthma, sleep apnoea). If yes, has your condition become worse in the last 3 months?	☐ No ☐ Yes **If yes, please give details**
5a.	Do you use home oxygen?	☐ No ☐ Yes
6.	Do you have, or have you ever had in the past, problems with your HEART? (High blood pressure, chest pain, angina, heart attack, rheumatic fever, murmurs). If yes, has your condition become worse in the last 3 months?	☐ No ☐ Yes **If yes, please give details**
6a.	Do you have a Pacemaker?	☐ No ☐ Yes
7.	Do you have heartburn, indigestion, hiatus hernia or reflux?	☐ No ☐ Yes
8.	Do you have any (BLEEDING PROBLEMS?) (Easy bruising, excessive bleeding after dental extractions)	☐ No ☐ Yes
9.	Have you ever had BLOOD CLOTS in the legs or lungs?	☐ No ☐ Yes **If yes, please give details**
10.	Have you ever had a blood transfusion?	☐ No ☐ Yes **If yes, please give details**
11.	Have you ever had a problem with epilepsy, stroke, leg or arm weakness, fits, faints or "funny turns"?	☐ No ☐ Yes
12.	Have you ever had jaundice or hepatitis?	☐ No ☐ Yes
13.	Do you have limited neck or jaw movement? Please specify	☐ No ☐ Yes
14.	Could you possibly be pregnant?	☐ No ☐ Yes **If yes, number of weeks**
15.	Have you had any tests done for your GP / Specialist in the last 6 months? (e.g. blood tests, xrays/echo/stress test) **Please list:**	☐ No ☐ Yes Specialist name and contact number
16.	Do you smoke? If yes, how many per day?	☐ No ☐ .....per day
16a.	Have you ever smoked? If Yes when did you stop?	☐ No ☐ Yes
17.	Do you have more than 3 alcoholic drinks most days?	☐ No ☐ Yes
18.	Have you ever injected yourself with a substance not prescribed by a doctor? Specify	☐ No ☐ Yes
19.	Can you normally walk without stopping? If no, please state why? (e.g. knee pain, shortness of breath)	
a)	more than 2 flight of stairs?	☐ No ☐ Yes
b)	one flight of stairs?	☐ No ☐ Yes
c)	around the house?	☐ No ☐ Yes
d)	Can you lie flat for 1 hour?	☐ No ☐ Yes



HAVE YOU ANSWERED EVERY QUESTION AND GIVEN DETAILS WHERE REQUIRED? ☐ No ☐ Yes

VMO ADMISSION

MRN Number

SURNAME

Other Names

DOB/Sex

Doctor/ Ward

Admitting Medical Officer:

Pre-Admission Medical Assessment required

☐ Yes ☐ No

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	☐	HbA1C	☐
LFT's	☐	Coags	☐
TFT's	☐	MSU	☐
G&H	☐	MRSA screen	☐
ECG	☐	CT / X-Rays	☐

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