

*To CONFIRM your admission, please complete this form and either post or deliver form to the Hospital. You will be contacted by the Hospital 1-2 days prior to admission. Thank you.*



# Patient Information Admission & Consent

[www.subiacoprivate.com.au](http://www.subiacoprivate.com.au)

Subiaco Private Hospital is committed to exceed your expectations as a patient by providing the highest standard of nursing care in a safe and caring environment.

The following information is provided to assist us in the delivery of care.

### Prior To Admission

Please ensure you have completed and forwarded the patient information, clinical details and consent forms given to you by your Surgeon and enclosed in this booklet.

The clerical staff from Subiaco Private Hospital will contact you to verify all details are correct. This ensures that any Health Fund payments can be accurately processed and you are aware of any costs not covered by the Health Fund.

A day or two prior to your admission, a pre-admission telephone interview by one of the nurses is the opportunity to have questions answered and to notify our staff of any specific needs you may have. Please advise of any special dietary needs so you can be accommodated.

Your doctor or nurse will inform you of your fasting times.

It is important to note that all patients undergoing a procedure involving sedation or general anaesthesia must be accompanied by a responsible adult on discharge and not drive or operate machinery for 24 hours following the procedure. It is strongly advised that you have someone stay with you for the remainder of the day and overnight.

### Day of Admission

Please arrive at the time allocated. Please bring with you:

- Relevant x-rays or pathology results
- Letter from your treating doctor or anaesthetist, if you have been given one
- Medicare card & Health Insurance Card
- Cash, cheque or credit card to settle your account if any fees are payable. EFTPOS facilities are available
- Consent form, if not sent prior to admission
- Medications you are taking - please bring in original packaging.

Do not wear makeup, nail polish or contact lenses. Remove all jewellery (wedding band may be worn).

On arrival the reception staff will check you in and notify the nursing staff of your arrival. Patients will be escorted to the Admission area in order of procedure. This may not be in order of arrival. We will do our best to ensure your comfort whilst you wait. Some areas of the hospital are restricted and at times only one parent/carer is permitted.

The Nurse will escort you through to prepare for your procedure. You will be asked to change into a gown and your belongings will be placed in a basket. We request you do not have large amounts of cash or valuables with you during your stay, as the hospital cannot accept responsibility in the event of loss or damage to personal belongings. The Nurse will place identity bands on your wrist or ankle and record your vital signs.

If you have not seen your Anaesthetist prior to admission he/she will see you before you are taken into the theatre for your procedure. If you have any questions regarding your anaesthetic please contact the Anaesthetist before the day of your procedure.

## After Your Procedure

Following your procedure you will be taken to the recovery area where Nurses will monitor you until you are awake and comfortable. When you are recovered you will be escorted to the discharge lounge where you will be offered light refreshments and your relative or escort will be contacted to pick you up. Your length of stay at the Hospital will be dependent upon your anaesthetic and type of procedure.

Upon discharge the Nurse will explain the post-operative instructions to you and your relative/escort. A written information sheet with contact numbers will be given to you. If you do not understand any of the instructions please let the nurse know so clarification can be made. A day or two after your procedure you will receive a call from one of the staff to enquire how you are feeling and if you have any questions.

## Overnight Admission

Subiaco Private hospital provides overnight accommodation for nine patients. Ward beds are all shared rooms. One parent/carer is permitted to stay with children. An evening meal and chair/folding bed to sleep in is provided.

To enable us to prepare the rooms for admission on the day of your discharge, we ask that you please organise transport by 8:30am.

## Account Information

If you are privately insured, a Veterans' Affairs patient, or a Workers' Compensation Claim, the Hospital will forward the account to the relevant fund. If you are uninsured or a health fund excess payment is required, settlement of the account is required on admission.

Please contact the hospital for a quote or to enquire of any monies due on admission. It is your responsibility to ensure that your procedure is covered by your Health Fund Provider. Please ensure you have met qualifying periods to avoid unexpected expenses.

## Parking

There is a Wilson Car Park in the basement of the building. Limited paid parking is available. The parking is pre-paid, the machine accepts coins and credit cards only. It is advisable to have coinage on the day of your surgery.

Alternative paid parking is also available within walking distance - please allow time to park.

From the basement please take the elevator to reception suite 9, situated on the ground floor.

## Mutual Rights And Responsibilities

Participating in your care as a patient involves the following rights and responsibilities:

- You should receive an explanation of any treatment and associated risks prior to giving your consent.
- Knowledge of financial costs involved in your treatment.
- Ability to seek a second opinion.
- All care is provided with respect, dignity and professional competence.
- All medical records are secured and confidentiality assured.
- Advice on how to make a complaint.
- Written instructions on your care after discharge.
- Access to your medical record if required.
- Honesty regarding any medical or surgical history.
- Disclosure of all medications you are taking, including non-prescription medications and alternative treatments.
- Agreement to follow medical advice and instructions.

## Privacy

In accordance with the Privacy Act, Subiaco Private Hospital ensures all personal information is professionally managed. A Privacy Information Brochure is available at the front reception of the Subiaco Private Hospital. Alternatively information is accessible on the website.

## Disclosure

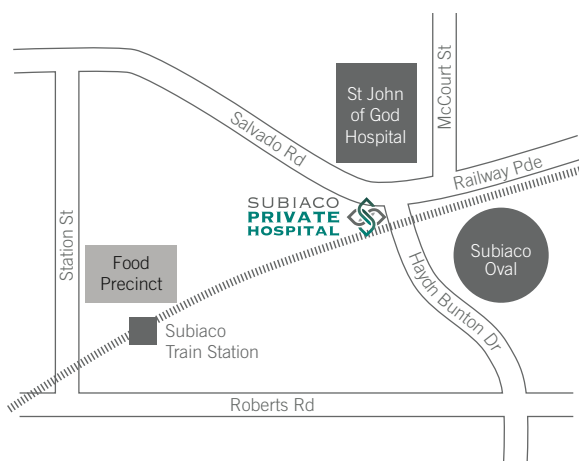
Your treating surgeon may have a financial interest in Subiaco Private Hospital.

## Comments & Complaints

Subiaco Private Hospital is committed to provide excellence of care and values feedback from patients. This ensures that any areas of improvement are promptly addressed and any feedback, positive or negative is directed to the appropriate staff member.

Following your procedure a survey form will be given to you with a stamped-addressed envelope. Please take the time to complete the form and return it to the hospital.

If you have any concerns on the day of your procedure the staff are very willing to listen and assist you. Alternatively, any comments or complaints can be addressed to the Chief Executive Officer/Director of Nursing. If you wish to confer with an external provider please contact office of Health Review WA, 9323 0600.



**Subiaco Private Hospital Pty Ltd** | ABN 22130978559

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t: (08) 6555 6599 | f: (08) 9388 1654 | e: [info@subiacoprivate.com.au](mailto:info@subiacoprivate.com.au)  
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## DOCTOR'S SECRETARY TO COMPLETE

Doctor	Admission Date	Time
Dr's Phone No.	Anaesthetist	
Admit Type:	<input type="checkbox"/> LA/Sedation	<input type="checkbox"/> Day Case <input type="checkbox"/> Overnight Stay

## Patient Admission Information

**To CONFIRM your admission, please complete this form and either post or deliver form to the Hospital. You will be contacted by the Hospital 1-2 days prior to admission. Thank you.**

### PART A PATIENT DETAILS (patient / guardian to complete)

Surname	Given Names		
Preferred Name	Title	Sex	Marital Status
Ethnic Origin (eg. Asian, Aboriginal, Caucasian, TSI)		Country / State of Birth	
Residential Address	Post Code		
Postal Address (if different from above)	Post Code		
Phone No: Home	Phone No: Mobile		
Employment Status			

### PART B CONTACT PERSON (patient / guardian to complete)

Next of Kin	Relationship		
Phone No: Home	Phone No: Mobile	Phone No: Work	
Residential Address	Post Code		
Other Contact (in Australia, not living with you)	Relationship		
Phone No: Home	Phone No: Mobile	Phone No: Work	
Residential Address	Post Code		

### PART C MEDICARE DETAILS (patient / guardian to complete)

Medicare Number	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	Individual patient number (to the left of name on card)
Card Valid to	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Name on Card

Please print name exactly as shown on Medicare Card

**Medicare**

1234 56789 1

① JOHN F CITIZEN

② MARY G CITIZEN

VALID TO 06/2010

### PART D PAYMENT / INSURANCE (patient / guardian to complete)

Name of Fund	Membership No. (include letter, if applic.)	Length of Membership	Contributors Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Private Fund	<input type="checkbox"/> Insured	<input type="checkbox"/> Uninsured	Excess Amount
			<input type="text"/>

**PLEASE NOTE:** Uninsured patients are required to pay full estimated fee on admission. Please contact the hospital for a quote. It is your responsibility to ensure that your procedure is covered by your Health Fund Provider.

**TRAVEL ARRANGEMENTS:** Have you arranged for someone to collect you from the hospital after your procedure? ☐ Yes ☐ No

Name	Relationship	Phone No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

PLEASE CONTINUE OVER PAGE

**PART D** *Continued***PAYMENT / INSURANCE DETAILS** (patient / guardian to complete)

If Workers' Comp or MVIT, please complete section below

**Workers Compensation**

Date of Accident

Claim Number

Employer Name

Address

Post Code

Insurance Co. - Name

Address

Post Code

**Motor Vehicle**

Date of Accident

Claim Number

Is this a W.A. Claim

Yes

No

If NO, which State?

Solicitor

Address

Post Code

**PART E****DEPT. OF VETERANS' AFFAIRS** (If applicable, patient / guardian to complete)

Cardholders Name

Card Number

Card Colour:

☐

White

☐

Gold

**PART F****HOSPITAL / PREVIOUS ADMISSION DETAILS** (patient / guardian to complete)

Have you previously been an inpatient in this Hospital?

Yes

if so, what year?

No

Have you been known by any other name(s) e.g Maiden Name.

If so, please state name(s) at last admission

Have you been hospitalised or worked in a health care facility in the last 12 months?

Yes

No

If YES, you must obtain VRE screening swabs and the results sent to the hospital. Please contact your doctor to arrange this.

If the Hospital was outside Western Australia please contact our Admissions Office immediately.

**PART G****DECLARATION** (patient / guardian to complete)

I hereby:

- a) acknowledge that I have received, read and understood a copy of Subiaco Private Hospital Health Care Privacy Guide for Patients which explains how the Hospital will handle my personal information.
- b) acknowledge that I have read and understood the information provided to me in this form.
- c) declare that the information provided by me in this form is true and correct:

Patient/Guardian signature

X

Date



## Clinical Information

PLEASE USE PATIENT ID WHEN AVAILABLE	
Surname	URN
Given Names	
D.O.B.	Sex
Doctor's Name	

**CLINICAL INFORMATION REQUIRED FOR ADMISSION** (patient / guardian to complete)

## Patient History

**Please complete the following (Please tick box and specify where necessary)**

**\*Please note that SPH have a Maximum Weight Policy of 120 kilos. Body mass index of 35. Your operation may be cancelled if your weight exceeds 120 kilos + BMI of 35. If unsure please call the hospital.**

YES	NO	
		<b>Weight _____ kg + Height _____ cms</b>
		Allergies (drugs, tapes, foods, latex)
		Heart problems (chest pain, heart attack)
		High blood pressure
		Bleeding/clotting problems
		Indigestion or reflux
		Fainting/blackouts/dizziness
		Breathing problems (shortness of breath, sleep apnoea)
		Asthma
		Epilepsy/fits
		Hepatitis
		Kidney disease
		Back or neck problems
		Chronic/Persistent Pain
		Diabetes
		Psychiatric problems (anxiety, depression)
		Dementia
		Do you have a pacemaker
		Recent sore throat, cold or flu in the last 2 weeks
		Problems with an anaesthetic in the past
		Do you drink alcohol
		Do you smoke
		Have you previously smoked
		Is English your first language
		Have you had previous surgery

**SPECIFY**

[illegible]

## MEDICATIONS

Please list your current medications and dosage

[illegible]

Have you ever taken or are you taking any of the following?  
If yes when did you stop taking

YES	NO		DATE CEASED
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	
<input type="checkbox"/>	<input type="checkbox"/>	Warfarin	
<input type="checkbox"/>	<input type="checkbox"/>	Steroid/Cortisone/Prednisolone	
<input type="checkbox"/>	<input type="checkbox"/>	Insulin	

Do you use any of these **AIDS** for **DAILY LIVING**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Crutches
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Walking Frame
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Walking Stick
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair			



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PLEASE USE PATIENT ID WHEN AVAILABLE

Surname

URN

Given Names

D.O.B.

Sex

Doctor's Name

## Consent to Procedure and Administration of Anaesthesia

### CONSENT

To be completed by treating medical practitioner

I, \_\_\_\_\_ of \_\_\_\_\_  
Address \_\_\_\_\_  
hereby consent to the  
following procedure of \_\_\_\_\_  
*No abbreviations, please print*

being performed on \_\_\_\_\_  
*if not self, state patient's name and relationship*  
the nature and purpose of which has been explained to me by \_\_\_\_\_  
*Medical Practitioner's name*

I consent to blood transfusion if needed ☐ Yes ☐ No (please tick appropriate box)

### CONSENT FOR BLOOD TEST - ACCIDENTAL INJURY TO STAFF

In view of the possibility of a staff member or doctor being injured and contaminated with a patient's blood, it is the policy of Subiaco Private Hospital to request all patients being admitted to consent to blood being collected and tested for any infectious agents, including Hepatitis B, Hepatitis C and HIV.

#### Consent to blood test

If any staff member or doctor is injured and exposed to my (or my child's) blood or any other body fluid, then I give my consent to blood being collected from myself or my child and tested for infectious agents, including Hepatitis B, Hepatitis C and HIV antibody.

I understand that:

1. I will be informed that blood has been taken for testing.
2. The results of the test will be made available to me, by my Medical Practitioner or the infection Control Coordinator of this Hospital (or his/her deputy)
3. All staff and doctors are bound by the hospital Privacy Policy to maintain confidentiality of the test results.

Patient/Guardian signature X

Date

### CONFIRMATION

MEDICAL PRACTITIONERS CONFIRMATION

I confirm that I have explained to the Patient/guardian the nature and purpose of this procedure.

Medical Practitioners signature \_\_\_\_\_ Date

### Medical Practitioner's Instructions

### POTENTIAL CREUTZFELDT - JAKOB DISEASE (CJD) RISK

For pre-operative patients undergoing neurosurgical and ophthalmological (posterior segment) sinus & mastoidectomy procedures.

- ☐ Do you think the patient may have CJD?
- ☐ Has the patient had a first degree relative with CJD?
- ☐ Does the patient have an unexplained progressive neurological illness of less than 12 months?
- ☐ Does the patient have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature prior to 1986?
- ☐ Has the patient previously had surgery on the brain or spinal cord that included a dura mater graft prior to 1990?
- ☐ Has the patient been involved in a "look back" for CJD or shown you a 'medical in confidence' letter regarding their risk 1990?

If YES is answered to one or more of these questions please contact the Infection Director of Nursing for further advice.

**Do not proceed to surgery prior to obtaining this advice.**

Medical Practitioners signature \_\_\_\_\_ Date

TEAR ALONG HERE

TEAR ALONG HERE