

Prince of Wales Private Hospital ●

PRE-ADMISSION FORMS

● It is essential that the hospital receives the pre-admission form as soon as possible following your visit to the doctor, in order to minimise delays on your day of admission.

Please take the time to read and fill out the relevant documents carefully.

Welcome to Prince of Wales Private Hospital

Our Address is:

Level 5, Barker Street, Randwick NSW 2031

Postal Address: Locked Bag 2, Randwick NSW 2031

Our Telephone number is (02) 9650 4000

Our Fax number is (02) 9650 4695

Admission Information:

You will be contacted by the Hospital the day prior to your admission after 4pm to confirm your admission time and other instructions.

If you do not hear from us by 7pm the evening prior to your admission, please contact us on:

02 9650 4306

Visiting Hours: Maternity 4pm to 7pm
(Fathers may visit at any time)

All other Ward areas 10am-1pm and 3pm-8pm.

Discharge Information:

Discharge time is 10am sharp (excluding Day Procedures)

This form must be FULLY completed in order for your admission to be processed.

Section A: Private Health Insurance (Please contact your health fund prior to admission to confirm your cover)

Fund Name: Membership No: Date Joined:/...../.....

Type of cover: Single Family Other Level of cover (if known) 12 months? No Yes

Do you have an excess? No Yes Amount \$ Have you paid an excess this year? No Yes Amount \$

Previous Hospitalisation

Have you previously been treated at this Hospital? No Yes Year:

Is this admission for a child? No Yes Was the child born at this Hospital? No Yes Mothers Name:

Have you been hospitalised within 7 days prior to this admission? No Yes Which Hospital? Dates:

GP / Local Doctor

Full name of GP:

GP Address:

GP Telephone: GP Facsimile: GP email:

How Will You Claim For This Admission (please tick ✓ one box only)

- Private Health Insurance – Please complete Sections A and C Repat/Veterans Affairs – Please complete Entitlements and Section C
 Workcover/Third Party/TAC – Please complete Sections B and C Uninsured – Please complete Section C only

Section B: WorkCover or Third Party

Workcover or Third Party or TAC (Please tick one box)

• The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company:

Address Street:

Suburb: State: Postcode:

Telephone: Claim No: Authorised by:

Has your insurance company accepted liability? Yes No Please specify reason (if no):

Workcover Patients Only – Employer Details: Name of Employer:

Address Street:

Suburb: State: Postcode: *Please go to Section C – "Payment of Account"*

Telephone: Date of Accident:/...../.....

Has your employer completed a Report of Injury Form?: Yes No Have you completed a Workcover Claim Form?: Yes No

Section C: Payment Of Account – all patients to complete

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. Maternity patients pay all extra fees prior to admission. I have signed a patient estimate of expenses form and understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of person responsible for account: Date/...../.....

Remove THIS form – return this to Hospital

Prince of Wales Private Hospital

Patient Information

Welcome and thank you for choosing Prince of Wales Private Hospital. We hope that your stay with us will be as comfortable and pleasant as possible.

Pre-Admission Information

Pre-admission is an important part of your hospital care. To ensure we can confirm your admission, financial and other arrangements, **we ask that you:**

- Have your Doctor complete the Doctor's Referral/Consent form
- Complete the Patient History form
- **Complete in full the Patient Pre-Admission form and return only this form to the Hospital immediately.**

You can do this in several ways:

- **In Person** at Reception (open Mon-Sat 8am-5pm)
- **By Fax** on (02) 9650 4695
- **By Post** to arrive no later than 48 hours prior to your admission.

You must bring the remainder of the booklet, which has been completed with you on the day of admission.

- Please ensure that you bring the following documentation with your Booklet with you to the Hospital on the day of admission:
 - Health fund book and/or card
 - Medicare card
 - Pharmaceutical entitlements card
 - Pension card/Health Care card
 - Repatriation/Veterans' Affairs card
 - This Admission Booklet
- If your account is subject to Work Cover or a Third Party claim, forward full details of the claim including a letter from your insurance company accepting liability for this admission to our pre-admission office at least 48 hours prior to your procedure.

Your doctor will notify the Hospital of the date of your procedure/operation and inform you of the day of admission. The doctor will also explain your procedure or operation and complete the consent form with you.

If you have any questions about hospital procedures, completion of forms, cost or health insurance status, our staff will be happy to assist you.

On The Day Of Admission

Bring into hospital any medications you are currently taking, any current x-rays and **this booklet**

DO NOT

(Unless your Doctor gives you special instructions):

- Eat or drink anything after midnight for morning surgery. You will be contacted by the hospital the day prior to surgery after 4pm and advised of your admission and fasting times. You will also be given any other instructions as necessary.
- Smoke cigarettes or chew gum
- Wear jewellery (wedding ring and watch are permitted)
- Wear make-up
- Bring any valuables with you

Please report to the main Reception Desk on Level 5 to be directed to the appropriate area of the hospital

Day Procedure Patients (additional information):

- Please shower on the day of admission before coming to the Day Procedure Unit
- 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

General Information:

- Prince of Wales Private Hospital is a smoke-free environment.
- Parking is available on-site. Charges are detailed at the entrance to the Car Park.
- The telephone beside each bed are for local calls only. \$10 Telephone cards are available for purchase from Level 5 Reception for STD, Mobile and International calls.

Patient Information

Accounts/Fees

If you are a member of a health fund it is important that you contact your Health Fund prior to admission to confirm:

- a) That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation outlined in the Pre-Admission Form. (eg: in the case of post natal patients, is your new born baby covered.)
- b) If an excess is payable for this admission.
- c) **If you have been a member of your Health Fund for less than 12 months your fund may not accept liability for the costs of this admission. eg. If your condition or any symptoms of your condition existed prior to your joining. If there is a question regarding pre-existing symptoms your health fund has the option to obtain details from your GP or specialist.**

Pharmacy and pathology, imaging and x-ray may attract an additional charge. Sundry item charges are payable on discharge. Please note that medical and allied health practitioner's fees may be billed separately by the practitioner.

Payment Procedure

- Private patients – the hospital will lodge a claim on your behalf. Should your insurance include an excess this must be paid on admission. Any additional costs incurred during your stay are payable prior to discharge. eg. Discharge Pharmacy Costs
- Repatriation (DVA) patients – the hospital will lodge a claim on your behalf
- Work Cover patients – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed
- Third party patients – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed
- Uninsured patients – total payment (aside from any ancillary charges) must be made on admission
- Other costs which may be incurred during your stay are payable on discharge.

Payment may be made by cash, credit card or eftpos.

Meals

Prince of Wales Private Hospital aims to provide a choice of meals and to supply special diets where it is in the interest of your medical care. Food or alcoholic drinks should not be brought to you by visitors without prior consultation with your Nurse.

Valuables

Please do not bring valuables or large amounts of money to the Hospital. Prince of Wales Private Hospital does not accept liability for any items brought into the Hospital.

Visiting

- General Wards, High Dependency and Post Natal: refer to Hospital Admission Information
- ICU/CCU – Visiting hours are restricted and limited to immediate family only. Visitors with children should check with the Nurse In Charge
- Arrangements for visiting outside of usual visiting hours can be made in consultation with the Nursing staff
- Relatives may stay with critically ill patients for extended periods, as may parents with their children
- Day procedure patients - please check with admission nurse
- If you have indicated that you would like a Religious or ESO/RSL visit, Prince of Wales Private will make every attempt to facilitate this. Please advise Nursing Staff.

Medical Records and Privacy

Records will be kept of your illness and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law.

Prince of Wales Private Hospital complies with the Privacy Act 1988, including the way we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our Hospital (eg. to your health funder, to our insurer, to an external company contracted by Prince of Wales Private Hospital to evaluate customer satisfaction).

Discharge Information

- **DISCHARGE TIME IS 10am SHARP**
(Excluding Day Procedure patients who will be informed of their approximate discharge time on admission)
- You **MUST** arrange for someone to escort you home
- You must not drive a car until the day following your operation/procedure or anaesthesia (your motor vehicle insurance may not cover you).
- Before you leave the hospital, make sure that you or your relatives/friends know how to care for you at home
- Check with your Nurse/Doctor about continuing medication, follow-up appointments, etc.
- Please do not forget to collect any x-rays or medications brought with you on admission

Please contact your Nurse if you have any concerns, problems or suggestions during your stay.

UR Number:

Surname:

Given Names:

Date of Birth: Doctor:

Hospital:

Patient Details

Doctor Referral/Consent Form

To be completed by Doctor. Please *PRINT* clearly.

Please Admit

Mr, Mrs, Miss, Master: Date Of Admission:/...../.....

Surname

Given Names

Address:

Telephone: Date of Birth:/...../..... Sex:

Home

Business

Clinical Details

Presenting symptoms:

Principal diagnosis, i.e. the condition which best accounts for patient's stay in hospital:

Other conditions present:

Medications:

ALLERGIES:

Operation

Proposed operation/treatment:

Date of Operation:/...../..... **Item Numbers:**

Expected length of stay: Day Only Overnight or longer days

Specific pre-operative instructions (including tests required):

Obstetric Details

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

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

Referring Doctor's Details

Name: Signature

DO NOT REMOVE

DOCTORS REFERRAL/CONSENT FORM

UR Number:

Surname:

Given Names:

Date of Birth: Doctor:

Hospital:

Patient Details

Request/Consent Form

REQUEST/CONSENT FORM
FOR SURGICAL OPERATION PROCEDURE
AND/OR MEDICAL TREATMENT

Part A: Provision of Information to Patient (To be completed by Medical Practitioner)

I, Doctor
(Insert name of medical practitioner)

have informed:
(Insert name of patient/parent/guardian)

of the nature, likely results, and material risks of the recommended operation/procedure and/or treatment. The agreed operation/procedure and treatment that the patient is to undergo is:

.....
(Insert name of operation/procedure and/or treatment)

Interpreter required? Yes No I,, an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to

Signature of Medical Practitioner Date:/...../..... Signature of Interpreter Date:/...../.....

Part B: Patient Consent (To be completed by Patient)

The doctor whose name appears in Part A above and I have discussed my/my child's/my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of an anaesthetic, medicines, and/or a blood transfusion may be needed in association with this operation/procedure and/or treatment and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedures and/or treatments being carried out if required as long as they are related to the primary procedure set out in Part A.
- Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risk.

I have been advised of the material risks associated with this operation/procedure and/or treatment.

I have had the opportunity to ask questions about the operation/procedure and/or treatment and I am satisfied with the answers and information I have received.

I understand that I may withdraw my consent at any time prior to the operation/procedure and/or treatment.

I consent/do not consent to a blood transfusion if needed. (circle one)
I request, understand and consent to the operation/procedure and/or treatment as outlined above in Part A

Signature of patient/parent/guardian Signature of witness to patient's signature

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

Print name of patient/parent/guardian Print name of witness

Address: Address:

Prince of Wales Private Hospital

UR Number:

Surname:

Given Names:

Date of Birth: Doctor:

Hospital:

Patient Details

Patient History Form

To be completed by Patient or Doctor.

Please **PRINT** clearly. Your responses are valuable in planning your admission and caring for you during your stay.

ADMISSION DETAILS

Please specify the reason for your admission

	NO	YES	COMMENTS OR FURTHER INFORMATION
Is this admission due to a past or present injury?			Cause of Injury: Place (e.g. School, Home) Date / /
Have pathology/blood test/autologous blood been taken for this admission?			Pathologist: Results with:
Have X-rays been taken for this admission?			<input type="checkbox"/> With patient <input type="checkbox"/> With doctor
What is your: Height.....cms Weight.....kgs Blood Group (if known)			

MEDICATIONS

Have you recently taken blood thinning/arthritis medication (Aspirin Based)?			Name of Medication:
Have you been instructed to cease this medication?			Date last taken / / or still taking <input type="checkbox"/> Yes
Have you previously taken any anti-coagulant therapy (Warfarin)?			Date last taken / / or still taking <input type="checkbox"/> Yes
Have you taken any steroids or cortisone tablets/injections in the last 6 months?			Name of Medication Date last taken / / or still taking <input type="checkbox"/> Yes
Are you taking any other prescription or non-prescription medication? List the medications you currently take (include name of medication). Please bring all medications you are currently taking with you on admission in the original packaging			

GENERAL MEDICAL CONDITION

SPECIFY DETAILS

Diabetes			<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure Managed by <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin
Cancer			Site:
Stroke			Date: / / Residual problems
Infectious diseases/recent infections			
High blood pressure			
Heart attack/chest pain/angina			Date / /
Palpitations/irregular heart beat/heart murmur			
Pacemaker			Make Model last checked / /
Prosthetic heart valve			Type
Rheumatic Fever			
Tendency to bleed/bloodclots/bruise easily			
Arthritis			
Asthma/bronchitis/pneumonia/hayfever			
Liver disease/hepatitis (Specify type A, B, C)			
Kidney/bladder problems			
Hiatus hernia/gastrointestinal ulcers/bowel disorder			
Thyroid problems			
Epilepsy/fits/febrile convulsions			
Depression/dementia/other mental illness			
Migraines			
Eye disease			
Recent cold or flu			
Female patients could you be pregnant?			Number of weeks:
Impairment e.g. vision, hearing, mobility			
Other			

DO NOT REMOVE

PATIENT HISTORY FORM

PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations, please list dates and operation performed:

Date / /
 Date / /
 Date / /
 Date / /
 Date / /
 Date / /

	NO	YES	SPECIFY DETAILS
Have you or anyone in your immediate family ever had a reaction to an anaesthetic?			Details of reaction
Have you ever had a blood transfusion?			Details of any reaction

PROSTHESIS / AIDS / OTHERS

Glasses/Contact Lenses			
Hearing aid or other hearing appliance			
Body Piercing			
Dentures/Caps/Crowns/Loose Teeth			
Artificial joints or limbs			
Metal plates/pins			

LIFESTYLE

Have you ever smoked?			Daily amount or date ceased / /
Do you drink alcohol?			Daily amount
Do you use recreational drugs?			Type Daily amount
Do you require a special diet?			Type of Diet
Do you exercise?			<input type="checkbox"/> < 30mins per day <input type="checkbox"/> 30mins per day <input type="checkbox"/> 30mins per day plus aerobic activity 3 times per week
Do you require an interpreter?			Language spoken at home
Do you have someone to interpret for you?			Name of Person
Have you a fear of falling or have fallen within the last 12 months?			
Have you experienced fainting or dizziness in the last 12 months?			

ALLERGIES

Do you have any allergies to medications, food, sticky plaster, latex/rubber (e.g. balloons, gloves) or other substances?			Specify Details and Reaction
---	--	--	------------------------------

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

Have you had a dura mater graft between 1972 - 1989?			
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?			
Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?			
Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?			

DISCHARGE PLANNING (This information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete)

Are you over 80 years of age?			
Do you live alone?			
I have no one to look after me after discharge.			or, name of person Relationship
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			
Do you require assistance with any aspect of day to day living?			Details
Do you have multiple health problems?			
Where do you plan to go after discharge?			How will you get there?

NURSES USE ONLY

Name of Admitting Nurse: _____ Signature: _____ Designation _____ Date / / Time: _____

NB: IF "YES" TO CJD, DISCHARGE PLANNING, LATEX/RUBBER, FOOD, STICKY PLASTER ALLERGY, ASTHMA/HAYFEVER or FALLS QUESTIONS PLEASE REFER TO RELEVANT POLICY AND COMPLETE RELEVANT ASSESSMENT FORM

WHERE WE ARE LOCATED

PRINCE OF WALES PRIVATE HOSPITAL
BARKER STREET
RANDWICK
LEVEL 5
PHONE 02 9650 4000
UBD SYDNEY STREET DIRECTORY
MAP 257 A-16



