Admission Information

Please read this booklet and return the completed forms to the hospital as soon as possible after your appointment with your specialist.

For your convenience, you can also fill these forms in online. Visit the hospital website and click on the **online admission forms** link or visit **mycare.ramsayhealth.com.au**

Nambour Selangor Private Hospital
Part of Ramsay Health Care

Thank you for choosing our hospital.

Please ensure all forms are forwarded to the hospital promptly in order to confirm your admission.

In order to ensure your admission is streamlined, we request that you complete this hospital admission form prior to your admission date.

You will need approximately 30 minutes to fill in this form. It may be faster and easier for you to fill in the form online. Visit the hospital website and click on the online admission form or visit **www.mycare.ramsayhealth.com.au.** By completing your admission form online, some of this information will be retained for future admissions and will only require updating.

We apologise for the length of these forms but much of the information required is dictated by Commonwealth or State legislation or is required by your health fund.

To assist you with this process, it is advisable that you have the following information at hand:

- Personal/Next of Kin details
- Medicare Card
- Funding details (e.g. DVA, Private health insurance, workcover or self funding)
- Benefit details (e.g. pharmacy benefit card or pension card)
- Item numbers if these were quoted by doctors' rooms
- Information your doctor supplied to you re implantable medical devices (e.g. prosthetic and disposables) – if applicable
- Medication information

If you have private health cover, we recommend you contact your health fund prior to admission to check for any excess or waiting periods. We know that health and billing charges can be difficult to understand and we are happy to assist in any way we can, however we also advise that you seek clarification from your doctor and health fund.

When you have completed filling in this admission form (and unless you have completed the forms online), please return it to the hospital in one of the following ways:

a. Post to

Nambour Selangor Private Hospital
62 Netherton Street
Nambour QLD 4560

b. Fax to 07 5441 7598;; or

c. Hand deliver to hospital reception.

If you have any concerns or queries through the process please email us at: onlinepreadmission.nph@ramsayhealth.com.au or phone on 07 5459 7476.

Nambour Selangor Private Hospital
62 Netherton Street, NAMBOUR QLD 4560

Tel: 07 5459 7444
Fax: 07 5441 7598

Web: **nambourselangor**.com.au

Preparing for your Admission

We are committed to providing patients with the highest standards of care. Throughout your stay, from pre-admission to discharge, you will be treated with the utmost respect and dignity.

After you have completed and returned the attached forms (or completed the online forms) you may be contacted by telephone prior to your day of admission by a preadmission nurse to get further details.

Your doctor will also explain your procedure or operation and complete the enclosed consent form with you.

Preadmission

You may be asked to attend a preadmission clinic or contacted by the hospital preadmission nurse prior to your admission so we can speak with you about your hospital stay, your operation, previous surgical and medical history, what to bring to hospital, as well as allay any concerns you may have.

Discharge planning will also be addressed at this time (e.g. who will care for you at home on discharge, who will take you home etc). You are welcome to bring a relative or friend to this clinic.

Day of Admission

On the day of admission

You will be informed of the scheduled time for your surgery and subsequent 'nil by mouth' time by your doctor or the hospital.

Fasting Time

This is a period of time, prior to your operation, when you will have a restricted diet or not be allowed to eat or drink (including water). This time is determined by your Anaesthetist or Surgeon and is related to factors such as your age and the type of operation. It is imperative that fasting times be observed for your safety during your anaesthetic.

If you have any questions about your fasting times please check with your doctor or contact the hospital.

Please shower before your admission to hospital.

Please bring with you into hospital anything applicable to your admission including:

- doctor's admission letter
- consent form (if not already returned to the hospital)
- health fund number / details (if applicable)
- medicare card
- regular medications in original packaging
- pension health benefits card (if applicable)
- pharmaceutical benefits card (if applicable)
- relevant x-rays and / or test results
- for a child - favourite toy, formula, bottle and any special dietary needs (if applicable)
- Children may go to the procedure/theatre in their own pyjamas. These pyjamas must be cotton or cotton interlock with button through/loose fitting tops
- comfortable closed in shoes/slippers with non-slip soles
- night attire (if staying overnight)
- toiletries
- aides such as walking sticks, hearing aides or glasses
- personal articles i.e. sanitary pads (if applicable)
- method for settling your account
- certified copy of Advanced Health Directive or Enduring Power of Attorney (if available)
- please do not bring valuables as the hospital will not be liable for any loss

DO NOT:

- Smoke cigarettes or **chew gum**
- Wear jewellery. A wedding ring and watch are permitted
- Bring valuables i.e. mobile phones and large amounts of cash. Mobile phones can interfere with some medical devices and may not be able to be used whilst in hospital.
- Wear make-up or nail polish

If you are feeling unwell (e.g. cold/flu) and are unsure if you are well enough for your procedure, please contact your treating doctor or GP for advice before admission.

Day procedure patients (additional information)

- Please shower with soap on the day of admission before coming to the Day Procedure Unit and put on clean clothes
- Wear garments that are comfortable and easy to remove
- Check with your nurse before informing relatives / friends regarding the time that you should be picked up

Day Patients

If you are coming into hospital as a day only patient (no overnight stay) then there are a couple of important things to note.

The major effects of your anaesthetic or sedation wear off quickly, however minor effects on memory, balance and muscle function may persist for some hours. These effects vary from person to person and are not individually predictable. Because of this please note the following:

Important information

- **You are not permitted to drive for at least 24 hours after a general anaesthetic or sedation.**
- **A responsible person must be available to transport you home in a suitable vehicle. A train or bus is usually not suitable**
- **A responsible person must be available to stay at least overnight following discharge from the Day Surgery Unit. This person must be physically and mentally able to make decisions for you if necessary.**
- **You must have ready access to a telephone in the post operative dwelling**
- **You must remain within 1 hour of appropriate medical attention until the morning after discharge**
- **You should not operate machinery or make any important decisions for at least 24 hours after your anaesthetic.**

Overnight patients

For patients staying overnight at hospital, please check your hospital website for information regarding the services and facilities that are available to you during your stay such as internet access, telephones, televisions, visiting hours and other relevant information.

There is some important information that we would like to share with you here about keeping safe and well during your stay in our hospital:

Infection Control

This hospital is committed to providing all patients with the highest quality of care by preventing the spread of infection.

Hand washing, high standards of housekeeping, and the use of sterile techniques and equipment are all part of our service to ensure your speedy recovery and to reduce the risk of infection.

Patients and visitors also have a role to play in reducing the risk of infection to themselves and other patients. Here are a few very simple guidelines:

- Hand hygiene is the most effective way to prevent the spread of infection. Alcohol based handrubs are a very effective form of hand hygiene and are located at strategic locations in the hospital. We encourage all patients and visitors to use these.
- We ask that people do not visit the hospital if they have gastroenteritis or other contagious diseases.

Falls Prevention

The unfamiliar environment of a hospital combined with the fact that you may be on medication or fatigued can increase the likelihood of falls in hospital. Below are a few ways that you can reduce the risk of falling whilst in hospital:

- Take special care when walking or taking to your feet particularly if you are on pain-relieving drugs or other medications.
- Ensure you know the layout of your room and take care when moving around at night. Please use your call bell if you need assistance.
- Check the floors in your area to ensure they are not wet before walking. Avoid using talcum powder which makes floors slippery.
- Ask your nurses for assistance if you need to use the toilet and feel unsteady on your feet
- Loose or full-length clothing can cause you to trip. Ensure your clothing is the right length for you
- Check that your slippers or other footwear fit securely. If your doctor has requested you to wear pressure stockings then it is a good idea to also wear slippers over the top to reduce the risk that you may slip. Rubber soled slippers are ideal footwear whilst in hospital.

Medication Safety

Please provide your nurse with any tablets or medicines (or prescriptions for these) that you have been taking before admission. These will be secured in a personal drug cabinet. Any additional medication you require while in hospital will be ordered by your doctor and supplied to you. When you are discharged, medications that you are required to take will be provided to you to take home.

Pressure Injury Prevention

A pressure injury is an area of skin and/or surrounding tissue that has been damaged due to unrelieved pressure. They may look minor, such as redness on the skin, but can hide more damage under the skin surface.

It is important that you relieve pressure by keeping active and changing your position frequently when you are lying in bed or sitting in a chair. If you are unable to move by yourself, the staff will help you change your position regularly. Special equipment such as air mattresses and booties may be used to reduce the pressure in particular places.

Tell staff if you have any tenderness, or soreness over a bony area or if you notice any reddened, blistered or broken skin.

Blood Clot Prevention

Blood clotting is the body's natural way of stopping itself from bleeding. Clotting only becomes an issue when it is in the wrong place and blocks blood flow. Being immobile is a big risk in developing a clot and so blood clotting can increase when you are staying in hospital and spending a long time immobile.

In addition, there are a number of risk factors to blood clotting including previous strokes, inherited blood clotting abnormalities, lung disease, being overweight, having had major surgery in the past, heart failure, smoking or taking contraception medications. If you have any of these risk factors, please alert your doctor or the staff.

While in hospital, staff will assess your risk of developing a clot and may ask you to wear compression stockings or sleeves, or they will provide you with blood thinning medication.

Staying mobile, taking any prescribed medications to reduce your risk of blood clotting, drinking plenty of fluid and avoiding crossing your legs can reduce your risk of clotting.

If you have sudden increased pain or swelling in your legs; pain in your lungs or chest; difficulty in breathing, please alert your nurse as soon as possible. If these symptoms occur after discharge, seek emergency treatment.

When You Leave

Before you leave hospital, please make sure you have the following:

- a discharge letter
- all personal belongings
- all personal x-rays
- all current medications
- follow-up appointment requirements

On your way out, please see staff at the Reception, to complete any discharge information.

If you have any excessive pain or are generally concerned about your condition after you leave hospital please contact your specialist, your GP or ring the hospital directly.

Payment Information

It is important that you approach your admission to hospital well informed of your financial obligations. Please read the following information and contact your hospital if you have any concerns or queries.

Insurers

PRIVATELY INSURED PATIENTS

Please confirm with your private health insurer prior to your admission to hospital:

- Does my hospital policy cover me for this procedure / treatment, or is there any exclusions, restrictions or waiting periods that apply (see brochure Am I adequately covered for private hospital care)?
- Is my procedure / treatment covered by a no-gap or gap cover scheme?
- Do I have to pay an excess, co-payment or any other gap under my hospital policy? If so, how much?
- Are any surgically implanted prosthetic devices or other medical devices not covered by my hospital policy?
- Do you have an agreement with the hospital I am going to be treated in?
- What are the insurance benefits payable for each of the estimated costs (e.g. hospital costs, doctors' fees)?
- Do I have to pay extra for my doctors' fees and those of anyone else involved with my treatment, or is it all covered?

Please note: *if you have been a member of your private health insurer for less than 12 months your insurer may not accept liability for the hospital costs associated with your admission (e.g. if your condition or any symptoms of your condition existed prior to your joining your private health insurer or upgrading your level of hospital cover). Any patient costs (e.g. your excess or daily co-payment) must be paid prior to or on your day of admission.*

REPATRIATION (DVA) PATIENTS

DVA Gold Card holders are covered for all treatment. DVA White Card holders are covered for treatment subject to approval from DVA.

WORKCOVER PATIENTS

The estimated hospital costs must be paid on admission unless the hospital has received payment approval from your insurance company.

THIRD PARTY PATIENTS

The estimated hospital costs must be paid on admission unless the hospital has received payment approval from your insurance company.

SELF-INSURED PATIENTS

Please contact the hospital prior to admission for an estimate of hospital costs. The estimated hospital costs must be paid prior to or on admission to hospital. Please note, whilst every effort will be made to provide you with an accurate estimate of hospital costs, the estimate may vary due to unforeseen circumstances, variations from the proposed treatment / procedures, or an extended length of stay in which case additional costs will apply.

OVERSEAS PATIENTS

If you are insured with an overseas insurance company, you will be asked to pay the estimated hospital costs on admission. Please contact the hospital prior to admission for an estimate of hospital costs. Whilst every effort will be made to provide you with an accurate estimate of hospital costs, the estimate may vary due to unforeseen circumstances, variations from the proposed treatment / procedures, or an extended length of stay in which case additional costs will apply.

FAQs

HOW DO I KNOW WHAT THE HOSPITAL COSTS WILL BE?

The hospital will provide you with an "Estimate of Patient Costs" once they have processed your online admission or admission paperwork.

WHAT COSTS COULD I INCUR THAT MAY NOT BE COVERED BY MY INSURER?

Costs that you may incur that may not be covered by your insurer include but are not limited to:

- Ambulance transfers;
- Non-medical services (e.g. hairdresser, beauty services etc.);
- Non-admission related, non-PBS and discharge medications;
- Interpreter and hearing or speech impairment services;
- Boarder accommodation / meals and visitors' meals;
- Non-Medicare rebateable items or services;
- Newspapers / magazines and personal items;
- Aids & equipment;
- Obstetric packages;
- Fee for incidentals (WiFi, Foxtel/Austar or business centre access – please check the hospital website as not all hospitals offer these services);
- Telephone calls and car parking; and
- Other goods or services.

You may also receive accounts from other providers associated with your hospital treatment, these may include:

- Emergency centre attendance (e.g. treatment provided in an emergency centre prior to admission to hospital);
- Treating doctor(s) and surgeon(s);
- Anaesthetist(s);
- Other medical practitioners, consultants or assisting surgeon(s);
- Medical and allied health services (e.g. physiotherapy, occupational therapy);
- Pharmacy (e.g. non-admission related, non-PBS and discharge medications);
- Pathology services (e.g. blood tests); or
- Radiology services (e.g. x-ray's).

HOW DO I PAY?

For your convenience, payments can be made to the hospital:

In Person: Cash, EFTPOS, Bank Cheque, Visa or Mastercard (please note: if you are wanting to pay by American Express or Diners, please check with the hospital if these cards are accepted)

Telephone Payment: Visa and Mastercard

BPAY™ Internet or Phone Banking

If you completed your admission form online using Ramsay MyCare™, you may have the option to pay online.

MyCare

If you have any further questions, please contact the hospital.

Privacy Policy

Ramsay Health Care Australia (Ramsay) is bound by the Australian Privacy Principles under the Privacy Act 1988 (Cth) and other relevant laws about how private health service providers handle personal information (including but not limited to patient health information).

We are committed to complying with all applicable privacy laws which govern how Ramsay collects, uses, discloses and stores your personal information.

This Privacy Statement sets out in brief how Ramsay will handle your personal information. For further information or to receive a copy of our full Privacy Policy, please ask a staff member, visit our website: www.ramsayhealth.com or telephone the Hospital and ask to speak with our Privacy Officer. You can also write to our Privacy Officer to request more information.

In respect of Patients, Ramsay will collect your personal information for the purpose of providing you with health care and for directly related purposes. For example, Ramsay may collect, use or disclose personal information:

- For use by a multidisciplinary treating team;
- Assessment for provision of health care services;
- To liaise with health professionals, Medicare or your health fund;
- In an emergency where your life is at risk and you cannot consent;
- To manage our hospitals, including for processes relating to risk management, safety and security activities and quality assurance and accreditation activities;
- For the education of health care workers or the placement of students or trainees at Ramsay facilities;
- To maintain medical records as required under our policies and by law; or
- For other purposes required or permitted by law.

In respect of other individuals, Ramsay will collect your personal information in order to engage with you in your dealings with Ramsay and for other related purposes.

Personal information may be shared between Ramsay facilities to coordinate your care. We also outsource some of our services. This may involve us sharing your personal information with third parties. For example, we outsource the conduct of our patient satisfaction surveys to a contractor who may write to you seeking feedback about your experience with Ramsay.

We may outsource information and data storage services (including archiving of medical records), which may involve storing that information outside of Australia. Where we outsource our services we take reasonable steps in the circumstances to ensure that third parties, including organisations outside of Australia, have obligations under their contracts with Ramsay to comply with all laws relating to the privacy (including security) and confidentiality of your personal information.

Ramsay will usually collect your personal information directly from you, but sometimes may need to collect it from a third party. We will only do this if you have consented or where it is not reasonable or practical for us to collect this information directly from you (for example, in relation to a patient, your life is at risk and we need to provide emergency treatment).

We will not use or disclose your personal information to any other persons or organisations for any other purpose unless:

- You have consented;
- For patients, the use or disclosure is for a purpose directly related to providing you with health care and you would reasonably expect us to use or disclose your personal information in this way;
- For other individuals, the use or disclosure is for a purpose related to providing you with services and you would reasonably expect us to use or disclose your personal information in this way;
- We have told you that we will disclose your personal information to other organisations or persons; or
- We are permitted or required to do so by law.

You have the right to access your personal information that we hold about you (for patients, this includes health information contained in your health record). You can also request an amendment to personal information that we hold about you should you believe that it contains inaccurate information.

Informed Financial Consent

Please read the following information carefully as it explains what you need to know about the cost of your hospital stay.

Terms and Conditions

When you or another person (e.g. your next of kin or legal guardian) indicate your acceptance of these terms you are acknowledging and agreeing to the matters listed below, which are conditions of admission to hospital.

(A) Actual Costs Incurred May Differ From The Estimate Provided

Whilst every effort has been made to provide an accurate estimate of the costs you may incur; **the estimate may vary**. This may be due to specific terms of your insurance policy or additional costs which are incurred during your hospital stay. The following examples listed below may result in additional costs payable
by you:

- The hospital relies on information provided by your insurer which may change;
- In some cases, if you have an early discharge from hospital or an extended length of stay your insurer may not cover you for the period of your admission, in which case you will be responsible for any additional costs;
- Your treating doctor(s) may vary the proposed treatment, procedure (MBS item numbers) or the proposed length of stay;
- There may be a change in the medication prescribed by your treating doctor(s) or a change in the medication costs;
- You may incur sundry charge during your stay (e.g. visitors' meals, boarder fees, and phone calls);
- Your doctor may recommend a surgically implanted prosthetic device that is not fully funded by your insurer; or
- If unforeseen circumstances should arise during your procedure it may be necessary for your doctor to use a different or more costly surgically implanted prosthetic device without prior notice to you.

(B) You Agree to Pay Any Balance of Costs Actually Incurred

Your final account will reflect:

- The actual procedure(s) performed, treatment and service provided and your length of stay at the hospital;
- Prosthetic or other medical devices used in your treatment;
- Pharmacy (medication) costs; and
- Any other goods or services provided by the hospital payable by you.

You will be provided with an "Estimate of Patient Costs" which details the estimated hospital costs, insurer benefits (if applicable) and patient costs which are payable by you or your nominee prior to or on the day of your admission to hospital. Any additional costs are payable on discharge or upon request.

You or your nominee are also responsible for any other costs your insurer may not provide a benefit for. These costs may include but are not limited to:

- Ambulance transfers;
- Non-medical services (e.g. hairdresser, beauty services etc.);
- Non-admission related, non-PBS and discharge medications;
- Interpreter and hearing or speech impairment services;
- Boarder accommodation / meals and visitors' meals;
- Non-Medicare rebateable items or services;
- Newspapers / magazines and personal items;
- Aids & equipment;
- Obstetric packages;
- Fee for incidentals (WiFi and Foxtel/Austar);
- Telephone calls and car parking; and
- Other goods or services.

As a condition of admission, once you have indicated your acceptance of these terms, you agree to pay your final account. If you have concerns, or a bona fide dispute regarding the final account (for example you did not receive a service for an item listed) you agree to raise this with the hospital as soon as possible and to resolve any dispute within 7 business days of receiving your account.

(C) You Must Pay Any Outstanding Balance if Your Insurer Does Not Cover The Hospital Costs

You or your nominee are responsible for paying the balance of your hospital costs:

- If the benefits paid by your insurer are less than the rates charges by the hospital (including cases where an early discharge from hospital may reduce the benefit the hospital receives from your insurer; or
- If for any reason your insurer does not provide benefits for hospital costs that arise from your admission.

(D) You Are Responsible For Accounts From Other Providers

You are responsible for accounts from other providers associated with your treatment. These may include:

- Emergency centre attendance (e.g. treatment provided in an emergency centre prior to admission to hospital);
- Treating doctor(s) and surgeon(s);
- Anaesthetist(s);
- Other medical practitioners, consultants or assisting surgeon(s);
- Medical and allied health services (e.g. physiotherapy, occupational therapy);
- Pharmacy (e.g. non-admission related, non-PBS and discharge medications);
- Pathology services (e.g. blood tests); or
- Radiology services (e.g. x-ray's).

(E) Do Not Bring Valuables to Hospital

The hospital does not accept any responsibility for and will not be liable for loss of or damage to, personal valuable items brought to the hospital by patients or their visitors (e.g. money or jewellery). Patients and visitors are strongly advised not to bring such items to the hospital.

Australian Government

Private Patients' Hospital Charter

Your rights and responsibilities as a private patient in a public or private hospital

As a private patient you have the right to choose your own doctor, and decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to hospital. Even if you have private health insurance you can choose to be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital.

- Information about your treatment - Your doctor should give you a clear explanation of your diagnosis, your treatment (and any associated risks), the associated cost, and other treatment options available. Except for in an emergency where it is not possible, they should obtain your consent prior to any treatment.
- Informed Financial Consent - Your doctor and other health service providers should provide you with information about the costs of your proposed treatment, including any likely out-of-pocket expenses, and obtain your agreement to the likely costs in writing before proceeding with the treatment.
- Other medical opinions - You can ask for referrals for other medical opinions (there may be additional costs associated with doing this that may not be covered by Medicare or your private health insurance).
- Visitors - The hospital you are going to can provide information about visiting arrangements for your family and friends while you are in hospital including family access (and who is considered family), arrangements for the parents or guardians if the patient is a child, and when your friends can visit you.
- Seek advice about costs - As a patient with private health insurance, all your hospital treatment and medical bills may be covered by your insurance, or you may have to pay some out-of-pocket expenses (gaps). In some cases you may also have to pay an 'excess' or co-payment. Before you go to hospital, ask your private health insurer, doctor(s) and hospital about the expected costs of your treatment, including possible costs for surgically implanted medical devices and prostheses. (See overleaf for some suggested questions to ask about costs).
- Confidentiality and access to your medical records - Your personal details will be kept strictly confidential. However, there may be times when information about you needs to be provided to another health worker to assist in your care if this is required or authorised by law. You will need to sign a form to agree to your health insurer having access to certain information to allow payments to be made for your treatment. Under the Freedom of Information legislation you are entitled to see and obtain a copy of your medical records kept in a public hospital. Under the National Privacy Principles you also have a general right to access personal information collected about you by the private sector.
- Treatment with respect and dignity - While in hospital you can expect to be treated with courtesy and have your ethnic, cultural and religious practices and beliefs respected. You should also be polite to your health care workers and other patients and treat them with courtesy and respect.
- Care and support from nurses and allied health professionals - Nurses and allied health professionals provide vital care and support and are an important part of your treatment in hospital. Staff who attend you should always identify themselves and you should feel confident to discuss any issues in relation to your treatment or hospital experience with your health care workers.
- Participate in decisions about your care – Before you leave hospital you should be consulted about the continuing care that you may need after you leave hospital. This includes receiving information about any medical care, medication, home nursing or other community services you may need after you go home.
- Comments or complaints - If you are concerned about any aspect of your hospital treatment you should initially raise this with the staff caring for you or the hospital. If you are not satisfied with the way the hospital has dealt with your concerns, each State and Territory has an independent organisation that deals with complaints about health services and practitioners. If your query or complaint relates to private health insurance, you should first talk to your health insurer. If your concerns remain unresolved you can contact the Private Health Insurance Ombudsman on 1800 640 695 (freecall).
- Provide accurate information - To help doctors/specialists and hospital staff provide you with appropriate care you will need to provide information such as family and medical history, allergies, physical or psychological conditions affecting you, and any other treatment you are receiving or medication you are taking (even if not prescribed by your doctor).
- Long-stay patients - If you are in hospital for a long period of time you may become a nursing home type patient. Talk to your hospital or health insurer about the arrangements for long-stay patients.

Find out about any potential costs before you go to hospital

Ask your treating doctor or specialist:

- for confirmation in writing of how much their fee will be and how much is likely to be covered under Medicare or your private health insurance.
- whether they participate in your health insurer's gap cover arrangements and if you are likely to have to pay a gap, how much it will be.
- which other doctors and medical staff will be involved in your treatment and how you can get information about their fees and whether they will be covered by your private health insurance.
- for an estimate of any other costs associated with your medical treatment that may not be covered by Medicare or your private health insurance (e.g. pharmaceuticals, diagnostic tests).
- whether you are having a surgically implanted device or prosthesis and if you will have to contribute towards the cost for this.

Ask your health insurer:

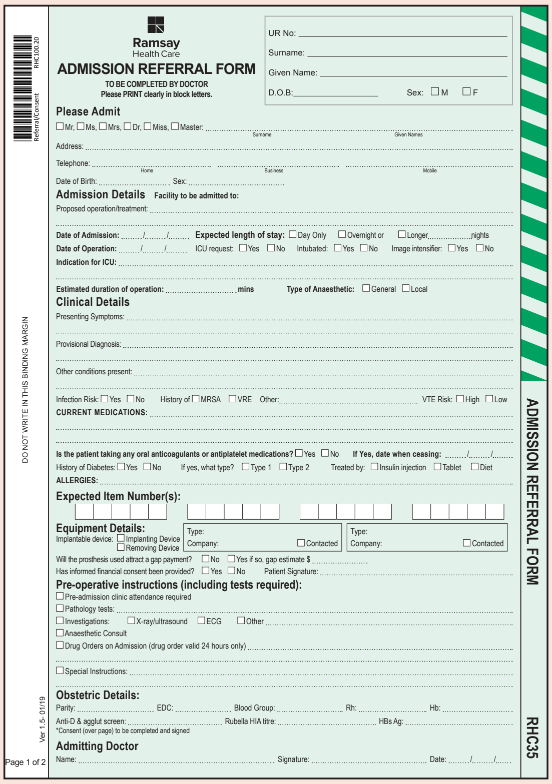
- whether the treatment you are having is covered by your private health insurance and if there are any exclusions or waiting periods that currently apply to this treatment under your policy. If you are having a baby, talk to your health insurer as early as possible in your pregnancy to find out what rules apply to obstetrics and newborn babies.
- whether you have to pay an excess or co-payment, and, if so, how much this will be.
- about the level of hospital accommodation covered by your policy (some policies only cover being a private patient in a public hospital).
- whether your insurer has an agreement with the hospital you are going to be treated in.
- whether you will need to pay extra for surgically implanted devices or prostheses.
- if any gap cover arrangements are in place that may apply to you.

Ask your hospital:

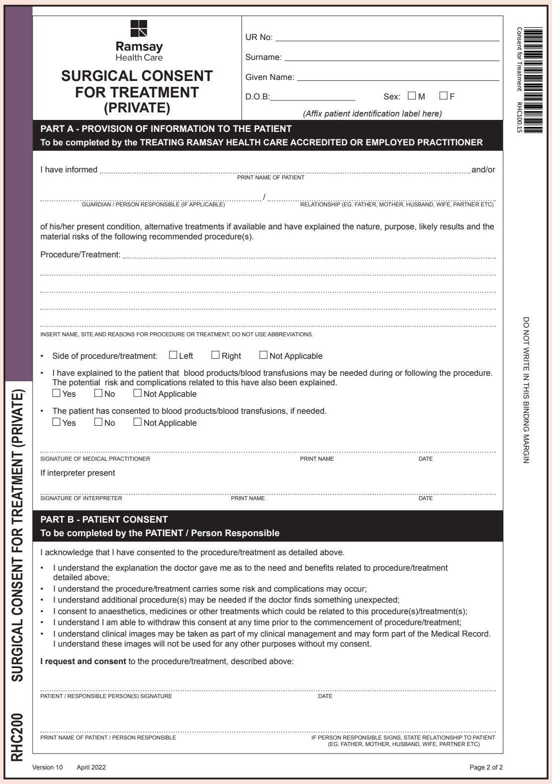
- whether the hospital has an agreement with your private health insurer.
- whether you will have to pay anything for your hospital accommodation out of your own pocket.
- whether you will have to pay any additional hospital charges which are not covered by your private health insurance (e.g. TV hire, telephone calls).

Important Information

DOCTOR OR PATIENT TO RETURN THE FOLLOWING TWO PAGES [RHC35 & RHC200] TO THE HOSPITAL AS SOON AS POSSIBLE FOLLOWING CONSULTATION CONFIRMING ADMISSION. FORMS CAN BE RETURNED VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.



Ramsay Health Care
ADMISSION REFERRAL FORM
TO BE COMPLETED BY DOCTOR
Please PRINT clearly in block letters.
UR No:
Surname:
Given Name:
D.O.B: Sex: M F
Please Admit
Admission Details
Clinical Details
Expected Item Number(s):
Equipment Details:
Pre-operative instructions (including tests required):
Obstetric Details:
Admitting Doctor
ADMISSION REFERRAL FORM
RHC35
Page 1 of 2



Ramsay Health Care
SURGICAL CONSENT FOR TREATMENT (PRIVATE)
UR No:
Surname:
Given Name:
D.O.B: Sex: M F
(Affix patient identification label here)
PART A - PROVISION OF INFORMATION TO THE PATIENT
To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED OR EMPLOYED PRACTITIONER
PART B - PATIENT CONSENT
To be completed by the PATIENT / Person Responsible
SURGICAL CONSENT FOR TREATMENT (PRIVATE)
RHC200
Version 10 April 2022
Page 2 of 2

YOU CAN COMPLETE THE SUBSEQUENT 8 PAGES OF FORMS [RHC31 - PATIENT ADMISSION DETAILS & RHC415 - PATIENT HEALTH HISTORY - GENERAL] ONLINE. GO TO HOSPITAL WEBSITE LISTED ON PAGE 2 OF THIS BOOKLET AND FIND THE ONLINE ADMISSION FORM LINK. THESE DETAILS WILL BE SAVED FOR FUTURE ADMISSIONS.

ALTERNATIVELY, PLEASE RETURN THESE FORMS AT YOUR EARLIEST CONVENIENCE VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ALSO ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.

IF YOU HAVE ANY CONCERNS OR QUERIES THROUGH THE PROCESS PLEASE EMAIL OR PHONE THE DETAILS IN RED ON PAGE 2 OF THIS BOOKLET.

Referral/Consent RHC100.20

DETACH ALONG PERFORATION

DO NOT WRITE IN THIS BINDING MARGIN

Ramsay Health Care

ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR
Please PRINT clearly in block letters.

UR No: ____________________

Surname: ____________________

Given Name: ____________________

D.O.B: ____________ Sex: ☐ M ☐ F

Please Admit

☐ Mr, ☐ Ms, ☐ Mrs, ☐ Dr, ☐ Miss, ☐ Master: .... Surname .... Given Names

Address: ....

Telephone: .... Home .... Business .... Mobile

Date of Birth: .... Sex: ....

Admission Details

Facility to be admitted to:

Proposed operation/treatment: ....

....

Date of Admission: ....../....../...... **Expected length of stay:** ☐ Day Only ☐ Overnight or ☐ Longer .... nights

Date of Operation: ....../....../...... ICU request: ☐ Yes ☐ No Intubated: ☐ Yes ☐ No Image intensifier: ☐ Yes ☐ No

Indication for ICU: ....

....

Estimated duration of operation: .... **mins** **Type of Anaesthetic:** ☐ General ☐ Local

Clinical Details

Presenting Symptoms: ....

....

Provisional Diagnosis: ....

....

Other conditions present: ....

....

Infection Risk: ☐ Yes ☐ No History of ☐ MRSA ☐ VRE Other: .... VTE Risk: ☐ High ☐ Low

CURRENT MEDICATIONS: ....

....

....

Is the patient taking any oral anticoagulants or antiplatelet medications? ☐ Yes ☐ No **If Yes, date when ceasing:** ....../....../......

History of Diabetes: ☐ Yes ☐ No If yes, what type? ☐ Type 1 ☐ Type 2 Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

ALLERGIES: ....

Expected Item Number(s):

Equipment Details:

Implantable device: ☐ Implanting Device ☐ Removing Device

Type:	Type:
Company: ☐ Contacted	Company: ☐ Contacted

Will the prosthesis used attract a gap payment? ☐ No ☐ Yes if so, gap estimate $ ....

Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature: ....

Pre-operative instructions (including tests required):

☐ Pre-admission clinic attendance required

☐ Pathology tests: ....

☐ Investigations: ☐ X-ray/ultrasound ☐ ECG ☐ Other ....

☐ Anaesthetic Consult

☐ Drug Orders on Admission (drug order valid 24 hours only) ....

....

☐ Special Instructions: ....

....

Obstetric Details:

Parity: .... EDC: .... Blood Group: .... Rh: .... Hb: ....

Anti-D & agglut screen: .... Rubella HIA titre: .... HBs Ag: ....

*Consent (over page) to be completed and signed

Admitting Doctor

Name: .... Signature: .... Date: ....../....../......

Ver 1.5- 01/19

ADMISSION REFERRAL FORM

RHC35

Ramsay
Health Care

SURGICAL CONSENT FOR TREATMENT (PRIVATE)

UR No: ____________________

Surname: ____________________

Given Name: ____________________

D.O.B: ____________________ Sex: ☐ M ☐ F

(Affix patient identification label here)

Consent for Treatment RHC100.15

PART A - PROVISION OF INFORMATION TO THE PATIENT

To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED OR EMPLOYED PRACTITIONER

I have informed .... and/or
PRINT NAME OF PATIENT

.... / ....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) RELATIONSHIP (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment: ....

....

....

....

....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

- Side of procedure/treatment: ☐ Left ☐ Right ☐ Not Applicable
- I have explained to the patient that blood products/blood transfusions may be needed during or following the procedure. The potential risk and complications related to this have also been explained.
  ☐ Yes ☐ No ☐ Not Applicable
- The patient has consented to blood products/blood transfusions, if needed.
  ☐ Yes ☐ No ☐ Not Applicable

....
SIGNATURE OF MEDICAL PRACTITIONER PRINT NAME DATE

If interpreter present

....
SIGNATURE OF INTERPRETER PRINT NAME DATE

PART B - PATIENT CONSENT

To be completed by the PATIENT / Person Responsible

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand clinical images may be taken as part of my clinical management and may form part of the Medical Record. I understand these images will not be used for any other purposes without my consent.

I request and consent to the procedure/treatment, described above:

....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE DATE

....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT (EG. FATHER, MOTHER, HUSBAND, WIFE, PARTNER ETC)

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

SURGICAL CONSENT FOR TREATMENT (PRIVATE) RHC200

RHC100.16

Patient Adm Details

DETACH ALONG PERFORATION

BINDING MARGIN - DO NOT WRITE

Ver 5.2 - 07/21

Ramsay
Health Care

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______

Surname: ______

Given Name: ______

DOB: ______ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

ADMISSION DETAILS

Specialist Surname: ...... Specialist First Name: ......

Overnight: ☐ No ☐ Yes Do you know your admission date: ☐ No ☐ Yes Date of Admission: ...... /...... /......

Reason for Admission: ...... (If unsure leave blank)

Item Numbers (if known): ......

Is admission due to an injury? ☐ No ☐ Yes Date of injury: ...... /...... /...... ☐ My Health Record Opt Out

How did the injury occur?: ☐ At work, going to/from work or as a result of being at work ☐ Motor Vehicle Accident ☐ Sport

Other (please specify): ......

Where did the injury occur?: ☐ Roadway ☐ Home ☐ Work ☐ Sports area ☐ Other (please specify): ......

Is the person completing the form the patient: ☐ No ☐ Yes

If No, Your Name: ...... **Your Phone No.:** ......

PATIENT DETAILS

Title: ...... Surname: ...... Maiden Name: ......

Given Names: ...... Preferred Name: ......

Residential Address: ......

Suburb: ...... State: ...... Postcode: ......

Postal Address: ☐ As above ☐ Different Details: ......

Suburb: ...... State: ...... Postcode: ......

Telephone (Home/AH) ...... (Work/Day) ...... (Mobile/Other) ......

Contact Preferences: (indicate your preferred contact option) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

If there is a voice message service, may we leave a message? ☐ No ☐ Yes

Email: ......

(Your email address is important as it is used to confirm your admission form has been received. It is NOT used for marketing purposes)

Date of Birth: ...... /...... /...... Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single/Never Married ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Child (not at school) ☐ Employed ☐ Home Duties ☐ Retired ☐ Student ☐ Unemployed ☐ Other

Are you an Australian Resident? ☐ No ☐ Yes Country / State of Birth: ......

Are you of Aboriginal / Torres Strait Islander (TSI) origin?

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown ☐ Decline to Answer

Are you of Australian South Sea Islander (SSI) origin? ☐ No ☐ SSI ☐ Not Stated/Unknown ☐ Decline to Answer

Religion: ......

Do you consent to the Hospital disclosing your name to the following visiting officials (if they are available)?

Chaplain Visit: ☐ No ☐ Yes Veteran Organisation Representative: ☐ No ☐ Yes

Language(s) spoken: ☐ English ☐ Other: ...... (please detail)

Are you able to read and understand English: ☐ No ☐ Yes Interpreter required: ☐ No ☐ Yes

MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ No ☐ Yes Medicare Number: ☐☐☐☐☐☐☐☐☐☐

Medicare Reference No: ...... (number in front of your name) Medicare Expiry date (MM/YYYY): ...... /......

NEXT OF KIN

Relationship to patient: ......

Title: ...... Surname: ...... Given Names: ......

Address: ☐ Same as patient ☐ Different from patient ......

Suburb: ...... State: ...... Postcode: ......

Country: ......

Telephone (Home/AH) ...... (Work/Day) ...... (Mobile/Other) ......

PERSON TO NOTIFY

☐ Same as next of kin Relationship to patient: ......

Title: ...... Surname: ...... Given Names: ......

Address: ☐ Same as patient ☐ Different from patient ......

Suburb: ...... State: ...... Postcode: ......

Telephone (Home/AH) ...... (Work/Day) ...... (Mobile/Other) ......

PATIENT ADMISSION DETAILS

RHC31

Ramsay Health Care

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______

Surname: ______

Given Name: ______

DOB: ______ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

☐ Self ☐ Next of Kin ☐ Workers Compensation ☐ DVA ☐ Third Party ☐ Other: ......

Title: ...... Surname: ...... Given Names: ......

Address: ...... Suburb: ...... State: ...... Postcode: ......

Telephone (Home/AH) ...... (Work/Day) ...... (Mobile/Other) ......

PENSIONS / CONCESSIONS / HEALTH CARE CARD / SENIORS CARD / CONCESSIONAL PHARMACY BENEFITS

Do you have any type of pension/concessional benefits card?

☐ No ☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: ...... Benefit Card No: ......

Have you reached the Safety Net for Pharmaceuticals? ☐ No ☐ Yes Safety Net No: ......

HEALTH INSURANCE DETAILS

Do you have entitlement to free treatment under Australian Veteran's legislation? ☐ No ☐ Yes

(**If yes**, *select DVA as your Insurance Type and complete the DVA questions*)

Has your injury or condition occurred due to the negligence of a third party? ☐ No ☐ Yes

(e.g. workers compensation, motor vehicle accident, common law)

If yes, have you lodged a claim for compensation or damages? ☐ No ☐ Yes Damages ☐ Yes Compensation

(**If yes**, *select Workers Compensation as your Insurance type and answer Workers Comp questions*)

Did your injury or condition occur at work, going to or from work or as a result of being at work? ☐ No ☐ Yes

Insurance Type:

☐ Private health fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ ADF ☐ Self Funded ☐ Public ☐ Overseas Insurer

Name of Health Fund: ...... Type of Cover: ......

Membership No: ...... Do you have an excess? ☐ No ☐ Yes Amount: $ ......

Have you changed your level of insurance cover in the last 12 months? ☐ No ☐ Yes

Workers' Comp Fund Name: ...... Claim No: ......

Employer: ...... HR Manager: ......

Phone: ...... Fax No: ......

Third Party Name: ...... Policy No.: ......

DVA No: ...... DVA Card Colour: ...... Details of cover (white card only) ......

ADF Service Branch: ...... Approval No.: ...... Entitled Personnel Identification No.: ......

ADF Medical Officer (MO) On-base: ...... MO Contact Number: ......

Overseas Insurance Name: ...... Policy No.: ......

Referring Doctor Surname: ...... First Name: ......

(Specialist or GP who referred you to the admitting specialist)

Address: ......

Suburb: ...... Postcode: ...... Phone No: ......

General Practitioner (GP) Surname: ...... First Name: ......

(If same as above write: "AS ABOVE")

Address: ......

Suburb: ...... Postcode: ...... Phone No: ......

ACCOMMODATION PREFERENCE (whilst every effort will be made to meet your preference, we cannot guarantee availability)

Room preference: ☐ Private room ☐ Shared room

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within this booklet:

☐ Hospital information (including pre-admission, day of admission, general information about our hospital as well as about no responsibility accepted if you bring valuables to hospital)

☐ Private Patients' Hospital Charter

☐ Your right to privacy under the Privacy Act

By ticking below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent

☐ Payment Information

Person responsible for payment of accounts – Please provide your name, signature and today's date.

Name: ...... Signature: ...... Date: ..../..../....

Patient's Signature

Signature: ...... Date: ..../..../....

PATIENT ADMISSION DETAILS

RHC31

BINDING MARGIN - DO NOT WRITE

DETACH ALONG PERFORATION

Patient Health History RHC100.11

BINDING MARGIN - DO NOT WRITE

DETACH ALONG PERFORATION

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ____________________

Surname: ____________________

Given Name: ____________________

DOB: ____________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

PROCEDURE / ADMISSION	NO	YES	If yes, please answer these questions If no, please progress to the next question	NURSING NOTES
1. Could you be pregnant?				
2. Is the patient under the age of 18 years?			Name of child's legal guardian:	
			Are the child's immunisations up to date: ☐ No ☐ Yes	
3. Have you had any of the following? Xray:			When / where:	
Blood tests:			When / where:	
MRI:			When / where:	
Scan:			When / where:	
4. Have any other doctors been consulted in relation to this admission? e.g. cardiologist, physician			Doctor consulted: .... Specialty:	
PREVIOUS HOSPITALISATIONS	**NO**	**YES**	**If yes, please answer these questions**	**NURSING NOTES**
5. Have you been admitted to this hospital before				
6. Have you been admitted to any hospital within the last 28 days?			In the last 7 days In the last 28 days Reason for admission: .... Hospital name:	
7. For WA residents only – Have you been admitted to a hospital outside WA in last 12 months?			Reason for admission: .... Hospital name:	
PREVIOUS SURGERY / PROCEDURES	**NO**	**YES**		**NURSING NOTES**
8. Have you had any previous surgeries or procedures? e.g. joint replacements, transplants, implants, colonoscopy			**If yes, please complete table below**	

OPERATION	APPROX YEAR	OPERATION	APPROX YEAR	NURSING NOTES

MEDICATIONS	NO	YES		NURSING NOTES
9. Are you currently taking medications?			**If no, go to question 12. If yes, please answer the questions below**	
10. Have you received advice from Specialist rooms regarding taking/ceasing medications prior to admission?			Details:	
11. Do you take any of the following: • anti-coagulant or blood thinning therapy e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaban, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor			Still take? ☐ No ☐ Yes Date to be ceased:	
• cortisone tablets/injections, anti-inflammatory drugs			Still take? ☐ No ☐ Yes Date to be ceased:	
• regularly take fish oil, krill oil, garlic or ginkgo supplements			Still take? ☐ No ☐ Yes Date to be ceased:	

IMPORTANT: Please either complete the medication table on page 4 OR bring a profile or list to hospital of all medications including anti-coagulant or blood thinning therapy as well as other tablets, puffers, patches, injections, nebulisers, ointments, drops and including non-prescription medications and herbal supplements. IF STAYING OVERNIGHT: please bring medications in the original packaging

PATIENT HEALTH HISTORY – GENERAL

RHC415

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.
Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______________________

Surname: ______________________

Given Name: ______________________

DOB: ______________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

NOTE: Please list all medications including those mentioned previously in the following section

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY	NURSING NOTES
						Patient own stock?
						☐ Pt med drawer
						☐ Schedule 8 store ☐ Sent home

LIFESTYLE	NO	YES	If yes, please answer these questions	NURSING NOTES
12. Do you have a medical required or special diet? e.g. diabetic, coeliac disease, lactose intolerance, vegetarian, vegan, kosher			Details:	
13. Have you ever smoked?			Daily amount: Ceased:	
14. Do you drink alcohol?			Daily amount:	
15. Do you use recreational drugs?			Daily amount: Type:	
16. What is your weight: .... **kg**				
17. Have you lost weight unintentionally?				☐ *Malnutrition risk*
18. What is your height: .... **cm**				☐ *Check BMI>30*

PROSTHETICS / AIDS	NO	YES	If yes, please answer these questions	NURSING NOTES
19. Do you use any prosthetics / aids? e.g. aids for vision and hearing loss, walking sticks, other aids for daily living			Details:	☐ *Falls risk screen*
20. Are you paraplegic or quadraplegic?			Details:	

DISCHARGE PLANNING	NO	YES	If yes, please answer these questions	NURSING NOTES
21. Where do you plan to go after discharge?				
22. Do you live alone or are solely responsible for the care of another person at home?			☐ I have someone to look after me after discharge ☐ I currently receive community support and/or nursing services. ☐ I require assistance with or have concerns with aspects of day to day living. ☐ I have concerns after discharge	
23. Do you have someone to take you home from hospital?			Name: Contact Number:	

ADVANCE HEALTH DIRECTIVE / POWER OF ATTORNEY	NO	YES	If yes, please answer these questions	NURSING NOTES
24. Do you have a current Advance Health Directive			Please bring copy with you on admission	
25. Do you have an enduring Power of Attorney – health & medical guardian?			☐ Same as next of kin Name: Relationship: Phone:	

PATIENT HEALTH HISTORY – GENERAL

RHC415

BINDING MARGIN - DO NOT WRITE

DETACH ALONG PERFORATION

Patient Health History RHC100.11

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______________________

Surname: ______________________

Given Name: ______________________

DOB: ______________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS

26. Do you have any ALLERGIES? (see conditions below) ☐ No ☐ Yes

*If No, go to question **27**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ You or a family member has had an adverse reaction to anaesthetic e.g. malignant hyperthermia or post operative nausea and vomiting	☐ You ☐ Family member Details:	
☐ Allergies or sensitivities including medications, latex, sticking plaster, iodine, xray dyes, food (e.g. seafood, nuts, gluten), food additives (e.g. salicylates, amines) or insects (e.g. bees, dust mites)	☐ You: Please list details below ☐ Family member Details:	

ALLERGY INCLUDING FOOD ALLERGIES	DETAILS / REACTIONS	☐ *Alert sticker*

27. Do you have/had any CARDIOVASCULAR problems? (see conditions below) ☐ No ☐ Yes

*If No, go to question **28**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Elevated cholesterol, triglycerides		
☐ Blood pressure problems e.g. low, high, hypertension		
☐ Cardiac conditions or irregularities, e.g heart attack, congestive heart failure, rheumatic fever, angina, palpitations, heart murmur		
☐ Cardiac surgery e.g. pacemaker, implants/devices, prosthetic heart valve, grafts, stents		Year: Model:
☐ Vascular disease e.g. carotid disease, aortic aneurysm, peripheral vascular disease		

28. Do you have/had DIABETES? (see conditions below) ☐ No ☐ Yes

*If No, go to question **29**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Type 1 diabetes	Controlled by: ☐ Diet ☐ Insulin ☐ Tablets	
☐ Type 2 diabetes		
☐ Gestational diabetes		
☐ Unsure		

29. Do you have/had any GASTROENTEROLOGY OR UROLOGY problems? (see conditions below) ☐ No ☐ Yes

*If No, go to question **30**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Hiatus hernia, gastrointestinal ulcers, reflux		
☐ Liver disease, hepatitis (e.g. A, B, C), jaundice, cirrhosis		
☐ Bowel problems/habits, stoma or bowel disease e.g. Crohns, IBS		
☐ Kidney disease, dialysis, renal impairment		
☐ Bladder problems or habits, stoma, incontinence, urinary retention		☐ *Falls risk screen*

DETACH ALONG PERFORATION

BINDING MARGIN - DO NOT WRITE

PATIENT HEALTH HISTORY – GENERAL

RHC415

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______________________________

Surname: ______________________________

Given Name: ______________________________

DOB: ____________________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS

30. Do you have/had any BLOOD OR CANCER problems? (see conditions below) ☐ No ☐ Yes

*If No, go to question **31**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Ever had a blood transfusion	Any reaction: Year Transfused:	
☐ History of cancer	Type: Body Site: Treatment: Date of Diagnosis:	
☐ Blood clot in lung / legs (DVT / PE)		
☐ Blood or bleeding disorders e.g. anaemia		

31. Do you have/had any MUSCULOSKELETAL conditions? (see conditions below) ☐ No ☐ Yes

*If No, go to question **32**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Arthritis e.g. rheumatoid arthritis, osteoarthritis		
☐ Back or neck injury or problems		

32. Do you have/had any NEUROLOGY problems? (see conditions below) ☐ No ☐ Yes

*If No, go to question **33**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Neuromuscular diseases e.g. MS, myasthenia, dystrophies, parkinsons		
☐ Stroke, mini stroke, TIA	Date: Impairment:	
☐ Limb paralysis or weakness		☐ *Falls risk screen*
☐ Fear of falling, unsteady or fallen in last 6 months		☐ *Falls risk screen*
☐ Epilepsy/fits, faints, blackouts, dizziness		☐ *Falls risk screen*
☐ Speech or swallowing problems e.g. coughing when eating / drinking		
☐ Difficulties with problem solving, attention span, understanding, post surgery confusion		☐ *Cognitive risk screen*
☐ Other neurological problems e.g. meningitis, migraine, polio, short term memory loss, dementia, Alzheimers		☐ *Cognitive risk screen*

33. Do you have/had any BREATHING problems? (see conditions below) ☐ No ☐ Yes

*If No, go to question **34**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Asthma, pneumonia, hay fever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary Disease (COPD)		
☐ Shortness of breath e.g. when walking more than 50m, climbing stairs/inclines		
☐ Sleep apnoea, disturbed sleep, snoring		
☐ Use a CPAP machine	Please bring CPAP to hospital	
☐ Other lung problems e.g. tuberculosis		☐ *Falls risk screen*

34. Do you have/had any OTHER conditions? (see conditions below) ☐ No ☐ Yes

*If No, go to question **35**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Chronic pain		
☐ Depression, other mental illness		
☐ Lymphoedema		
☐ Thyroid problems, hypothyroidism, goitre		
☐ Any other medical conditions		

BINDING MARGIN - DO NOT WRITE

DETACH ALONG PERFORATION

Patient Health History RHC100.11

DETACH ALONG PERFORATION

BINDING MARGIN - DO NOT WRITE

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ______

Surname: ______

Given Name: ______

DOB: ______ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS continued

35. Are you susceptible to possible INFECTION ISSUES?? (see conditions below) ☐ **No** ☐ **Yes**

*If No, go to question **36**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	**DETAILS**	**NURSING NOTES**
☐ Ever had MRSA, VRE, CRE or ESBL		
☐ I have had other infection issues previously		
☐ In the last 12 months have you been treated, admitted or worked in a healthcare facility overseas, including a nursing home or aged care facility		

36. Are you being admitted in the next 7 days? ☐ **No** ☐ **Yes**

*If No, go to question **37**. If Yes, please tick the relevant conditions below.*

☐ Do you currently have any wounds or breaks on your skin? **In the last 3 weeks have you:** ☐ Travelled to a country or area with current health alerts (if known) ☐ Travelled to areas of high prevalence for acute respiratory infections/illnesses ☐ Had contact with anyone with an acute respiratory infections/illnesses ☐ Had a fever or respiratory symptoms e.g. cough, sore throat, runny nose ☐ Had vomiting and/or diarrhoea		

37. Are you having an operation on your brain, spinal cord, pituitary gland, nerve root ganglia, retina, optic nerve or having maxillary or dental surgery? ☐ **No** ☐ **Yes**

If No, please go to the next section. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	**DETAILS**	**NURSING NOTES**
☐ I think I may have Creutzfeldt-Jakob Disease (CJD)		
☐ I have had two or more first or second-degree relatives with CJD		
☐ I have an unexplained progressive neurological illness of less than 12 mths		
☐ I have a history or receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)		
☐ I have previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)		
☐ I have been involved in a look back for CJD or have a "medical-in-confidence" letter regarding your risk for CJD		
☐ I am not sure		

To find out more about CJD please go to the following URL – http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf

I confirm that the information completed in this Patient Health History form is correct.

Patient Name (print): ......

Signature: ...... Date: ......

PATIENT HEALTH HISTORY – GENERAL

RHC415

Ramsay Health Care

Patient Health History – General

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

UR: ____________________

Surname: ____________________

Given Name: ____________________

DOB: ____________________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

NURSE USE ONLY

RISK ASSESSMENT	NO	YES	Completed	Signature	*Refer to Facility Policy*
Falls risk assessment required					*Refer to Facility Policy*
Infection risk assessment required					*Refer to Facility Policy*
Pressure injury risk assessment required					*Refer to Facility Policy*
Delirium/Dementia risk assessment required					*Refer to Facility Policy*
Cognitive risk assessment required					*Refer to Facility Policy*
Malnutrition risk assessment required					*Refer to Facility Policy*

Confirmation that Patient Health History form reviewed by Preadmission Staff ☐ **No** ☐ **Yes** — *Refer to Facility Policy*

Name of Preadmission Nurse (print):		Designation:
Signature:	Date:	Time:

Confirmation that Patient Health History form reviewed by Admitting Nurse ☐ **No** ☐ **Yes** — *Refer to Facility Policy*

Name of Admitting Nurse (print):		Designation:
Signature:	Date:	Time:

Confirmation that Patient Health History form reviewed by DSU / Ward Staff ☐ **No** ☐ **Yes** — *Refer to Facility Policy*

Name of DSU/Ward Nurse (print):		Designation:
Signature:	Date:	Time:

CLINICAL / PRE-ADMISSION NOTES

PATIENT HEALTH HISTORY – GENERAL

RHC415

BINDING MARGIN - DO NOT WRITE

DETACH ALONG PERFORATION

Compliments/ Complaints

Nambour Selangor Private Hospital welcomes and actively encourages your feedback. Feedback enables us to ensure we are providing a high quality service and meeting the expectations of our customers.

Therefore if you have a complaint:

1) Firstly we encourage you to discuss your concerns with the Nurse Unit Manager or Team Leader.

2) If you are dissatisfied with the response or feel you are unable to discuss your concerns directly :

- The NSPH Bedside feedback card can be used to capture your feelings regarding your experience with us or
- You can directly contact the Executive Assistant on extn: 54597436 during office hours or the Afterhours Coordinator on extn: 5459 7461

The Executive Management Team takes feedback seriously. Therefore if you provide us with your name and contact number we will contact you to discuss your concerns and outline the actions we will take to prevent reoccurrence.

Care Escalation

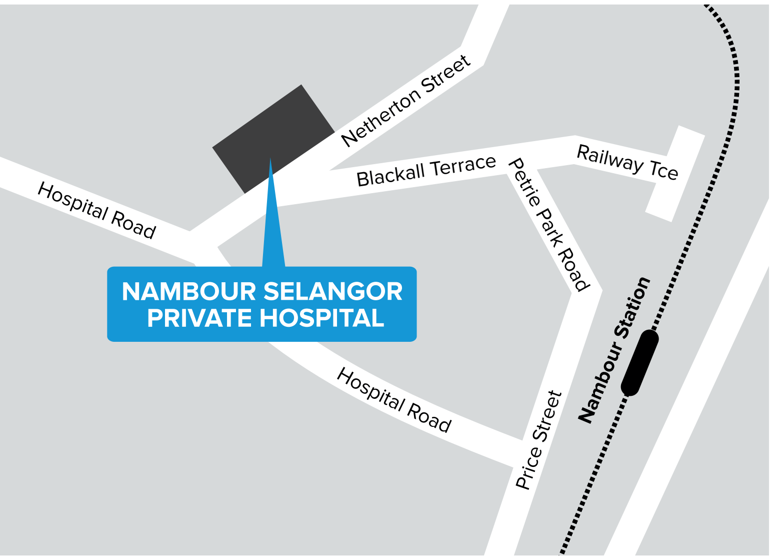
Nambour Selangor aims at ensuring patients are well cared for and informed however

If you or your loved ones feel:

- that you are not being heard
- have concerns regarding your care /treatment
- require a second opinion

We encourage you to speak with the Team Leader / Nurse Unit Manager /Treating Medical Officer on the ward

However if you feel unable to discuss your concerns with the treating team we encourage you to contact the Facility Day / Afterhours Nurse Manager on Ph: 07 5459 7461- who will be able to escalate your concerns immediately.



Nambour Selangor
Private Hospital
Part of Ramsay Health Care

62 Netherton Street
NAMBOUR QLD 4560
Tel: 07 5459 7444 Fax: 07 5441 7598
nambourselangor.com.au

People caring for people.

Nambour Selangor Private Hospital - Pre-Admission Booklet / ver. 11 - January 2023