WESTERN
YOUR HOSPITAL THAT CARES

168 CUDMORE TERRACE, HENLEY BEACH SA 5022 **TELEPHONE (08) 8356 1222** FACSIMILE (08) 8353 4051
Email: reception@westernhospital.com.au Website: www.westernhospital.com.au

PRELIMINARY INFORMATION

INTRODUCTION

Western Hospital is a health services hub, providing facilities for Surgical and Medical patients.

The hospital's primary purpose is to care for you and your needs and the staff strive to maintain a high standard of patient care. The staff work as a team and will do their utmost to make your stay as comfortable as possible.

ACCOMMODATION

Subject to bed availability at the time of admission, patients have a choice between private or shared accommodation. Every effort is made to provide the accommodation requested but circumstances sometimes may make this impossible and as a consequence, the hospital reserves the right to provide alternative accommodation.

ADMISSION

Admission to the hospital is arranged by your doctor and in order to minimise delays we request that you lodge or post or fax your **admission form prior to your admission date**. Your doctor will advise you of your admission time. If you have any queries in relation to your admission requirements, please do not hesitate to contact the hospital.

PRE-ADMISSION SERVICE

A pre-admission service for patients undergoing surgery is provided by the hospital. Nursing staff will contact you as required.

DISCHARGE TIME

On the day of **Discharge** patients are encouraged to vacate their rooms by 10.00am to enable us to prepare for incoming patients. Day patients arrange pick up time with nursing staff on admission.

WHAT TO BRING

- Details of health insurance membership, WorkCover, Pension or Veterans Affairs Card, Pharmaceutical Entitlement Card, Medicare Card and Safety Net Entitlement Card.
- Sleep Apnoea Patiences – please ensure that you bring your CPAP Machine with you to be checked by our Maintenance Department between 8.00am and 4.00pm Monday to Friday priur to use.
- All relevant Xrays/scans.
- All medication you care currently taking.
- Nightwear, dressing gown, slippers.
- Personal toiletries (including soap).

WHAT NOT TO BRING

Talcum Powder is prohibited in the hospital.

Please remove any fingernail polish, makeup & jewellery prior to admission.

Western Hospital **strongly** recommends that you do not bring anything of value into hospital (e.g. large amounts of money, credit cards or any items of personal value). **The hospital does not accept any responsibility for lost or stolen items.** We request that in the interest of electrical safety, you do not bring electrical items, eg. hairdryers, electrical chargers or electric shavers.

TELEVISION, RADIOS AND TELEPHONES (OVERNIGHT ACCOMMODATION ONLY)

Televisions, radios and telephones are provided at each bed. Phone cards are available at Reception for mobile and STD calls. The use of mobile telephones within the hospital is permitted in some areas only. Local calls are free of charge.

INSURED PATIENTS

Your account for hospitalisation will include accommodation, theatre fees, and other chargeable items in accordance with Western's current fee arrangement with your health fund.

On signing your claim form on admission, an account for your hospital stay will be forwarded directly to your health fund for prompt reimbursement.

All excesses and co-payments for all patients (inc. Day Surgery) are payable on admission.

In the event your health fund rejects your reimbursement claim for any reason, the hospital will seek to recover any amounts outstanding from you.

PHARMACY

Discharge medications will be required to be paid by you on discharge.

SELF INSURED PATIENTS

If you are a self insured patient (ie you do not have private health cover), you will be required to pay an estimate of the total account on or prior to admission.

WORKCOVER/THIRD PARTY INSURANCE PATIENTS

If you are a WorkCover or Third Party Insurance patient, Western will require written approval for your admission from the relevant insurance company on or prior to admission.

SMOKING

Western Hospital is a no smoking environment and smoking is not permitted anywhere on the hospital grounds.

VISITORS

Normal visiting hours are: **11.00am to 8.00pm.**

CHILDREN IN HOSPITAL

Parents may visit their children at any time.

Arrangements can be made for one parent to be accommodated with their child. If your child has a special toy, etc. please bring it with him/her.

MAIL

Mail will be delivered to you daily, the correct address to inform your relatives is:

C/- Western Hospital
168 Cudmore Terrace
Henley Beach SA 5022

FREE PARKING

Ample parking space is provided on the hospital grounds. Please ensure your vehicle is not parked in unauthorised areas.

FURTHER INFORMATION

If you require any further information or would like to talk to someone about your planned hospital stay, please contact us on 8356 1222 and ask to speak to our Patient Services Coordinator or Preadmission Nurse.

YOUR PRIVACY, RIGHTS & RESPONSIBILITIES

Respecting your privacy

The privacy of your personal information is important to us at Western Hospital and we are committed to ensuring it is protected. Western Hospital complies with the National Privacy principles under the Commonwealth Privacy Act 1998 and all other state legislative requirements in relation to the management of personal information.

Collecting personal information

In order to provide you with the health care services that you have requested when you become a patient with us, we need to collect and use your personal and health information. If you provide us incomplete or inaccurate information, we may not be able to provide you with the services you are seeking. When you become a patient at Western Hospital, a medical record is created, and it includes person information such as your name and contact details, as well as information about your health problems and the treatment you received. Each time you attend the hospital we will update your medical record, collecting information necessary for the provision of healthcare and services for you. Our staff will always endeavour to be sensitive to your needs when obtaining personal and health information. However they are also committed to acting in your best interests by making a thorough assessment of your condition and medical history.

Protecting your personal information

In addition to complying with all relevant privacy and confidentiality legislation, Western Hospital has strict policities with respect to the collection, use, disclosure and storage of patient information. We have taken measures to ensure both paper based and electronic information on our computer system are stored securely. Only authorised personnel have access to your information.

Using and disclosing your personal information

During your hospitalisation there may be occasions when we may be obliged to or authorised under law to disclose patient information, regardless of your consent, including subpoena of records for legal action, mandatory reporting to government authorities (such as registration of births, deaths, diseases and treatments) or reporting information about care provided as required by SA Department of Health. In order to provide care and services for you, we may also need to use your personal information where necessary for the management of the hospital, liaising with your health fund and Medicare and for activities such as quality assurance processes, accreditation, audits, risks and claims management and education of healthcare professionals involved in your care and treatment.

Accessing your personal information

You have a right to have access to the health information we hold in your medical record, subject to some exceptions by law. You can also request an amendment to your health record should you believe it contains inaccurate information. For more information about accessing your records, please contact our Privacy Officer.

Rights and responsibilities

As a consumer of healthcare services at Western Hospital you have specific rights and responsibilities regarding your care and treatment. Western Hospital Rights and Responsibilities Charter recognise that people receiving care and people providing care all have important parts to play in achieving healthcare rights. These rights and responsibilities are essential to make sure that care provided is of a high quality and is safe.

You have the right to:

- have access to the best and most appropriate care available for your needs
- be shown respect, dignity and consideration
- be informed of all aspects of services, options, treatments and costs in an open and clear way
- be included in decisions and choices about your care
- privacy and confidentiality of your personal information
- ask the identity, professional status and qualifications of any healthcare worker providing care and services
- express your concerns or provide feedback by making suggestions and complaints and you have the right to have these addressed

You have the responsibility to:

- answer questions about your health openly and completely
- comply with prescribed treatments, seeking clarification if you are unsure and to inform staff and your doctor if you have concerns about your conditions
- discuss with your healthcare professionals if you wish to refused treatment
- respect the dignity and rights of other patients, visitors and hospital staff
- contact the hospital should you wish to postpone or cancel your admission or if you are unable to arrive at the scheduled time
- respect hospital property, policites and regulations
- finalise your accounts pertaining to your hospitalisation
- direct any complaint to a staff member so that appropriate steps can be taken to address your concerns

Complaints and feedback

If you have concerns about our information handling practices, you are encouraged to speak directly to our staff. If after dealing with us and you feel the matter has not been addressed, please contact the Federal Privacy Commissioner. If you have any other complaints or concerns about your Rights and Responsibilities, or would like to provide us with feedback, you can speak to our staff directly or contact our Chief Executive Officer:

Western Hospital
168 Cudmore Terrace
Henley Beach SA 5022
Phone: 8356 1222
Fax: 8353 4051

PATIENT ADMISSION FORM

WESTERN
YOUR HOSPITAL THAT CARES

OFFICE USE ONLY
UR No:

PLEASE COMPLETE AND RETURN ADMISSION FORM AND PATIENT HISTORY FORM TO WESTERN HOSPITAL PROMPTLY PRIOR TO YOUR ADMISSION

REASON FOR ADMISSION: _____

ADMISSION DATE: _____ **TIME:** _____ **ADMITTING DOCTOR:** _____

HOSPITAL STAY: **OVERNIGHT** ☐ **DAY** ☐

PATIENT DETAILS

TITLE: MR ☐ MRS ☐ MISS ☐ MS ☐ MASTER ☐ DR ☐ MALE ☐ FEMALE ☐

SURNAME: _____ GIVEN NAMES: _____

DATE OF BIRTH: _____ PREVIOUS SURNAME (IF APPLICABLE): _____

ADDRESS: _____ POST CODE: _____

POSTAL ADDRESS (IF DIFFERENT FROM ABOVE): _____

TELEPHONE HOME: _____ WORK: _____ MOBILE: _____

OCCUPATION: _____ COUNTRY OF BIRTH: _____ RELIGION: _____

MARITAL STATUS: SINGLE ☐ MARRIED/DEFACTO ☐ WIDOWED ☐ DIVORCED ☐ SEPARTED ☐

RACE: CAUCASIAN ☐ ABORIGINAL ☐ ASIAN ☐ TSI ☐ OTHER ☐
(REQUIRED BY SA HEALTH)

GP / LOCAL DOCTOR DETAILS

DOCTOR: _____ PHONE No.: _____

ADDRESS: _____ FAX No.: _____

NEXT OF KIN OR CONTACT PERSON

TITLE: _____ SURNAME: _____ GIVEN NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ POST CODE: _____

TELEPHONE HOME: _____ WORK: _____ MOBILE: _____

OTHER CONTACT PERSON: _____ PHONE: _____ RELATIONSHIP: _____

MEDICARE AND CONCESSION DETAILS

MEDICARE No.: ☐☐☐☐☐☐☐☐☐☐ No. PREFIXING NAME: ☐ VALID TO: MONTH ☐☐ / YEAR ☐☐

PENSION NUMBER: _____ EXPIRY DATE: _____

PBS SAFETY NET CARD No.: _____ EXPIRY DATE: _____

DEPT OF VETERANS AFFAIRS FILE No.: _____ EXPIRY DATE: _____ CARD: GOLD ☐ WHITE ☐ OTHER ☐

WEST 005

HEALTH INSURANCE DETAILS

INSURED PATIENTS: It is recommended that you contact your Health Fund prior to completing this form to check your level of cover, particularly if you have been a member for less than 12 months or have changed your cover in the same period. Please be aware of the PRE-EXISTING CONDITION RULE. It is important that you are aware of all financial costs relating to your stay in hospital.

HEALTH FUND: _____ MEMBERSHIP No.: _____ TABLE: _____

CURRENT TABLE MEMBERSHIP: OVER 12 MONTHS ☐ LESS THAN 12 MONTHS ☐

DO YOU HAVE AN EXCESS OR CO-PAYMENT TO PAY? YES ☐ NO ☐ IF SO, HOW MUCH: $ _____

*** ANY EXCESS OR CO-PAYMENT DUE, MUST BE PAID PRIOR TO OR ON ADMISSION ***

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (IF NOT YOURSELF):

NAME: _____ PHONE: _____

ADDRESS: _____ POST CODE: _____ RELATIONSHIP: _____

OUT OF POCKET EXPENSES

HAS YOUR ADMITTING SPECIALIST/ANAESTHETIST EXPLAINED TO YOU HIS/HER ACCOUNT DETAILS IN RELATION TO YOUR ADMISSION?

YES ☐ NO ☐

If you answered NO it is recommended you talk to your Admitting Specialist/Anaesthetist PRIOR to your Admission to obtain information on any out-of-pocket expenses that may apply.

SELF-FUNDED PATIENTS

Please obtain the following information from your doctors' rooms: item numbers (s) for planned procedure, and then contact the hospital for an estimate of costs:

All costs for uninsured patients are payable on or prior to admission and are not covered by Medicare.

COMPLETE ONLY FOR COMPENSABLE ADMISSIONS

PLEASE TICK APPROPRIATE BOX: WORKCOVER ☐ THIRD PARTY ☐ PUBLIC LIABILITY ☐

DATE OF ACCIDENT: _____ CLAIM NUMBER: _____

EMPLOYER'S COMPANY NAME: _____ CONTACT PERSON: _____

ADDRESS: _____ PHONE: _____ FAX: _____

INSURER'S NAME: _____ CONTACT PERSON: _____

PHONE: _____ FAX: _____

INSURANCE COMPANY APPROVAL MUST BE OBTAINED BEFORE ADMISSION.

PREVIOUS HOSPITAL ADMISSION

HAVE YOU BEEN A PATIENT AT WESTERN HOSPITAL SINCE AUGUST 2003? YES ☐ NO ☐

HAVE YOU BEEN A PATIENT AT **ANY** HOSPITAL WITHIN THE PAST 7 DAYS? YES ☐ NO ☐

IF YES, PLEASE STATE WHICH HOSPITAL: _____

DATE OF HOSPITALISATION: FROM: _____ TO: _____

FINANCIAL INFORMATION AND CONSENT

1. I accept full responsibility for accounts rendered by Western Hospital, including any shortfall in reimbursement by my health fund/or workers compensation gap following settlement by a health fund and/or insurance company.
2. I have had the financial costs of my hospitalisation clearly explained to me and understand that:
   - Total costs cannot be quoted, but only estimated in advance
   - My obligation to pay for my hospitalisation is independent of any benefits I may be able to claim for my private health insurance and that I will be liable for any debt collection and/or solicitor's fees incurred in the collection of these accounts.
3. I understand that any excess payable under my private health insurance fund will be paid on admission.
4. I understand that I may be required to pay for some items used in theatre that may not be covered by my health fund.

SIGNATURE

Date: / /

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PATIENT HISTORY

Stick patient identification label in this box

UR No: _____

Surname: _____

Given Names: _____

DOB: _____ Sex: _____

Hospital/Health Unit Name: _____

(or affix patient label)

PLEASE COMPLETE ALL THREE (3) PAGES OF PATIENT HISTORY, SIGN AND RETURN COMPLETED FORM TO PRE-ADMISSION NURSE PRIOR TO PLANNED ADMISSION DATE

DAY CASE ☐ OVERNIGHT STAY ☐

PLEASE REMEMBER TO BRING WITH YOU ALL YOUR CURRENT MEDICATION AND RELEVANT X-RAYS TO HOSPITAL. IT IS ADVISABLE THAT YOU DO NOT BRING ANY VALUABLE ITEMS INTO HOSPITAL. THE HOSPITAL CANNOT TAKE ANY RESPONSIBILITY FOR ANY VALUABLES.

If you have any queries, do not hesitate to contact the hospital and the Admissions Officer will be able to assist you. The information you provide will assist us to streamline your hospital admission and discharge, and allow the nursing care to be planned to meet your individual needs.

What is your admission date? _____ What is your expected discharge date? _____

What is your understanding of the reason for admission? _____

What name would you prefer to be called? _____

If you speak another language other than English, please specify _____ Interpreter required? Yes ☐ No ☐

DAY PATIENTS

Do you have an escort and transport home? Yes ☐ No ☐

Is home support overnight organised? (You must have a responsible adult stay with you) Yes ☐ No ☐

What is the name of the person taking you home? _____ Relationship _____

What is the phone number of the person taking you home? _____

The nursing staff will be contacting you the day after surgery

What phone number are you able to be contacted on? _____

MEDICATION HISTORY

ALLERGIES / SENSITIVITIES Nil known ☐	ADVERSE REACTION
Example: Penicillin/Latex/Tape/Food	Example: Rash/nausea/vomiting/anaphylaxis

Are you taking or have you recently been treated with any of the following medications? (please tick)

Steroids ☐ Aspirin ☐ Warfarin ☐ Anti-inflammatories ☐ Antibiotics ☐ Anti-depressants ☐

Stopped prior to surgery? Yes ☐ No ☐ Date stopped _____

Please list all medication you are currently taking (prescribed, over the coutner, vitamins, complementary)

Do you have a local Community Pharmacy? Yes ☐ No ☐

What is the name of the Pharmacy _____

Own medications brought in? Yes ☐ No ☐ Administration aid (specify) _____

Please bring in labelled bottles – No dosettes please – Supply list if more medications taken

Medicines usually administered by Self ☐ Carer ☐ Nurse ☐

Medication	Dose & Directions	Medication	Dose & Directions

PATIENT HISTORY

WEST 008

SURGICAL HISTORY

Have you ever had an anaesthetic before? Yes ☐ No ☐

Have you or any family members ever had any problems with anaesthetics? Yes ☐ No ☐

If yes, please describe: _____

Have you had any previous operations? Yes ☐ No ☐

Is your admission the result of an injury due to an accident e.g. sports, fall, car)? Yes ☐ No ☐

If yes, give details of how accident happened: _____

LIST ANY PAST OPERATIONS (include approximate year)

Operation Include any implants, eg. Pacemaker, Infusaport, Epidural Steroid, etc	**Year**

MEDICAL HISTORY

CVS

If known, what is your weight? _____ Your height? _____

- Do you have any **heart problems?** Y ☐ N ☐ Do you have any **blood pressure problems?** Y ☐ N ☐
  If yes, please describe: _____
- Do you get short of breath or have **chest pain/palpitations** after exercise or climbing stairs? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any problems with your blood (eg, bleeding/clotting/blood discorders)? Y ☐ N ☐
  If yes, please describe: _____
- Have you had any previous blood transfusions? Y ☐ N ☐
  If yes, please describe: _____
- Do you have a history of **Pulmonary Embolism**? Y ☐ N ☐ **Deep Vein Thrombosis**? Y ☐ N ☐
  If yes, please describe: _____
- Do you have a history of **CVA/Stroke**? Y ☐ N ☐
- Have you ever been diagnosed with **Cancer**? Y ☐ N ☐
  If yes, what type of Cancer: _____ Year diagnosed: _____

RESP

- Do you have **Sleep Apnoea?** Y ☐ N ☐ Have you had speed studies? Y ☐ N ☐
  If yes, please bring your CPAP with you
- Do you smoke? Y ☐ N ☐ If yes, how many per day? _____ Have you ever smoked? Y ☐ N ☐
- Have you had a cold or flu in the last two weeks? Y ☐ N ☐
- Have you had a lung or chest condition (eg, asthma, bronchitis, emphysema)? Y ☐ N ☐
  If yes, please describe: _____

CNS

- Have you had any **fits, convulsions or blackouts** (eg, epilepsy)? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any problems with your vision (eg, cataracts, glaucoma, wear glasses/contact lenses)? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any problems with your hearing? Y ☐ N ☐ Do you wear a hearing aid? Y ☐ N ☐ **L** ☐ **R** ☐
  If yes, please describe: _____
- Do you suffer from short term memory loss or other memory problem? Y ☐ N ☐
  If yes, please describe: _____
- Have you ever suffered from depression or an anxiety-related illness? Y ☐ N ☐
  If yes, please describe: _____
- Do you drink alcohol? Y ☐ N ☐ If yes, how much per day / week? _____

MET

- Do you have **Diabetes**? Y ☐ N ☐ If yes, Insulin Dependant ☐ Tablet ☐ Diet controlled ☐
  If yes, please describe: _____
- Do you have any **Thyroid** problems? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **jaundice, hepatitis or liver disease**? Y ☐ N ☐
  If yes, please describe: _____

GIT

- Do you have any dentures, caps, crowns or loose teeth? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **gastric problems** (eg, hiatus hernia, stomach ulcers, reflux)? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **bowel problems** (eg, diarrhoea, constipation, incontinence, diverticultisis)? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any special dietary requirements? Y ☐ N ☐
  If yes, please describe: _____

RENAL

- Do you have any **kidney disorders**? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **bladder problems** (eg, urgency, frequency, incontinence, burning, catheter)? Y ☐ N ☐
  If yes, please describe: _____

INTEG / MS

- Do you have any open wounds, skin breaks, fistulas or stomas? Y ☐ N ☐
  If yes, please describe: _____
- Have you ever had a multi-resistant organism infection (eg, MRSA [golden staph])? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **jaw or neck stiffness**? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **mobility problems** (eg, arthritis, back pain, leg weakness, etc)? Y ☐ N ☐
  If yes, please describe: _____
- Do you require the use of any mobility aids (eg, walking frame, stick, stick, wheelchair)? Y ☐ N ☐
  If yes, please describe: _____
- Do you have any **circulation problems** (eg, numbness, tingling, cold hand/feet)? Y ☐ N ☐
  If yes, please describe: _____
- Have you had any falls in the past 6 months? Y ☐ N ☐
  If yes, please describe: _____

DISCHARGE PLANNING

Do you live Alone ☐ With family/friends ☐ In a hostel ☐ In a nursing home ☐ Other ☐

Do you anticipate returning home after discharge? Y ☐ N ☐

If no, please describe: _____

Do you currently utilise any support services (eg, RDNS, Dom Care, MOW, etc)? Y ☐ N ☐

If yes, please describe: _____ Cancelled for admission Y ☐ N ☐

Do you anticipate requiring any support services on discharge (eg, RDNS, MOW, etc) Y ☐ N ☐

If yes, please describe: _____

Have you ever had an Aged Care Assessment (ACAT)? Y ☐ N ☐

Have you been approved for any of the following?

High Level Care (Nursing Home)	Y ☐	N ☐	Respite ☐	Permanent ☐
Low Level Care (Hostel)	Y ☐	N ☐	Respite ☐	Permanent ☐
Community Care Package	Y ☐	N ☐		

Please list any special needs or concerns you may have regarding your discharge

_____

Do you have any special requests of the hospital? ie, Religious/Cultural _____

Have you completed any of the following:

Enduring Power of Attorney (Financial Decisions) Y ☐ N ☐

Enduring Power of Guardianship (Personal Decisions) Y ☐ N ☐

Medical Power of Guardianship (Medical Decisions)* Y ☐ N ☐

Anticipatory Directive* Y ☐ N ☐

If yes to any of the above marked with a star, please provide a copy to the Hospital

TO THE BEST OF MY KNOWLEDGE, THE ABOVE DETAILS ARE TRUE AND CORRECT

Patient signature: _____ **Please print name:** _____

THIS SECTION TO BE COMPLETED BY PRE-ADMISSION NURSE

PRE ADMISSION ASSESSMENT

Date: _____ / _____ / _____ In person ☐ Telephone ☐

PRE-OP PHYSIO REVIEW: Y ☐ N ☐

TED STOCKING GIVEN: Y ☐ N ☐

TRIFLOW GIVEN: Y ☐ N ☐

INFO BOOKLETS GIVEN: Y ☐ N ☐

PRE-OP CARE DISCUSSED: Y ☐ N ☐

PAIN RELIEF (PAC/ANALGESIA etc): Y ☐ N ☐

POST-OP CARE DISCUSSED: Y ☐ N ☐

ADVISED X-RAYS TO BE BROUGHT INTO HOSPITAL: Y ☐ N ☐

PATHOLOGY

1. Autologous blood Y ☐ N ☐
   Pathology group: _____
2. Group & save serum Y ☐ N ☐
3. Group & cross match Y ☐ N ☐
   No. of units: _____
4. Bloods – CBP Y ☐ N ☐
   – E/LFT Y ☐ N ☐
5. Urine MC&S Y ☐ N ☐
6. ECG Y ☐ N ☐
7. MRSA/VRE swabs taken Y ☐ N ☐
8. Results returned Y ☐ N ☐

Date:

_____ / _____ / _____

EQUIPMENT NEEDS

1. Crutches Y ☐ N ☐
2. Walking stick Y ☐ N ☐
3. Frame Y ☐ N ☐
4. Toilet raiser Y ☐ N ☐
5. Shower chair Y ☐ N ☐
6. Hip chair Y ☐ N ☐
7. Reaching aid Y ☐ N ☐
8. Other Y ☐ N ☐

_____

BMI _____

DISCHARGE PLANS DISCUSSED? Y ☐ N ☐

Comments: _____

_____

_____

_____

_____

_____

Pre-admission Nurse signature, print name & designation: _____ RN/EN

THIS SECTION TO BE COMPLETED BY ADMISSION NURSE

ON ADMISSION DOSA/WARD

Date of admission: _____ / _____ / _____ Name band with correct details insitu: Y ☐ N ☐

List of prosthesis and equipment brought in: _____

If valuables brought in to hospital have they been: **Taken home?** Y ☐ N ☐ N/A ☐ **Locked away securely?** Y ☐ N ☐ N/A ☐

If yes, where? Cupboard in Room/Bay No: _____ Safe ☐

- Has the patient been hospitalised or a resident in a nursing home or hostel within the past two weeks? Y ☐ N ☐
- MRSA/VRE testing required? Y ☐ N ☐ Swabs Taken? Y ☐ N ☐
- Pre-admission medication confirmed with patient? Y ☐ N ☐
- Patient History Form and NOK details checked and discussed with patient or carer? Y ☐ N ☐

Nurse's signature _____ RN/EN Date _____ / _____ / _____ Time ____ : ____

RN to countersign _____

ORIENTATION BY WARD NURSE FOR OVERNIGHT PATIENTS ONLY

- Use of services and facilities, TV, call bell? Y ☐ N ☐
- Patient aware of information folder located in bedside drawers? Y ☐ N ☐
- Telephone, visiting hours, admission/discharge information? Y ☐ N ☐

Nurse's signature _____ RN/EN Date _____ / _____ / _____ Time ____ : ____

RN to countersign _____

PRIVACY CONSENT FORM

WESTERN
YOUR HOSPITAL THAT CARES

Affix patient sticky label

The Federal Privacy Act 2001 (Clth), states that your consent needs to be obtained prior to our collecting personal and health information about you.

Please read carefully the Privacy Policy information included with your admission forms, which provides details related to the management of your Personal Health Information, prior to signing this consent form.

Consent for Collection and use of Personal and Health Information.

1. I have read the information provided and am aware of the Western Hospital Policy for the management of personal health information.
2. I understand I am not obliged to provide any information required of me, but that my failure to do so may compromise the quality of the health care and treatment given to me.
3. I am aware of my right to access the information collected about me, except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.
4. I understand that if my personal and health information is to be used for any other purpose than set out in the information provided, my further consent will be obtained.
5. I understand that I may notify the hospital of specific limitations on access or disclosure which will be documented in my health record.
6. I consent to the handling of my personal health information by Western Hospital for the purposes set out in the information provided, subject to any limitations on access or disclosure that I may notify the hospital of.

In addition:-

I consent to Western Hospital providing my name and religion / denomination to chaplains registered with the facility so that I may be provided with pastoral care Yes ❑ No ❑

Signature of patient / person responsible _____

Print Full Name _____

Date _____

* A "person responsible" means a person defined as a "person responsible" under the Privacy Act 2001 (Clth) including the patient's partner, family member, carer, guardian, close friend and a person exercising power under an enduring power of attorney.

PRIVACY CONSENT FORM

WEST 006