ST LUKE'S
PRIVATE HOSPITAL

PRE-ADMISSION FORM

Attach patient identification label (Hospital Use Only)

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

DOCTOR TO COMPLETE

To be completed by Doctor. Please PRINT clearly.

PLEASE ADMIT

Title: Name: Surname:

Date of Birth: / / Gender: ☐ Male ☐ Female

Address:

Telephone (Wk/Day): (Home): (Mobile):

OPERATION AND CLINICAL DETAILS

Date of admission: / /

Allergies:

Additional medical conditions:

Proposed operation/procedure/treatment:

Date of operation: / / Estimated time in operating theatre:

Item numbers:

Expected length of stay: ☐ Day Only ☐ Overnight or longer Number of days:

Patient for Rehabilitation post operatively? ☐ Yes ☐ No

If yes, at St Luke's? ☐ Yes ☐ No (please specify location):

SPECIFIC ORDERS ON ADMISSION

Blood group and hold: ☐ to be attended on admission ☐ I have already arranged with:

Blood cross match: ☐ to be attended on admission ☐ I have already arranged with:

Thromboembolism prophylactic measures to be initiated on admission: ☐ Yes ☐ No

Details:

Other instructions/investigations on admission (e.g. medications, pathology, x-rays, ECG etc.):

Please note that ordering equipment is the responsibility of the surgeon

Specific surgical equipment requirements (e.g. loan sets, prostheses, implants):

Name of company equipment ordered from:

Gap prostheses or non-rebatable item to be used: ☐ Yes ☐ No

If yes, I confirm the patient has been informed of the cost and reason for the choice of this item: ☐ Yes ☐ No

PRE-ADMISSION FORM

MR1

LC4913 SLC 270516

ST LUKE'S
PRIVATE HOSPITAL

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Attach patient identification label (Hospital Use Only)

UR No.: ____________ Admission No.: ____________

Surname: ____________

Given Names: ____________

Date of Birth: / / Gender: ____________

Doctor: ____________

DOCTOR AND PATIENT TO COMPLETE

PART A: DOCTOR TO COMPLETE. Please print clearly and do not use abbreviations.

I, Dr (please print) ____________

have discussed with the Patient/Parent/Guardian/Person Responsible

Given Names: ____________ Surname: ____________

Date of Birth: / /

- The benefits of the proposed operation/procedure/treatment
- The common and serious risks of the proposed operation/procedure/treatment
- Additional procedures or treatments that may be needed if something unexpected is found or occurs
- Alternative treatments available and their associated risks

The proposed operation/procedure/treatment is:

____

____

Treating Medical Practitioner's signature: ____________ Date: / /

PART B: PATIENT CONSENT (to be completed by patient)

I, ____________

Consent to the above operation/procedure/treatment to be performed on me/upon my child/dependant

(Patient's name if not self): ____________

- I am satisfied with and understand the information I have received
- I understand that an anaesthetic and medicines may be administered, and these do have risks
- I have been advised of the risks and complications that may occur with this operation/procedure/treatment including those risks and complications that are specific to me
- I consent to information regarding my condition being shared with other health professionals involved in my care e.g. shared medical practitioners, allied health professionals, community services and my General Practitioner
- I understand that I may withdraw my consent at any time prior to the operation/procedure/treatment
- I consent to any recording, photographs, or filming of care for the purposes of my clinical management
- I understand that tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital
- I ☐ consent / ☐ do not consent to the administration of blood transfusion/blood products if needed

Signature of Patient/Parent/Guardian/Person responsible: ____________

Date: / /

Signature of witness to Patient/Parent/Guardian/Person responsible: ____________

Name of witness to Patient/Parent/Guardian/Person responsible: ____________

Interpreter present: ☐ Yes ☐ No Signature of Interpreter: ____________

Name of Interpreter: ____________

PRE-ADMISSION FORM

MR2

ST LUKE'S
PRIVATE HOSPITAL

PATIENT DETAILS FORM

Attach patient identification label (Hospital Use Only)

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT TO COMPLETE

To be completed by patient. Please PRINT clearly.

Your responses are valuable in planning your admission and caring for you during your stay.

ADMISSION DETAILS

Admitting Doctor:

Date of Admission: / / Date of Operation: / /

Admission Type: ☐ Overnight ☐ Day Patient ☐ Rehabilitation

PERSONAL DETAILS

Title: Given Names:

Surname: Previous Surname (if applicable):

Residential Address:

Postal Address:

Telephone (Wk/Day): (Home): (Mobile):

Email:

Gender: ☐ Male ☐ Female Date of Birth: / / Age:

Marital status: ☐ Single ☐ Married ☐ De-facto ☐ Divorced ☐ Separated ☐ Widowed

Country of birth: Are you an Australian resident? ☐ Yes ☐ No

Language spoken at home: Religion:

Are you of Aboriginal or Torres Strait Islander descent? ☐ Yes ☐ No

St Luke's Hospital Foundation Member? ☐ Yes ☐ No

PERSON TO CONTACT (NEXT OF KIN)

Name: Relationship to Patient:

Address:

Telephone (Wk/Day): (Home): (Mobile):

Second Contact / Power of Attorney: Telephone:

DETAILS OF GP

Name:

Address:

Telephone: Fax: Email:

PREVIOUS HOSPITALISATION

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

Have you been hospitalised for more than 48 hours within the past 3 months: ☐ Yes ☐ No

Dates: From / / To / / Name of hospital:

PATIENT DETAILS FORM

MR3

LC4913 SLC 270516

PATIENT TO COMPLETE

ST LUKE'S
PRIVATE HOSPITAL

PATIENT DETAILS FORM

PERSON RESPONSIBLE FOR ACCOUNT

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

Title: Surname: Given Names:

Address:

Telephone (Wk/Day): (Home): (Mobile):

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the financial information as outlined in the Pre-Admission Information.

Name: Signature: Date:

MEDICARE DETAILS

Medicare No: | | | | | | | | | | | Medicare Reference Number: Expiry Date: /

CONCESSIONAL BENEFITS

Do you hold any of the following cards:

☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: Benefit Card No:

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

HEALTH INSURANCE DETAILS

Insurance Type: ☐ Private Health Fund ☐ Workers Compensation ☐ Third Party ☐ DVA ☐ Self Funded

Name of Health Fund: Type of Cover:

Membership No: Do you have an excess? ☐ Yes ☐ No

Has this cover changed in the last 12 months? ☐ Yes ☐ No

Workers Comp Fund Name:

Address:

Claim Number: Date of Accident: / /

Employer Name: Telephone:

HR Manager: Fax Number:

Third Party Name: Details: Policy Number:

Serving Member of: DVA No.: DVA Card Colour:

Details of cover (white card only):

PATIENT RESPONSIBILITY

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following sections of the Pre-Admission Booklet:

☐ Pre-Admission Information ☐ Responsibilty of Personal Items ☐ Privacy Information

Name: Signature: Date:

PATIENT DETAILS FORM

MR3

ST LUKE'S
PRIVATE HOSPITAL

PATIENT HISTORY FORM

Attach patient identification label (Hospital Use Only)

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT TO COMPLETE

PATIENT HISTORY FORM

MR4

ADMISSION DETAILS

Please specify the reason for your admission:

	NO	YES	PLEASE SPECIFY
Have pathology (blood tests) been taken for this admission?			Pathology results with:
Have x-rays been taken for this admission?			☐ With Patient ☐ With Doctor

What is your: Height: cm Weight: kg Blood group (If known):

ALLERGIES	NO	YES	PLEASE SPECIFY
Do you have any allergies to medications, food, sticking plaster, latex/rubber or other substances?			Details and reaction:

MEDICATIONS (including herbal preparations and/or over the counter preparations)

Medications	Dosage	Frequency

RECENTLY CEASED OR CHANGED MEDICATIONS

Medications	Dosage	Frequency

Name of Community Pharmacist: Contact Phone Number:

GENERAL MEDICAL CONDITION

	NO	YES
Have you lost weight recently without trying?		
Have you been eating poorly because of a decreased appetite?		
Do you have a history of diabetes?		
Do you have a history of cancer? If yes, type:		
Do you have a history of stroke? If yes, year:		
Do you have a history of infectious diseases? e.g. HIV, Tuberculosis		
Have you ever had a multi resistant organism such as MRSA, VRE, ESBL?		
Have you had vomiting and/or diarrhoea in the last 48 hours?		
Do you have, or have you recently had, a fever with/without respiratory symptoms, e.g. cough, sore throat, runny nose?		
Have you travelled to a country in the past month with a current health alert?		
Do you have a history of high blood pressure?		
Do you have a history of heart attack/chest pain/angina?		
Do you have a history of palpitations/irregular heart beat/heart murmur?		
Do you have a history of rheumatic fever?		
Do you have a history of tendency to bleed/blood clots/bruise easily?		

LC4913 SLC 270516

PATIENT TO COMPLETE

ST LUKE'S

PRIVATE HOSPITAL

PATIENT HISTORY FORM

GENERAL MEDICAL CONDITION (continued)

	NO	YES
Do you have a history of arthritis?		
Do you have a history of asthma/bronchitis/pneumonia/hay fever?		
Do you have sleep apnoea?		
Do you use a CPAP machine?		
Do you have a history of liver disease/hepatitis? (Specify type A, B, C)		
Do you have a history of kidney/bladder problems?		
Do you have a history of hiatus hernia/gastrointestinal ulcers/bowel disorder?		
Do you have a history of thyroid problems?		
Do you have a history of epilepsy/seizures/febrile convulsions?		
Do you have a history of depression/dementia/other mental health disorder or illness?		
Do you have a history of migraines?		
Do you have a history of eye disease?		
Female patients, could you be pregnant?		
Do you have an impairment, e.g. vision, hearing, mobility?		

If yes to any of the above, please specify details:

ADVANCED CARE DIRECTIVE

Do you have an Advanced Care Directive or any treatment limiting orders? ☐ Yes ☐ No

If yes, please provide a copy on admission.

Contact name: Contact number:

PREVIOUS OPERATIONS/CHEMOTHERAPY/RADIOTHERAPY DETAILS

Please list dates and procedures 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 and reaction:
Have you ever had a blood transfusion?			If yes - what year? Did you have any adverse reactions? ☐ Yes ☐ No

PROSTHESIS AND IMPLANTS

	NO	YES	SPECIFY DETAILS
Hearing Aid or other Hearing Appliance			
Body Piercing			
Dentures/Caps/Crowns/Loose Teeth			
Artificial Joints or Limbs			
Metal Plates or Pins			
Pacemaker			Make: Model: Last checked:

PATIENT HISTORY FORM

MR4

ST LUKE'S
PRIVATE HOSPITAL

PATIENT HISTORY FORM

Attach patient identification label (Hospital Use Only)

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT TO COMPLETE

PROSTHESIS AND IMPLANTS (continued)

	NO	YES	SPECIFY DETAILS
Glasses/Contact Lenses			
Prosthetic Heart Valve			
Other Implants e.g. Intraocular Lens			

LIFESTYLE

	NO	YES	SPECIFY DETAILS
Have you ever smoked?			Daily Amount: or Date Ceased /
Do you drink alcohol?			Amount: Frequency:
Do you use recreational drugs?			Amount: Frequency: Type:
Do you require a special diet?			Type of Diet:
Do you exercise?			☐ <30 mins/day ☐ 30 mins/day ☐ >30 mins/day Type: Frequency/wk:
Do you require an interpreter?			Language spoken at home:
Do you have someone to interpret for you?			Name of interpreter:

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE (CJD)

	NO	YES
Have you had surgery on the brain or spinal cord that may have included a dura mater graft prior to 1990?		
Have you had two or more first degree relatives who have been diagnosed with CJD or other Prion Disease, where a genetic cause has not been excluded?		
Have you received pituitary hormone treatment for infertility or human growth hormone for short stature prior to 1986?		
Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been identified?		
Have you been involved in a 'Look Back' study for CJD, or are you in possession of a 'Medical in Confidence Letter' regarding the risk of CJD?		

DISCHARGE PLANNING

	NO	YES	SPECIFY DETAILS
Are you over 80 years of age?			
Do you live alone?			
Do you have someone to care for you after discharge?			Name of person: Relationship:
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			Details:
Do you have difficulty walking?			
Do you currently use any mobility aids?			Type:
Have you a fear of falling or have you fallen recently?			
Have you experienced dizziness in the last 12 months?			
Do you require assistance with any aspect of daily living?			
Do you have multiple health problems?			Details:
Where do you plan to go after discharge?			
How do you plan to get there?			

Name of person completing form:

Relationship: Date: / /

PATIENT HISTORY FORM

MR4

LC4913 SLC 270516

NURSE TO COMPLETE

ST LUKE'S

PRIVATE HOSPITAL

PATIENT HISTORY FORM

NURSE'S USE ONLY

If 'yes' to any of the Creutzfeldt Jakob Disease (CJD) questions, please refer to the 'HICMR' manual and contact the Infection Control Manager.

If 'yes' to any 'Mobility and Daily Activities/Discharge Planning' questions, please refer to relevant policy and complete assessment tools, e.g. 'Pressure Injury Risk Assessment Tool', 'Falls Risk Assessment Tool'.

If 'yes' to the weight/appetite changes questions in 'General Medical Condition', please refer to Malnutrition Universal Screening Tool in Pressure Injury policies.

If 'yes' to recent respiratory illness, multi resistant organism or recent hospitalisation questions, please refer to 'HICMR' manual for appropriate course of action or contact the Infection Control Manager.

PATIENT HISTORY REVIEW

Patient history form reviewed by pre-admission staff: ☐ Yes ☐ No

Name of pre-admission nurse: ______________ Designation: ______________

Signature: ______________ Date: / / Time: ______________

Patient history form reviewed by admitting nurse: ☐ Yes ☐ No

Name of admitting nurse: ______________ Designation: ______________

Signature: ______________ Date: / / Time: ______________

CLINICAL/PRE-ADMISSION NOTES

PATIENT HISTORY FORM

MR4