THE SYDNEY PRIVATE HOSPITAL

Date of Admission:_____

Surgeon:_____

PATIENT INFORMATION FORM

TO BE COMPLETED IN FULL BY PATIENT AND PRESENTED TO THE ADMISSION OFFICE ONE WEEK PRIOR TO ADMISSION

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

For Emergency Admissions, patients may give the information over the phone

Have you been a patient in this Hospital before ☐ Yes ☐ No
Year _____

Have you been admitted to hospital in the last 2 months?
1 ☐ No 2 ☐ This Hospital 3 ☐ Other Hospital

PERSONAL DETAILS PLEASE PRINT

Title: Mr., Mrs., Miss., Ms.

Surname

Given Names

Previous Surname

Sex ☐ M ☐ F Date of birth / /

☐ Nursing Home ☐ Hostel

Address

Postcode

Phone Private Business

Mobile

Email

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Defacto

Religion

Country of birth

Aboriginality 1 ☐ Aborigine 2 ☐ Torres Strait Islander 3 ☐ Neither

Language spoken at home

Country of perm. residency

MEDICARE No.

Expiry Date / / Patient's Line Number

PENSION INFORMATION

Please fill out the following if you are a Pensioner or dependant

Pension No. Exp.

H.C.C. No. Exp.

Veteran Affairs Card/colour

NEXT OF KIN/CONTACT 1

Name

Address

Postcode

Phone Private Business

Relationship

NEXT OF KIN/CONTACT 2

Name

Address

Postcode

Phone Private Business

Relationship

GP Phone No.

Address

Postcode

OVERNIGHT ACCOMMODATION PREFERRED

(While no guarantee can be given, every effort will be made to accommodate patients as requested) ☐ Private Room ☐ Shared Ward

HOSPITAL INSURANCE

Name of Fund

Membership No.

Name on Membership Card

Is there an excess?

CAUSE OF INJURY (if applicable)

Date of Injury / /

If injury, where did it occur

0 ☐ Home
1 ☐ Residential institution
2 ☐ School, other institution, public administrative area
3 ☐ Sports & athletics area
4 ☐ Street & highway
5 ☐ Trade & service area
6 ☐ Industrial & construction site
7 ☐ Farm
8 ☐ Other specified place
9 ☐ Unspecified place

WORKER'S COMPENSATION

Liability must be accepted before admission

Date of accident

Employer

Address

Phone

Contact Name

Claim No. (Compulsory to complete)

Your solicitor

Address

Phone

THIRD PARTY/TRANSCOVER

Date of accident / /

Claim No.

Insurance Company

Address

Phone

Contact Name

Your solicitor

Address

PAYMENT OF ACCOUNTS

The balance of account is payable at the time of admission and patients without insurance are required to settle their account on admission.

INFORMED FINANCIAL CONSENT I understand and agree to pay all hospital accounts including any not covered by - Health Insurance Funds, WorkCover, Transport Accident Commission or any other relevant body. I understand that the hospital will not be liable for any valuables I bring to hospital. I also understand any allied health, any patient transport to and from the hospital is my responsibility.

Signed

Person responsible for account:

Write "as above" if same as patient

Surname*

Given Names*

Address*

Postcode

Explained by

BINDING MARGIN – NO WRITING

MSO 93583/09/17

THE SYDNEY PRIVATE HOSPITAL

CONSENT FOR USE OF INFORMATION

The Health Records Information Privacy Act 2002 No 71 and the Australian Privacy Principles prohibit the use of the personal information that The Sydney Private Hospital collects and holds about you for certain purposes in the event that you do not consent to the use of such information for those purposes.

The Sydney Private Hospital would like you to indicate in this form whether or not you consent to the use of the personal information it holds about you for the purposes described below.

You should note that in the event you do provide consent, the information would be used in an identified format. That is, your identity will be clear in any material generated for which you provide your consent.

You are under no obligation to provide consent to the use of your personal information for any of the purposes described below. In the event that you do not consent, we will respect your wishes and will not use the information for that purpose in any identified format.

Should you have any privacy concerns, please contact privacyofficer@iphoa.com.au

Please provide your consent to the use of your personal information for the purposes described below, by signing and dating the form.

To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted the medical practitioner or institution about. This may include a requirement to forward relevant prior information for example anaesthesia records.
To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I may not able to provide such consent.
To assist in the development of service delivery and planning.
For research and development projects undertaken by The Sydney Private Hospital in its own right or in conjunction with medical practitioners who work in the facility or drug companies.
To assist the hospital in undertaking **quality improvement activities.**
To provide members of **Returned Service Organisations and Ministers** of Religion with sufficient details to enable them to visit me whilst I am a patient in this facility.
To **provide access to my information to the Health Fund** of which I am a member if requested by the Health Fund to do so.
To receive educational materials on the condition I was treated for at The Sydney Private Hospital.
Photographic images may be taken during your procedure. This information will be maintained in your medical records. Should your doctor require this information for use outside of the hospital, a separate consent is required by your doctor.

I hereby consent to the use of my personal information for the purpose indicated above.

Signature _____ Date _____

Print full name _____

Irrespective of any request received, I direct you NOT to provide my personal information to (please specify name/details):

_____

Power of Attorney / Enduring guardian / Advance care directive

Do you have an advance care directive ☐ YES ☐ NO Please provide a copy

Name of Enduring Guardian (if appointed one) Phone No.

Name of Power of Attorney (if appointed one) Phone No.

BINDING MARGIN – NO WRITING

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.

BINDING MARGIN – NO WRITING

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 HEALTH CARE

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 confidentially 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.

If you do not understand or require a different language, please make the staff aware and they will assist you.

I have read and understand my rights.

Patient Signature: _____

THE SYDNEY PRIVATE HOSPITAL

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

Patient Name: _____

PATIENT HISTORY

PLEASE CIRCLE THE APPROPRIATE ANSWER OR TICK THE APPROPRIATE BOX

Please specify reason for this admission

ENDOCRINOLOGY		Name of Specialist(s):
Do you have Diabetes	NO	☐ Type 1 Controlled by: ☐ Diet ☐ Injection ☐ Tablet ☐ Type 2 MR22
If you are a diabetic and you monitor, are your blood sugar levels generally below 8 mmol/L	NO	YES
Thyroid problems	NO	YES
Low blood sugar	NO	YES
CARDIOVASCULAR SYSTEM		Name of Specialist(s):
Elevated cholesterol / triglycerides	NO	YES
High blood pressure / hypertension	NO	YES
Chest pain, angina	NO	YES
Heart attack(s)	NO	YES
Palpitations/heart murmur/irregular heart beat / AF	NO	YES
Previous deep venous thrombosis / pulmonary embolism / varicose veins	NO	YES ☐ Need for anti-embolic stockings Size:
Artificial implants / devices / grafts — Coronary artery bypass		YES Year: _____
Artificial implants / devices / grafts — Coronary/vascular stent		YES Year: _____
Artificial implants / devices / grafts — Artificial heart valve		YES Year: _____
Artificial implants / devices / grafts — Pacemaker		YES Make: _____ Model: _____ Last checked _____/_____/_____
Heart failure / congestive cardiac failure	NO	YES
Rheumatic fever / valve disease	NO	YES
Other cardiac problems	NO	YES Specify: _____
Family history of cardiac disease	NO	YES
RESPIRATORY SYSTEM		Name of Specialist(s):
Recent cold	NO	YES
Bronchitis / asthma / emphysema / chronic obstructive pulmonary disease / shortness of breath / bronchiectasis / asbestosis	NO	YES Specify: _____ Do you use: ☐ Nebulisers ☐ Puffers ☐ Home Oxygen
Any other lung problems	NO	YES Specify: _____
GASTROINTESTINAL SYSTEM		Name of Specialist(s):
Gastric ulcer / reflux / hiatus hernia	NO	YES
Jaundice	NO	YES
Hepatitis	NO	YES Which type?:
Stoma	NO	YES
HAEMOTOLOGY		Name of Specialist(s):
Previous blood transfusion	NO	YES Reason: _____ Last given: _____
Anaemic	NO	YES
Blood disorders/bleeding problems/bruise easily/clotting disorders	NO	YES
Do you take blood thinning / arthritis / aspirin based medication / Warfarin?	NO	YES Specify: _____
If Yes Have you been instructed to cease this medication?	NO	YES Date last taken _____/_____/_____ ☐ Notify VMO if not ceased

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D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

Patient Name: _____

PATIENT HISTORY

PLEASE CIRCLE THE APPROPRIATE ANSWER OR TICK THE APPROPRIATE BOX

Please specify reason for this admission

GENITOURINARY SYSTEM		Name of Specialist(s):
Kidney trouble / dialysis / renal impairment	NO	YES
Stomas	NO	YES
Bladder problems	NO	YES ☐ Urinary incontinence ☐ Frequency ☐ Urgency ☐ Pain
NEUROLOGY		Name of Specialist(s):
Fits / faints / funny turns / epilepsy	NO	YES
Stroke / mini stroke / T1A	NO	YES Any residual weakness If Y, Type: _____
Limb paralysis	NO	YES ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg
Speech / swallowing problems	NO	YES
Polio / meningitis	NO	YES Specify: _____
Previous falls / unsteady on feet	NO	YES Specify: _____
Short term memory loss / dementia	NO	YES Specify: _____ NB: If Yes, you may be asked to provide a family member or carer who must be in attendance for the hospital stay
MUSCULOSKELETAL SYSTEM		Name of Specialist(s):
Arthritis	NO	YES
Back / neck injury or problems	NO	YES
Metal plates / pins	NO	YES Specify site: _____
Hip, knee or shoulder replacements	NO	YES Specify site: _____ ☐ L ☐ R YES Specify site: _____ ☐ L ☐ R
Other implants / devices	NO	YES Specify site: _____ ☐ L ☐ R
GENERAL HEALTH & LIFESTYLE		Name of Specialist(s):
Have you ever smoked?	NO	YES Daily amount: _____ Date ceased: ____/____/____
Do you presently smoke?	NO	YES _____ per day
Do you drink alcohol?	NO	YES _____ standard drinks per week
Past history of drug dependency		YES Specify: _____
Do you have chronic pain?		YES Specify: _____
Disturbed sleep pattern / sleep apnoea		YES ☐ CPAP used ☐ Sedation
Do you exercise regularly?	NO	YES
Depression / mental illness / anxiety attacks	NO	YES
For female patients - are you pregnant?	NO	YES _____ weeks

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D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

Patient Name: _____

PATIENT HISTORY

PLEASE CIRCLE THE APPROPRIATE ANSWER OR TICK THE APPROPRIATE BOX

Please specify reason for this admission

SUMMARY OF PREVIOUS HISTORY

PREVIOUS SURGERY	NO	YES Please specify below
Year Specify		
Year Specify		
Year Specify		
Year Specify		
Year Specify		
Year Specify		
Problems with anaesthetics (self or family) eg. malignant hyperthermia	NO	YES ☐ Self ☐ Family ☐ If YES, advise Anaesthetist ☐ Alert Sheet Specify: _____
Cancer / Lymphoma / Leukaemia	NO	YES Date: ____/____/____ Site: _____ Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiotherapy
Transplants	NO	YES Specify: _____

OTHER

Did you have a dura mater graft between 1972 and 1989?	NO	YES
Do you have a history of 2 or more relatives with CJD or other unspecified progressive neurological disorders?	NO	YES
Did you receive human growth hormones, gonadotrophins prior to 1985?	NO	YES
Have you suffered from a recent progressive dementia, the cause of which has not been identified?	NO	YES
Have you been involved in a "look back" for CJD or received an "In Medical Confidence" letter notifying you of a potential exposure to CJD	NO	YES

PROSTHETICS/AIDS/OTHER

			N/A	Kept at own risk	Ward Storage	Taken home by: (Signature)	
VISUAL AIDS	NO	☐ Glasses ☐ Contact lenses ☐ Sight impaired ☐ Eye prosthesis	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		**DIETARY REQUIREMENTS**
HEARING AIDS	NO	☐ Left ☐ Right	☐ ☐	☐ ☐	☐ ☐		**Do you have a special diet?** ☐ No ☐ Diet office contacted ☐ Yes If Yes, specify:
WALKING AIDS	NO	☐ YES Specify	☐ ☐	☐ ☐	☐ ☐		
DENTURES	NO	☐ Upper ☐ Partial ☐ Full ☐ Lower ☐ Partial ☐ Full	☐ ☐	☐ ☐	☐ ☐		
OTHER	NO	☐ YES Specify _____ ☐ Left ☐ Right	☐	☐	☐		

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SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

Patient Name: _____

PLEASE DOCUMENT ANY KNOWN ALLERGIES OR SENSITIVITIES e.g. MEDICATIONS. LATEX PLANTS, TAPE

ALLERGIES & SENSITIVITIES

ALLERGIES	SENSITIVITIES	REACTION
Food Allergy		

STAFF ONLY

☐ Red Allergy Band applied

☐ Alert Sheet

☐ Diet Office contacted

YOUR CURRENT MEDICATIONS

Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. *Consult your GP or surgeon if you are unsure of any details about your medications or which medications should be ceased prior to your surgery.* ***Bring to the hospital all current medications you are taking, in their original individual packaging (ie. not in Webster or Dorset packs)***

PRESCRIPTION MEDICATION	STRENGTH	DOSE & FREQUENCY (ie. how much/how often)	LAST TAKEN

If you are taking any non-prescription medication eg. Complementary therapies, natural therapies, herbal preparations or vitamins, please specify
NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)

NON-PRESCRIPTION MEDICATION	STRENGTH	DOSE & FREQUENCY	PURPOSE	LAST TAKEN/ BROUGHT IN BY PT.

Has the patient brought own stock (including complementary therapies) to hospital? ☐ Yes ☐ No ☐ N/A

If Yes ☐ Sent home ☐ Schedule 8 cupboard ☐ Patient medication drawer

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Patient Name: _____

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B.	SEX ☐ MALE ☐ FEMALE
WARD	DOCTOR

HEIGHT & WEIGHT DETAILS

Height: _____ cms | Weight: _____ kgs | BMI: _____ $\frac{\text{Weight}}{\text{height x height}}$

INFECTION RISK SCREEN

Previous history of Multi-resistant Organisms (MRO) Infection or colonisation (eg. MRSA, VRE)?		**Swab Result** ☐ Yes ☐ No ☐ N/A
Wound/Ulcer site + Description + Ulcer Dressing		Please inform infection control co-ordinator ☐ Notified
HIV/HEP B		

DISCHARGE PLANNING (For Day Patients only)

Who will be taking you home and be with you for 24 hours?

Name:	Relationship:
Best contact Phone No.:	Or Mobile No.:

DISCHARGE PLANNING - Discharge time is 10.00am (Staff only)

Estimated date of discharge: _____/_____/_____

Person responsible for taking patient home: _____

Do you have problems caring for yourself at home	☐ Yes	☐ No	If Yes to any question, refer to your Nurse Unit Manager ☐ Notified
Do you live alone	☐ Yes	☐ No	
Do you care for someone else?	☐ Yes	☐ No	
Do you receive community services? If Yes, ☐ Nurses ☐ Home Care ☐ Meals on Wheels	☐ Yes	☐ No	

VALUABLES (Staff only

Whilst all care will be taken, TSPH does not accept responsibility for valuables or personal belongings

Personal property ☐ N/A ☐ Kept at own risk ☐ Ward Storage ☐ Taken home by: _____ (sign)

Valuables ☐ N/A ☐ Kept at own risk ☐ Ward Storage ☐ Taken home by: _____ (sign)

Cash exceeding $100 placed in hospital safe Patient/Carer to sign: _____

ORIENTATION TO WARD (Staff only)

Clinical Pathway/Care Plan ☐ Yes ☐ No

Patient Information Brochures given to patients ☐ Yes ☐ No

☐ Buzzer
☐ Bathroom
☐ No smoking policy
☐ Discharge time - 10.00am
☐ Customer satisfaction survey
☐ Lights
☐ Newspaper
☐ Visiting hours
☐ Meal times
☐ Hospital Patients Guide
☐ Patients Rights and Responsibilities Brochure
☐ Check out at reception prior to discharge
☐ Telephone
☐ TV
☐ Pharmacy

SIGNATURE PATIENT/CARER

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature: _____

Date: _____/_____/_____

Form completed/reviewed by:

Doctor: _____/Sign

Patient: _____/Sign

Carer: _____/Sign

Pre Admission: _____/Sign

Admitting Nurse: _____/Sign

Patient History Form reviewed by (OT Nurse)

Signature: _____ Print Name: _____ Designation: _____ Date: ____/____/____

Patient History Form reviewed by (Ward Staff)

Signature: _____ Print Name: _____ Designation: _____ Date: ____/____/____

BINDING MARGIN – NO WRITING