RECOMMENDATION FOR ADMISSION

Admission Date: .....

Admission Time: .....

Fasting Time: .....

RDS riverina day surgery

Best Of Care...Close To Home

2-8 Meurant Ave, Wagga Wagga NSW 2650
Phone 02 6925 6256
Fax 02 6925 6257
Email admin@riverinadaysurgery.com.au
Web www.riverinadaysurgery.com.au

REV 30 03/2015

ADMISSION INFORMATION

Thank you for choosing Riverina Day Surgery.

This package contains information that is important for you to read:

- the forms you need to complete in order to provide us with the information we need to finalise your booking and let us know about any special care you may require
- information on how to prepare for your surgery
- information about your hospital bill and how you can pay your account
- information on how we protect your privacy
- information on your rights and responsibilities whilst in hospital.

COMPLETING THE FORMS

Please complete the following three forms using black ball point pen.

1. Patient Registration Details - pages 7 & 8
2. Day Patient Health Assessment - pages 9 & 10
3. Privacy Consent/Rights and Responsibilities Acknowledgment - page 11

Tear off the forms along the perforated lines and return them to the hospital at least 1 week before your admission. You keep the rest of the package. Forms can be delivered in the following ways:

FAX

(02) 6925 6257 If the forms are faxed please remember to bring the originals with you on your day of admission.

POST

Riverina Day Surgery
PO Box 5904
Wagga Wagga NSW 2650

HAND DELIVERED

Riverina Day Surgery
2-8 Meurant Avenue
Wagga Wagga NSW 2650

MEDICINES

Before your admission to hospital please let your doctor know what medicines you are taking including prescription, non-prescription, and complementary medicines (including creams, eye drops, puffers, vitamins, herbal preparations, etc).

It is important that your Doctor and the hospital staff know exactly what medicines you are taking as medicines can adversely react with one another and your treatment. Your doctor can then tell you which medicines you need to stop before your surgery (if any) and when to stop taking them.

Please bring all your medicines in their original packaging into hospital with you (even if you use a Webster/ Blister pack). This ensures the medicines you need are available when you need to take them.

ADMISSION DATE / TIME

On the last working day before your scheduled procedure please contact Riverina Day Surgery between the hours of 10:00am and 5:30pm to confirm your admission, fasting times and pre-procedure information.

If you are having a bowel procedure please check your preparation and fasting requirements with your doctor. You will still need to contact the hospital the day before the procedure to confirm your admission time.

Please advise your doctor and the hospital of any change in your condition, such as a cold or fever, between now and the day of admission.

PLEASE BRING WITH YOU

On day of admission please bring:

- all forms, letters, and requests from your doctor
- all prescription, non-prescription and complementary medicines you are currently taking unless advised otherwise by hospital staff
- printed list of current medicines from your GP or pharmacist
- X-rays and scans related to your admission and/or procedure (your procedure may be cancelled if x-rays or scans needed for your procedure are not available)
- Medicare card and health fund details
- Department of Veterans' Affairs (OVA) card
- letter of approval for WorkCover, Third Party or Public liability claims (if applicable)
- any other items (eg. crutches, boots, brace) as instructed by your Doctor

MONEY / JEWELLERY / VALUABLES

We advise you to leave valuables such as jewellery, large amounts of cash (unless you are paying an excess or co-payment on admission) and electronic items at home as we cannot accept responsibility for them if they are lost or stolen.

YOUR ADMISSION

DO NOT

- smoke for 24 hours before admission - please talk to your Doctor if you require nicotine replacement treatment during your stay in hospital
- chew gum or suck lozenges while fasting
- wear jewellery including piercings (a wedding ring is permitted)
- wear make-up or nail polish (false nails are permitted but are discouraged)
- bring children (unless the patient)
- use talcum powder on day of the procedure.

Please shower on the day of the procedure.

DISCHARGE

Please make arrangements in advance for a responsible adult to accompany you when you leave hospital and stay with you overnight. Failure to comply with this may result in the cancellation of your procedure.

YOU MUST NOT DRIVE YOURSELF HOME OR STAY AT HOME ALONE as it is unsafe to do so no matter how well you may feel.

You will be given written post-procedure instructions to take home.

ACCOUNT FEES AND PAYMENTS

ESTIMATE OF EXPENSES

- An estimate of the expenses for your hospital stay can be obtained by contacting Riverina Day Surgery on (02) 6925 6256
- Whilst every effort will be made to provide an accurate estimate of expenses additional costs are confirm your cover, including any exclusions, sometimes incurred. This may be due to:
    - Variations in proposed treatment, procedure, prosthesis, or length of stay
    - Sundry charges, take home items, medications
- You will need to sign a copy of the IFC (Informed Financial Consent) to acknowledge that you have received and understand any unforeseen charges.
- If responsibility for payment of the claim is not accepted by your health insurer, Department Veterans' Affairs/Defence or other insurer (WorkCover, Third Party and Public Liability) then you or the person nominated as responsible for the account on the Patient Registration Details form (if other than patient), are responsible for payment of the entire account.

COSTS OF OTHER HEALTH CARE PROVIDERS

- Please contact your doctor for an estimate of his/her costs as these are separate to those of the hospital.
- Other providers including anaesthetists, surgical assistants, pathology and x-ray are responsible for advising you of any out of pocket expenses.

PROSTHESIS COSTS AND CONSENT

- Where a prosthesis is required your Doctor will discuss any possible out of pocket expenses and obtain your signed consent for payment of the gap, if any.

HEALTH FUND PATIENTS

- Please contact your health fund before admission to check your level of cover and clarify any excesses or co-payments you may have.
- The hospital will also contact your health fund to confirm your cover, including any exclusions, pre-existing illness not covered, excesses or co=payments. These costs will be included in your estimate of expenses.
- Excesses and co-payments are payable on admission.

UNINSURED PATIENTS

- Uninsured patients are required to pay the total estimated cost of their hospital stay on admission.
- Any shortfall in the estimate and other charges will be payable prior to or on discharge.
- Over-payments will be refunded as soon as possible after discharge.

DEPARTMENT OF VETERANS' AFFAIRS (DVA) PATIENTS

- If you are a gold card holder and require a cosmetic procedure your doctor must seek authorisation from DVA prior to admission.
- If you are a white card holder your doctor must seek authorisation from DVA for any admission.

WORKCOVER, THIRD PARTY AND PUBLIC LIABILITY PATIENTS

- A letter of approval from the relevant insurer must be provided with the Patient Registration Details form prior to admission for WorkCover, Third Party and Public Liability claimants.

ACCOUNT PAYMENTS

- Accounts can be paid by credit card (Visa, Mastercard), cash, EFTPOS, or cheque.

REQUEST FOR ADMISSION

RDS riverina day surgery

Recommendation for Admission

DOCTOR TO COMPLETE

PATIENT ID LABEL - Attach if available

UR No: .....
Surname: .....
Given Names: .....
D.O.B: .....
Address: .....
Phone Number: .....
Health Fund: ..... No: .....

ADMITTING MEDICAL OFFICER

PROVISIONAL DIAGNOSIS

PROPOSED OPERATION / PROCEDURE

SPECIAL SURGICAL REQUIREMENTS / PROSTHESIS

ADMISSION DETAILS	PROPOSED ITEM NUMBERS
Proposed Date of Admission:	
Estimated Operating Time:	
Anaesthetic ☐ GA ☐ Local ☐ Sedation	

RELEVANT PAST MEDICAL / SURGICAL HISTORY

KNOWN ALLERGIES

SPECIFIC INSTRUCTIONS (please complete appropriate forms for patient)

Pre-operative

☐ Bowel Prep ☐ FBC ☐ LFTs ☐ U&Es ☐ Coags

☐ X-Ray ☐ ECG ☐ Other

Medications you have advised the patient to cease prior to admission:

Medications: Date to Cease:

DOCTOR'S SIGNATURE: **DATE:**

FOLD BEFORE TEARING - PLEASE TEAR HERE

RDS riverina day surgery

Consent for Medical/ Surgical Treatment

PATIENT ID LABEL - Attach if available

Surname: .....
Given Names: .....
D.O.B: .....

Admission Date: .....
Time: .....

DOCTOR TO COMPLETE

I, Dr

(please print)

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

(Patient's name)

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

The proposed treatment is

Medical Officer's signature

PATIENT TO COMPLETE

I, Mr / Mrs / Ms / Miss

Consent to the above 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 required, and these do have risks.
- I consent to information regarding my condition being shared with other health professionals involved in my care, eg. 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 procedure/treatment.
- I have been informed that the procedure/treatment may be performed by another doctor (obstetric and public patients only).
- I consent/do not consent (strike out what is not applicable) to the administration of blood transfusion/blood products if needed.

*Signature of Patient / Guardian / Person Responsible** Date:

*Signature of Witness to Patient / Guardian / Person Responsible** *Name of Person Responsible / Guardian / Medical Agent**

Interpreter present: ☐ Yes ☐ No

Signature of Interpreter Name of Interpreter

* Strike out what is not applicable ** "Person responsible" means a person exercising power under the Guardianship Act 1987.

DOCTOR:

1. Please complete the Recommendation for Admission form (overleaf) in full
2. Please ensure that the Consent for Medical/Surgical Treatment form is fully completed, signed and witnessed
3. Please forward the Request for Admission and Consent for Medical/ Surgical Treatment forms by fax to Riverina Day Surgery on (02) 6925 6257 as soon as possible (please ensure the originals are sent to the hospital with the patient)

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Patient Registration Details

PATIENT TO COMPLETE

PATIENT ADMISSION DETAILS

Admission Date: Admitting Specialist:

Referring Doctor (Name): Phone:

PATIENT DETAILS

Title: Surname: Given Names:

Gender: Date of Birth: Country of Birth:

Marital Status: ☐ Married ☐ De facto ☐ Single ☐ Divorced ☐ Widow ☐ Other

Spoken language: Interpreter required: ☐ Yes ☐ No

Address: Postcode:

Phone: (Home) (Work) (Mobile)

Email:

Indigenous Group: ☐ Non Indigenous ☐ Aboriginal& TSI ☐ Aboriginal ☐ Torres Strait Islander

Religion: Preferred Name:

Have you ever been admitted to Riverina Day Surgery before? ☐ Yes ☐ No

If your name has changed since last admission, name previously admitted under:

PERSON FOR NOTIFICATION

Next of Kin:

Title: Surname: Given Name:

Relationship: Address:

Phone: (Home) (Work) (Mobile) Email:

Alternative Emergency Contact:

Title: Surname: Given Name:

Phone: (Home) (Work) (Mobile) Relationship:

PERSON RESPONSIBLE FOR ACCOUNT (If other than patient)

Title: Surname: Given Name: Relationship:

Address:

Phone: (Home) (Work) (Mobile) Email:

HOSPITAL INFORMATION

Have you been or do you expect to be an inpatient in any hospital within 7 days of admission date? ☐ Yes ☐ No

If yes, name of hospital: Admission date: Discharge date:

If yes, was an excess paid? ☐ Yes ☐ No Amount Paid $ Name of hospital:

OFFICE USE ONLY	
OPV:	Excess: Co-payment:
Quote Sent:	Sent by:
Exclusions:	Quote/IFC Signed:
Waiting Periods: ☐ Yes ☐ No	Pre-Existing Condition Warning: ☐ Yes ☐ No
Financial: ☐ Yes ☐ No	Apprvd WC/TP/PL:

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PATIENT REGISTRATION DETAILS

Tick/Complete applicable section

☐ UNINSURED PATIENTS

Quote: $ | Quote given by: | Date:

☐ HEALTH INSURANCE DETAILS

Private Health Fund Name: Table:

Name of Policy Holder: | Membership No: | Patient Reference No:

Date of Joining Fund: | Current Table Membership: ☐ Less than 12 mths ☐ Over 12 mths

If current table membership is less than 1 year, name of fund and table transferred from:

Do you have an excess: ☐ Yes (Amt: $) ☐ No Do you have a co-payment: ☐ Yes (Amt: $) ☐ No

It is recommended that you contact your fund to confirm your level of cover. Please Note: All excesses and co-payments are payable on admission.

☐ DEPARTMENT OF VETERANS' AFFAIRS & DEPARTMENT OF DEFENCE PATIENTS

DVA Card No: | Expiry Date: | Card Colour:

For Veterans with a Gold Card admitted for cosmetic surgery, or White Card holders admitted for any treatment, the admitting doctor must seek authorisation prior to admission.

Auth'n No:

Defence Personnel Service No: | Ref No: | Rank:

MEDICARE CARD INFORMATION AND GENERAL PRACTITIONER

Medicare No: | Patient Reference No: | Expiry Date:

General Practitioner (Name) : | Phone:

WORK COVER, THIRD PARTY AND PUBLIC LIABILITY CLAIMS

Date of Accident: | Nature of Claim: ☐ WorkCover ☐ Third Party ☐ Public Liability ☐ Other

WorkCover: | Employer's Name: | Contact:

Address: | Phone: | Claim No:

Employer's Insurance Company: | Contact: | Phone:

Third Party / Public Liability / Other (please specify):

Patient's Solicitor / Insurance Company: | Contact:

Address: | Phone: | Claim No:

Note: If responsibility is not accepted through compensation the person responsible for the account (refer previous page) is personally responsible for payment.

DECLARATION (To be completed by patient or parent/ guardian if the patient is a minor)

I have read and understand the information contained in the Patient Registration Details form. I certify that to the best of my knowledge the particulars set out on this form are correct. I understand the conditions relating to payment as set out below*. I understand that total costs cannot be quoted, only estimated in advance. My obligation to pay for the hospitalisation is independent of any benefits claimable from Medicare or Private Health Insurance. I release Riverina Day Surgery (the Hospital) from any claim for whatever loss, theft or damage of any property or valuables.

1. I accept personal responsibility for full payment of the Hospital's account, or balance remaining in the event that my claim is rejected in full or partly paid as applicable.
2. In the event that I am uninsured while an inpatient of the Hospital, I accept personal responsibility for full payment of the Hospital's account.
3. I accept personal responsibility for full payment of the Hospital's account in the event that my compensation claim (if applicable) is not settled within 90 days of being an inpatient of the Hospital.
4. In the event that the whole or any part of the account shall be unpaid after my discharge from the Hospital and the Hospital appoints an agent for the purpose of recovering any such amount from me, I acknowledge that I am personally responsible for any fees, charges and/or commission which the Hospital may pay to such an agent for the collection of such an account.

Signature: | Date:

Print Name:

FOLD BEFORE TEARING - PLEASE TEAR HERE

Day Patient Health Assessment

PATIENT TO COMPLETE

- Please fill in this form using **black** ballpoint pen
- **Please ensure your name and date of birth are written on each page**

PATIENT ID LABEL - Attach if available

Surname: .....

Given Names: .....

D.O.B: .....

Surgeon: **Planned Admission Date: / /** **Height:** **Weight:**

In your own words please tell us why you are being admitted to hospital:

PLEASE TICK BOX	YES	NO		Staff Use Only Initial Actions
Do you require an interpreter?			Specify language / type:	
Are you sensitive or allergic to medicines, foods, tapes, metals, latex/rubber, antiseptics, other?			Specify allergy and reaction *(attach a list if there is not enough room)*	
Have blood tests or other pathology tests been taken for this admission?			If yes, when and where?	
Have X- rays I CT scan I MRI I Ultrasound been taken for this admission?			Please bring your x-rays/scans to hospital with you.	
Could you be pregnant?			If Yes, when was your last period? / /	
Do you have any physical disabilities? If yes please contact the Booking Office so we can meet your needs			Please specify:	
Do you have specific dietary requirements?			Please specify:	
Do you or have you ever smoked?			Number per day: Date stopped: / /	
Do you drink alcohol?			Amount per day:	
Do you use recreational drugs (other than alcohol or tobacco)?			Type: Daily Amount:	
Are you currently receiving community nurse visits?			Please specify:	
Do you require a Doctor's Certificate?			If yes, please discuss with your Doctor	
Do you take or have you recently taken blood-thinning medicine)s ie. Aspirin (Astrix, Cartia, Aspro, Disprin etc), Warfarin (Marevan, Coumadin), Clopidogrel (Iscover, Plavix), Eliquis, Xarelto, or drugs for arthritis?			Name of medicine: Date last taken: / / or still taking? ☐ Yes	
Do you have an advanced care directive?			If yes, please bring with you on the day of your procedure	

MEDICINES **If you do not have a current printed list of your medicines from your GP please list all medicines including vitamins, herbal preparations and alternative medicines below (please attach a list if there is not enough room.)**

Current Medicines	Dose	How often do you take it?	What is it for?

Please bring to hospital any medicines/insulin/puffers you are currently taking in their packages.

PAST MEDICAL & SURGICAL HISTORY **Please list previous illnesses, operations and the years you had them (Please attach a list if there is not enough room).**

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DAY PATIENT HEALTH ASSESSMENT

PATIENT ID INFO - Please ensure your name and date of birth are written on each page

Surname: ..... Given Names: ..... D.O.B: .....

DO YOU HAVE/HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO		YES	NO
Side effects / reactions to an anaesthetic such as nausea, confusion, aggression or poor recovery?			Chest pain / angina / heart attack		
An immediate blood relative who has had side effects or reactions to an anaesthetic			Heart surgery / pacemaker / inflatable defibrillator / cardiac stent		
Asthma / shortness of breath / hayfever / sleep apnoea *(please bring your CPAP machine to hospital with you if you use one)*			Palpitations / irregular heart beat / heart murmur		
Diabetes *please specify type*			Are you under the care of a cardiologist? If so, who? _____		
Do you have a cold or the flu?			Rheumatic fever		
Stroke / mini strokes			High or low blood pressure		
Bleeding problems			Do you have a fear of needles?		
Blood clot in legs (DVT) or lungs			Have you experienced fainting or blackouts?		
Epilepsy / fits / seizures / faints			Cancer		
Hepatitis or jaundice / liver disease			Are you immunocompromised? *please specify why*		
Do you have any difficulties with mobility? *eg. back or hip problems*			Lymphodema *please specify*		
Do you have dental problems? ☐ Caps ☐ Crowns ☐ Loose Teeth			Ankle / leg swelling		
Do you have false teeth / dentures? ☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Full			Kidney trouble *please specify*		
Mental illness / nervous breakdown / PTSD / anxiety attacks / depression			Hiatus Hernia / reflux / indigestion		
Dementia / short term memory loss			Do you wear glasses / contact lens?		
Other illnesses please specify in Past Medical and Surgical History section overleaf			Do you have any prostheses? *please specify*		
Creutzfeldt-Jakob Disease (CJD) Do you believe that you may be at risk of Creutzfeldt-Jakob Disease after receiving human growth hormone for short stature or human pituitary hormone for infertility prior to 1986?			Do you have any piercings? *please specify*		
Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?			Do you have an Advanced Care Directive?		
			Have you had a history of MRSA or VRE?		
			Do you know of two or more close relatives in your family (ie grandparent, mother, father, aunt, uncle, brother, sister) who have had a history of CJD, or a related disease (ie Familial Insomnia, Gerstmann Straussler-Scheinker Syndrome)?		
			Have you had a dura mater graft prior to 1989?		

PATIENT COMPLIANCE STATEMENT

I certify that I have a responsible adult to both accompany me home and stay with me overnight. I understand that surgery may be cancelled if I do not have a responsible adult to accompany me home and stay overnight.

Name of responsible adult: **Contact number:**

I understand the importance of and agree to follow instructions regarding my post-operative care. I undertake not to drive, operate machinery, drink alcohol, sign legal documents or make significant decisions following my anaesthetic, until the next day or as advised by my doctor.

Patient Signature: **Date:**

STAFF USE ONLY Information on this Day Patient Health Assessment has been discussed and confirmed with the patient

Name of admitting nurse:	Signature:	Designation:	Date:

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Rights & Responsibilities Acknowledgement

PATIENT TO COMPLETE

- Please fill in this form using **black** ballpoint pen
- **Please ensure your name and date of birth are written on each page**

PATIENT ID LABEL - Attach if available

Surname: .....

Given Names: .....

D.O.B: .....

PRIVACY CONSENT FORM

By signing and dating in the space below you are acknowledging receipt of our Privacy Policy on Page 13 of this package and giving your consent to the collection and use of your personal information as described in that policy.

In addition, if you do not consent to your information being used in the manner described below, please cross out the choice, for example ~~cross out the choice~~.

- I consent to Riverina Day Surgery providing information about my condition and treatment to my nominated next of kin.
- I consent to Riverina Day Surgery providing my name to members of Returned Services organisations if appropriate.
- I consent to Riverina Day Surgery sending me confidential surveys to obtain my feedback as to the quality of care I received during my stay.

*Signature of Patient / Person Responsible**: Date:

Name:

Irrespective of any request received, I direct you **NOT TO PROVIDE** my personal information to *(please specify name/details):*

Signature: Date:

Name:

RIGHTS & RESPONSIBILITIES

By signing and dating in the space below you are acknowledging that you have read and understand the information we have provided about your Rights & Responsibilities on pages 14 & 15 of this package.

*Signature of Patient / Person Responsible**: Date:

Name:

* Strike out what is not applicable.

** "Person Responsible" means a person defined as a "person responsible" under the Privacy Act 1988 (Amended) including the patient's partner, family member, carer, guardian, close friend, and a person exercising power under an Enduring Power of Attorney

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PRIVACY POLICY

The Riverina Day Surgery is committed to providing quality health care for its patients. As a fundamental part of this commitment, management and staff of the Riverina Day Surgery recognise the importance of ensuring that our patients are fully informed and involved in their health care.

The Riverina Day Surgery is as a health provider in the private sector bound, by the National Privacy Principles. These principles set the standards by which we handle personal information collected from our patients. A copy of these Principles is available for inspection at the reception desk.

As a part of our commitment to providing quality health care it is necessary for us to maintain files pertaining to your health. These files contain the following types of information.

- Personal details (your name, address, date of birth, Medicare number).
- Your medical history.
- Notes made during the course of medical consultations and procedures.
- Referrals to other health service providers.
- Results and reports received from other health care providers.

The information held about you is provided by you or arises as a consequence of information provided by you.

Your medical file is handled with the utmost respect for your privacy. Your file will be accessed by your doctor. It will also be necessary for our staff to handle your file to address administrative requirements. **Our staff are bound by strict confidentiality requirements as a condition of employment regarding your medical records.**

Ordinarily we will not release the contents of your medical file without your consent. However, we advise that there may be occasions where we will be required to release the details of your file irrespective of whether your consent to the disclosure of the information is given. This will occur where the law requires disclosure, such as pursuant to a subpoena.

We advise that as a patient of the Riverina Day Surgery you have rights of access to any information we hold concerning you. Should you wish to access this information we refer you to our handout entitled **ACCESSING YOUR MEDICAL RECORD.** As part of our commitment to preserving the confidentiality of the information contained in your medical record we advise that strict secure storage policies are observed. Your electronic records are accessible only by staff of Riverina Day Surgery and are protected by a security password. Your paper records are kept in secure filing cabinets and accessible only by Riverina Day Surgery staff. Each member of staff is well versed in the principles and importance of doctor-patient confidentiality.

Should you, at any time have a query or complaint in relation to the privacy policies in place at the Riverina Day Surgery please contact the CEO who will be able to address any concerns you may have. We advise that it is the Riverina Day Surgery's policy that any complaint is required to be made in writing and addressed to the CEO and marked private and confidential. We advise that we will endeavour to address complaints within 60 days.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

RIGHTS & RESPONSIBILITIES

If you have a complaint or any concern about our service:

- Talk to the person in charge or any health worker at the time of the problem
- You can write to, phone or see the person in charge at any time during your care or afterwards
- If you are not satisfied with the results of your complaint you can contact the Riverina Day Surgery, PO Box 5904, Wagga Wagga NSW 2650.
- If you have not been able to resolve the problem, you can write to the appropriate State or Federal independent complaints organisations:

NSW Health Care Complaints Commission
Locked Mail Bag 18
Strawberry Hills NSW 2012
Phone: 1800 043 159

NSW Medical Board
PO Box 104
Gladesville NSW 1675
Phone: (02) 9879 2200
(For complaints against Medical Practitioners)

Private Health Insurance Ombudsman
Phone: 1800 640 695 (free call)
(For matters relating to health insurance)

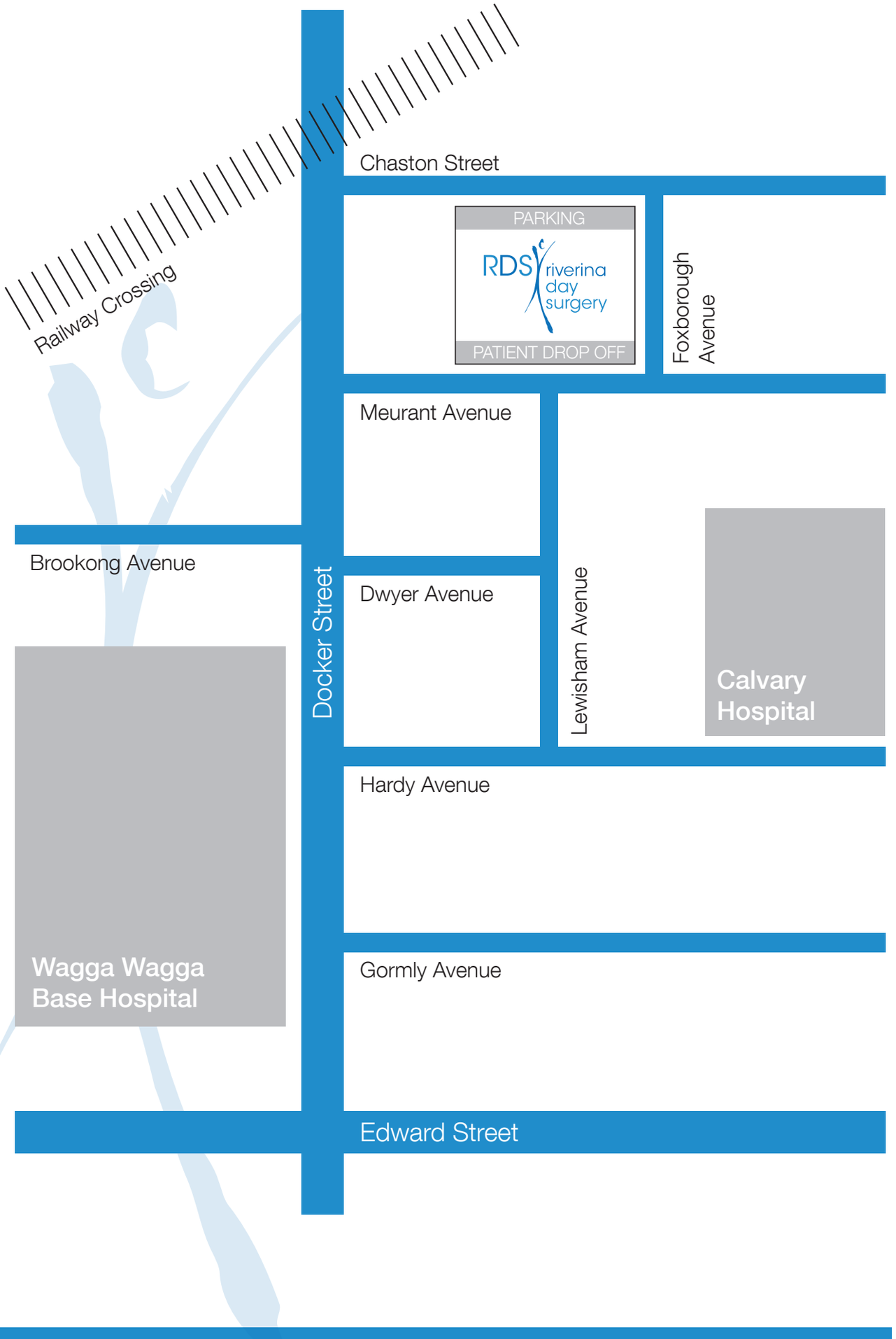
Be assured that:

- Riverina Day Surgery wants to resolve your concerns to your satisfaction
- You can expect any complaint to be dealt with quickly and fairly
- Your complaint will not adversely affect the service you receive
- Your complaint will be handled with complete confidentiality
- You have the right to an advocate
- An advocate is someone who can work and speak on your behalf at your direction. It is your right to obtain an advocate

Partnering with Consumers

Here at the Riverina Day Surgery we are always looking for ways we can improve our service to you.

We welcome your suggestions, experiences, thoughts and ideas.


Railway Crossing
Chaston Street
PARKING
RDS riverina day surgery
PATIENT DROP OFF
Foxborough Avenue
Meurant Avenue
Brookong Avenue
Docker Street
Dwyer Avenue
Lewisham Avenue
Calvary Hospital
Hardy Avenue
Wagga Wagga Base Hospital
Gormly Avenue
Edward Street