WAVERLEY PRIVATE HOSPITAL

Pre-Admission Summary

343 - 357 Blackburn Road, Mount Waverley 3149
Telephone (03) 9802 0522 Facsimile (03) 9803 9611

Unit Record Number: ______
Admission Number: ______
Surname: ______
Given Names: ______
DOB: ______ Doctors: ______
☐ Hospital ☐ DPC
(OR ATTACH PATIENT ID LABEL)

FORM MUST BE RETURNED AT LEAST 5 DAYS PRIOR TO ADMISSION TO CONFIRM BOOKING

Admitting Doctor		General Practioner (Name & Address)
Date of Admission	Time	Date of Operation
Operation / Procedure		
Maternity: Due Date		Blood Group

Have you previously been an inpatient at Waverley Private? Yes ☐ No ☐ If Yes, Year ☐
Have you been hospitalised anywhere in the last seven days? Yes ☐ No ☐ If Yes, Hospital ☐
Did you receive a copy of the Rights and Responsibilities brochure? Yes ☐ No ☐

TO BE COMPLETED BY PATIENT

PATIENT DETAILS - please print

Title	Surname	Previous Surname
Given Names		
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)

Sex	Male		Female		Married		Divorced		Widowed	
Date of Birth					Single		Separated		Defacto	

Country of Birth	(If Australia, which State)	Are you an Australian Resident?	Yes		No	
Religion		Are you of Aboriginal/Torres Strait Island descent	Yes		No	

Medicare No.		Patient's Reference No.	Expiry Date	Veteran's Affairs No.
Pension No./ Health Care Card	Full	Part	Expiry Date	Safety Net Number

CONTACT PERSON / NEXT OF KIN

Surname	Given Name	Relationship
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)

2ND CONTACT PERSON

Surname	Given Name	Relationship
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)

HEALTH FUND INSURER

Fund		Membership Number	
Level of Cover		Date Joined	
Previous Fund	Confirmed By	Confirmed With	Date Time

WORKCOVER / TRANSPORT ACCIDENT COMMISSION DETAILS

Employer Name			Employer Address
Contact			Phone
Date of Accident		Claim Number	Claims Agent

Pre-Admission Summary

TO BE COMPLETED BY PATIENT

PATIENT PRE ADMISSION HISTORY

ADMISSION DIAGNOSIS - What condition are you being admitted to hospital for?

Weight ☐ Height ☐ BMI - Anaesthetic chart

Expected length of Stay Day Case ☐ Overnight ☐ 2 - 3 days ☐ more than 3 days ☐

Do you have x-rays relevant to your admission? ☐ Yes, please bring on admission ☐ No

MEDICAL HISTORY Have you ever had the following?

	YES	NO		YES	NO		YES	NO
High Blood pressure	☐	☐	Blood Clot in legs / lungs	☐	☐	Pneumonia	☐	☐
Coronary (Heart Attack)	☐	☐	Anaemia	☐	☐	Asthma / Bronchitis	☐	☐
Angina	☐	☐	Bleeding Disorder	☐	☐	Tuberculosis	☐	☐
C.V.A. (stroke)	☐	☐	Bowel Bleeding	☐	☐	Rheumatic Fever	☐	☐
Diabetes	☐	☐	Stomach Ulcer	☐	☐	Epilepsy or fits	☐	☐
Kidney Disease	☐	☐	Jaundice / Hepatitis	☐	☐	Psychiatric Treatment	☐	☐
Blood Transfusion	☐	☐	AIDS Risks	☐	☐	Are you / could you be pregnant	☐	☐
Other	☐	☐	Liver Disease	☐	☐			

Please give details

SURGICAL HISTORY Have you had any previous surgery? Yes ☐ No ☐

Please give details (state year)

CJD / SARS

	YES	NO
Have you completed the attached form?	☐	☐

ANAESTHETIC HISTORY

	YES	NO
Have you ever had any previous anaesthetics?	☐	☐
Have you or a member of your family ever had special problems with anaesthetics?	☐	☐
Have you ever smoked tobacco in the past?	☐	☐
Have you smoked within the last month?	☐	☐
How many do you smoke a day? ☐ per day		
Do you consume alcohol? ☐ standard drinks per week	☐	☐

MEDICATION

	YES	NO
Are you taking any medication at present?	☐	☐

Please give details (include contraceptive pill, herbal remedies, blood thinning eg. Aspirin, Warfarin, Plavix)

Medication	Dose	Frequency

Have you recently stopped any medications? Yes ☐ No ☐

If yes, please provide details:

Drug Name	Approx date when stopped

ALLERGIES Are you allergic to any of the following? Yes ☐ No ☐

	YES		YES		YES		YES
Penicillin	☐	Morphine	☐	Adhesive plaster	☐	Aspirin	☐
Sulphonamides	☐	Tetanus Toxoid	☐	Latex	☐	Foods	☐
Iodine	☐	Other	☐				

Please give details

Do you require a **SPECIAL DIET?** Yes ☐ No ☐

If yes, please provide details

ADMITTING NURSE

Comments :

Information verified Signature: ___________________________ Print: ____________________________ Date: ____________

Preoperative Eye Drops	**Side**	**Drug**	**Time**	**Frequency**	**Times given & initials**			
Medications	Left							
	Right							

Doctor's Signature: ____________________________________

Preoperative Medications:

Date	Time	Medication	Dose	Route	Date to be given	Time to be given	Signature	Time Given	Given by

RAMSAY
HEALTH CARE

Unit Record Number: ______________________

Surname: ______________________

Given Names: ______________________

DOB: ______________ Doctors: ______________

(ATTACH PATIENT ID LABEL)

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

I have informed .... and / or .... / ....
Print name of patient *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 ☐ 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 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*

WAVERLEY PRIVATE HOSPITAL

Admission questionnaire for patients regarding SARS / Avian Influenza / undiagnosed related Respiratory Infection & Creutzfeldt-Jakob Disease (CJD)

Unit Record Number: ____________________

Surname: ____________________

Given Names: ____________________

DOB: ____________ Doctors: ____________

(ATTACH PATIENT ID LABEL)

In order to ensure the safety of all our patients, visitors and staff it is essential that you complete the following questionnaire regarding recent travel history and your current state of health. This vigilance is a recommendation of the Australian Government Department of Health and Ageing and the Department of Human Services, Victoria.

1. Have you travelled to the following Avian Influenza / SARS affected areas recently?

Cambodia	Laos	Mongolia
China	Malaysia	Russia
Hong Kong	Vietnam	Kazakhstan
Indonesia	Taiwan (Tapei China)	Turkey
Singapore	Thailand	Romania

(November 2005) Yes ☐ No ☐

2. Have you been back in Australia for 14 days or less? Yes ☐ No ☐

3. Do you have signs or symptoms of a respiratory infection or a fever? Yes ☐ No ☐
(Significant, only if patient answers "YES" to question (1) and (2).

NB: If patient answer YES to all 3 questions please contact Infection Control Consultant immediately

In addition, the countries on this form may be updated at regular intervals, your HICMR Consultant will keep you informed of same.

1. Have you had a dura mater graft? (prior to 1989). Yes ☐ No ☐

2. Do you have a family history of two or more first degree relatives with Creutzfeldt-Jakob disease or other unspecified progressive neurological disorder? Yes ☐ No ☐

3. Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed? Yes ☐ No ☐

4. Have you received human pituitary hormones prior to 1985? Yes ☐ No ☐

5. Have you been involved in a 'Look-Back' for Creutzfeldt-Jakob Disease or alternatively have received an 'In Medical Confidence' letter notifying you of a potential exposure to Creutzfeldt-Jakob Disease? Yes ☐ No ☐

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