

ADMITTING MEDICAL OFFICER PRE-ADMISSION RECOMMENDATION

To be completed by Admitting Medical Officer

Admitting Medical Officer Name

PATIENT IDENTIFICATION

.....
 Patient Surname Given Names Date of Birth

ADMISSION DETAILS

Admission Date Proposed Operation Date Estimated Time in
 Operating Theatre

Estimated Length of Stay nights OR Day Only Yes

Reason for Admission

.....

Expected Item Numbers

Relevant clinical conditions and medical history

.....

Current Medications.....

.....

Allergies No Yes Give Details.....

Known Infection risk No Yes
 Pacemaker No Yes
 Sleep Apnoea No Yes
 CPAP Required No Yes

I will arrange:
 Pre-admission Blood Group & Hold No Yes N/A
 Pre-admission Blood Cross Match No Yes N/A
 If yes, name of pathology company

ADMISSION/ PRE-OPERATIVE INSTRUCTIONS

Specific instructions/investigations/equipment requirements on admission.....

.....

.....

Blood Group & Hold on admission No Yes Blood Cross Match No Yes Units

Thromboembolism prophylactic measures to be initiated on admission Yes No

Details

Medication orders for admission

.....

.....

Gap Prostheses or non rebateable item to be used Yes No. If yes, I confirm the patient has been informed of the cost and reason for choice of this item Yes.

Admitting Medical Officer's Signature Date

Please complete Consent Form over page.

REQUEST FOR SURGICAL OPERATION, PROCEDURE AND / OR MEDICAL TREATMENT

To be completed in Doctor's rooms prior to admission:

Note to patients:

1. Before signing this form you should be satisfied that your doctor has fully explained the nature of the procedure/treatment and any associated risks.
2. If you are in any doubt about the procedure/treatment or the associated risks, DO NOT sign this form until you have discussed these with your doctor.

Patient's Name:

Treating Doctor/Surgeon:

Proposed treatment/procedure:

.....

I,

of,

have been fully informed of the nature of *my/ my child's illness and have agreed to the above *operation/ procedure / treatment / investigation being performed upon *me/my child.

Following discussion of *my/ my child's present condition, I accept the professional opinion of

Dr that it is the appropriate *operation/ procedure/ treatment/ investigation for *my/ my child's condition.

I request and consent to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this *operation/ procedure/ treatment/ investigation.

I understand that other unexpected *operation/ procedure/ treatment/ investigation may be necessary and I request that these be carried out if required.

Although this *operation/ procedure/ treatment/ investigation is to be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I understand that complications may occur with any *operation/ procedure/ treatment/ investigation and accept the possible risks associated with this *operation/ procedure/ treatment/ investigation.

.....
*Signature of Patient/ Parent /Guardian **

.....
Signature of Witness

.....
Full Name of witness (please print)

.....
Address of witness

.....
Date

****Delete as required***

PERSON TO CONTACT (usually next of kin):

Name Relationship to patient
Residential Address Post Code
Home Tel. Business/contact Tel. Mobile Tel.

Local Doctor
Name and Address

WORKERS' COMPENSATION/ THIRD PARTY PATIENTS (if applicable) ALL DETAILS MUST BE COMPLETED

Workers' Compensation patients cannot be admitted without prior written approval from the nominated insurance company.

Nominated Insurance Company Claim Number

Insurance Company Address Contact Name

..... Post Code Telephone

Employer Telephone

Employer's Address Date of Accident

..... Post Code Type of Accident

PHARMACY CONCESSIONS

Are you eligible for pharmacy concessions? Yes No

Entitlement Number

- Type of Entitlement Pension /Social Security
 Veterans' Affairs/ Repatriation
 Pharmaceutical Concession Card
 Safety Net

PREVIOUS HOSPITALISATION

Have you ever been admitted to St Luke's Hospital before? Yes No

If yes, when

Have you been admitted to any hospital in the last 28 days? Yes No

If yes, date and name of Hospital

Interpreter Required? Yes No

St Luke's Hospital Foundation Member? Yes No

Special needs/dietary requirements?.....

NO RESPONSIBILITY FOR PERSONAL ITEMS

All care is taken, but St Luke's Care cannot accept liability for losses of personal items. It is strongly recommended that jewellery or large amounts of money not be brought to the Hospital, as provision for safe custody is limited. Any patients who bring valuables to the Hospital who do not put all or part of such valuables into safe custody will be required to document that they have declined such custody offer.

PRIVACY STATEMENT & CONSENT TO COLLECT & USE INFORMATION

We acknowledge our obligations to you under Privacy Legislation. Personal information we collect from you will be used primarily to ensure that you receive optimal care, but may be used for other purposes. Personal information is released under legislation to the State Health Authority, Health Funds and the Private Hospital Data Bureau.

We may also release your contact details to the St Luke's Hospital Foundation, which is a charitable organisation that supports St Luke's Care through fundraising activities. The Foundation may send you a newsletter or information on the work it does. If you do not wish to receive this information, please contact the St Luke's Care Privacy Officer on (02) 9356 0200 or inform one of our administrative staff at the time of your admission. Fundraising staff do not have access to your health information.

Our Personal Information Management Policy is available at reception and our Privacy Officer, who can be contacted by telephone through our main switchboard, is happy to answer any questions you may have concerning the policy.

I hereby consent to the collection and use of my personal information for the purpose of my care and well-being and in accordance with the St Luke's Care privacy policy and reporting requirements under legislation.

Further, I understand that my health fund/ a third party insurer may require details of my hospital care, including information on my medical condition/s and treatment/s given by the Hospital, to enable payment of benefits for my hospitalisation. I hereby authorise the Hospital and/or my treating doctor to provide this information for this purpose to the health fund/insurer nominated by me on this form.

Date Patient / Responsible Person Signature

On completion of this form please forward to St Luke's Hospital. Thank you