INDEPENDENT PRIVATE HOSPITALS OF AUSTRALIA

CONSENT FOR USE OF INFORMATION

The Health Records Information Privacy Act 2002 No 71 and The Australian Privacy Principles prohibit the use of the personal information that Independent Private Hospitals of Australia collects and holds about you for certain purposes in the event that you do not consent to the use of such information for those purposes.

Independent Private Hospitals of Australia would like you to indicate in this form whether or not you consent to the use of the personal information it holds about you for the purposes described below.

You should note that in the event you do provide consent, the information would be used in an identified format. That is, your identity will be clear in any material generated for which you provide your consent.

You are under no obligation to provide consent to the use of your personal information for any of the purposes described below. In the event that you do not consent, we will respect your wishes and will not use the information for that purpose in any identified format.

Should you have any privacy concerns, please contact privacyofficer@iphoa.com.au

Please provide your consent to the use of your personal information for the purposes described below, by signing and dating the form.

Initial	
	To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted the medical practitioner or institution about. This may include a requirement to forward relevant prior information for example anaesthesia records.
	To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.
	To assist in the development of service delivery and planning in facilities owned and operated by Independent Private Hospitals of Australia.
	For **research and development projects** undertaken by Independent Private Hospitals of Australia in its own right or in conjunction with medical practitioners who work in the facility or drug companies.
	To assist Independent Private Hospitals of Australia in providing **practical training and education to medical, nursing and other allied health students.**
	To assist Independent Private Hospitals of Australia in undertaking **quality improvement activities.**
	To enable Independent Private Hospitals of Australia to provide members of **Returned Service Organisations and Ministers of Religion** with sufficient details to enable them to visit me whilst I am a patient in this facility.
	To enable Independent Private Hospitals of Australia to **provide access to my information to the Health Fund** of which I am a member if requested by the Health Fund to do so.
	To receive educational materials on the condition I was treated for at Independent Private Hospitals of Australia.

BINDING MARGIN – NO WRITING

Please initial in the box if you object to use of your personal information for the purposes described above.

I hereby consent to the use of my personal information for the purpose indicated above.

Signature _____ Date _____

Print full name _____

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

.....

Power of Attorney / Enduring guardian / Advance care directive

Do you have an advance care directive ☐ No ☐ Yes Please provide a copy

Name of Enduring Guardian (if one appointed) Phone No.

Name of Power of Attorney (if one appointed) Phone No.

HOLROYD
PRIVATE HOSPITAL
Independent Private Hospitals of Australia

PATIENT INFORMATION FORM

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B. SEX	MEDICAL NUMBER
WARD	DOCTOR

ID LABEL

To be completed in full by patient and presented to the Admission Office one week prior to admission

FOR EMERGENCY ADMISSIONS, PATIENTS MAY GIVE THE INFORMATION OVER THE TELEPHONE.

Have you been a patient in this Hospital before Yes ☐ No ☐

Year.....

Have you been admitted to hospital in the last 2 months?

1 ☐ No 2 ☐ This Hospital 3 ☐ Other Hospital

PERSONAL DETAILS PLEASE PRINT

Title: Mr., Mrs., Miss., Ms.

Surname

Given Names

Previous Surname

Sex ❑ M ❑ F Date of Birth

Nursing Home ❑ Hostel ❑

Address

Postcode

Phone Private Business

Mobile Email

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑ Defacto

Religion

Country of Birth

Aboriginality ❑ 1 Aborigine ❑ 2 Torres Strait Islander ❑ 3 Neither

Language spoken at home

Country of Perm. Residency

MEDICARE No.

Expiry Date Patient's Reference Number

PENSION INFORMATION

Please fill out the following if you are a Pensioner or dependant

Pension No.	Exp.
H.C.C. No.	Exp.
Veteran Affairs	Card/Colour

NEXT OF KIN/CONTACT 1

Name

Address

Postcode

Phone Private Business

Relationship

NEXT OF KIN/CONTACT 2

Name

Address

Postcode

Phone Private Business

Relationship

Referring Doctor Phone No.

Address

Postcode

OVERNIGHT ACCOMMODATION PREFERRED

(While no guarantee can be given, every effort will be made to accommodate patients as requested) ❑ Private Room ❑ Shared Ward

HOSPITAL INSURANCE

Name of Fund

Table/Scale Membership No.

Date joined this table Date Paid to

Is there an excess on your table?

Contributor's Name

CAUSE OF INJURY(if applicable)

Date of Injury

If injury, where did it occur:

0 ❑ Home 1 ❑ Residential Institution
2 ❑ School, Other Institution, Public Administrative Area 3 ❑ Sports & Athletics Area
4 ❑ Street & Highway 5 ❑ Trade & Service Area
6 ❑ Industrial & Construction Site 7 ❑ Farm
8 ❑ Other Specified Place 9 ❑ Unspecified Place

WORKER'S COMPENSATION

Liability must be accepted before admission

Date of Accident

Employer

Address

Phone

Insurance Company

Address

Phone

Contact Name

Claim No. (Compulsory to complete)

Your Solicitor

Address

Phone

THIRD PARTY/TRANSCOVER

Date of Accident

Claim No.

Insurance Company

Address

Phone

Contact Name

Your Solicitor

Address

PAYMENT OF ACCOUNTS

The balance of account is payable at the time of admission and patients without insurance are required to settle their account on admission.

INFORMED FINANCIAL CONSENT I understand and agree to pay all hospital accounts including any denied by - Health Insurance Funds, WorkCover, Transport Accident Commision or any other relevant body. I understand that the hospital will not be liable for any valuables I bring to hospital.

Signed

Person responsible for account.....

*Write "as above" if same as Patient

Surname*

Given Names*

Address*

Postcode

Explained by

BINDING MARGIN – NO WRITING

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

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.

If you do not understand or require a different language please make the staff aware and they will assist you.
I have read and understand my rights

Patient Signature _____

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

MR 4

BINDING MARGIN – NO WRITING

HOLROYD PRIVATE HOSPITAL
Independent Private Hospitals of Australia

PATIENT ADMISSION FORM

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
D.O.B. SEX	MEDICAL NUMBER
WARD	DOCTOR

ID LABEL

PATIENT HISTORY
(Please circle the appropriate answer or tick the appropriate box)

Please specify reason for this admission

Endocrinology		Name of Specialist(s)	
Have you Diabetes		N	☐ Type 1 Controlled by : ☐ Diet ☐ Injection ☐ Tablet ☐ Type 2 MR 22
If you are a diabetic & you monitor, are your blood sugar levels generally below 8 mmol/L		N	Y
Thyroid problems		N	Y
Low blood sugar		N	Y
Cardiovascular system		Name of Specialist(s)	
Elevated cholesterol / triglycerides		N	Y
High blood pressure / hypertension		N	Y
Chest pain, angina		N	Y
Heart attack(s)		N	Y
Palpitations / heart murmur / irregular heart beat / AF		N	Y
Previous deep venous thrombosis / pulmonary embolism / varicose veins		N	Y ☐ Need for anti - embolic stockings Size:
Artificial implants / devices / grafts	Coronary artery bypass		Y Year .....
	Coronary / vascular stent		Y Year .....
	Artificial heart valve		Y Year .....
	Pacemaker		Y Make.....Model ..... Last checked ...../...../ .....
Heart failure / Congestive cardiac failure		N	Y
Rheumatic fever / valve disease		N	Y
Other cardiac problems		N	Y specify.....
Family history of cardiac disease		N	Y
Respiratory System		Name of Specialist(s)	
Recent cold		N	Y
Bronchitis / Asthma / Emphysema / Chronic obstructive pulmonary disease / Shortness of breath / bronchiectasis / asbestosis		N	Y Specify ..... Do you use : ☐ Nebulisers ☐ Puffers ☐ Home Oxygen
Any other lung problems		N	Y Specify .....
Gastrointestinal System		Name of Specialist(s)	
Gastric ulcer / reflux / hiatus hernia		N	Y
Jaundice		N	Y
Hepatitis		N	Y Which type?
Stoma		N	Y
Haematology		Name of Specialist(s)	
Previous blood transfusion		N	Y Reason ..... Last given .....
Anaemic		N	Y
Blood disorders/bleeding problems/bruise easily/clotting disorders		N	Y
Do you take blood thinning / arthritis / aspirin based medication / Warfarin? If Yes		N	Y specify .....
Have you been instructed to cease this medication?		N	Y Date last taken ...../...../..... ☐ Notify VMO if not ceased

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(Please circle the appropriate answer or tick the appropriate box)

Genitourinary system	Name of Specialist(s)	
Kidney trouble / dialysis / Renal impairment	N	Y
Stomas	N	Y
Bladder problems	N	Y ☐ Urinary Incontinence ☐ Frequency ☐ Urgency ☐ Pain
Neurology	Name of Specialist(s)	
Fits / faints / funny turns / epilepsy	N	Y
Stroke / mini stroke / T1A	N	Y Any residual weakness If Y Type .....
Limb paralysis	N	Y ☐ Right arm ☐ Left arm ☐ Right Leg ☐ Left Leg
Speech / swallowing problems	N	Y
Polio / meningitis	N	Y Specify .....
Previous falls / unsteady on feet	N	Y
Short term memory loss / dementia	N	Y Specify ..... NB:If Yes, you may be asked to provide a family member or carer who must be in attendance for the hospital stay
Musculoskeletal system	Name of Specialist(s)	
Arthritis	N	Y
Back / neck injury or problems	N	Y
Metal plates / pins	N	Y Specify site .....
Hip, knee or shoulder replacements	N	Y Specify site ..... ☐ L ☐ R Y Specify site ..... ☐ L ☐ R
Other implants / devices	N	Y Specify ..... ☐ L ☐ R
General Health & Lifestyle		
Have you ever smoked?	N	Y Daily amount ..... Date ceased ...../...../.....
Do you presently smoke ?	N	Y ..... per day
Do you drink alcohol?	N	Y ..... standard drinks per week
Past history of drug dependency	N	Y Specify .....
Do you have chronic pain?	N	Y Specify .....
Disturbed sleep pattern / Sleep apnoea	N	Y ☐ CPAP used ☐ Sedation
Do you exercise regularly?	N	Y
Depression / mental illness / anxiety attacks	N	Y
For female patients - are you pregnant?	N	Y .....weeks

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Whilst all care will be taken Holroyd Private does not accept responsibility for valuables or personal belongings. Please label where applicable.

Summary of Previous History

Previous surgery	N	Y Please specify below
Year	Specify	
Year	Specify	
Year	Specify	
Year	Specify	
Year	Specify	
Year	Specify	
Problems with anaesthetics (self or family) eg. Malignant hyperthermia	N	Y If Yes ☐Self ☐Family ☐ If Yes, advise ☐ Alert Specify ..... Anaesthetist Sheet
Cancer / Lymphoma / Leukaemia	N	Y Date ...../...../..... Site ..... Treatment ☐Surgery ☐Chemotherapy ☐Radiotherapy
Transplants	N	Y Specify

Other

Do you have a dura mater graft between 1972 and 1989?	N	Y
Do you have a history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?	N	Y
Did you receive human (growth hormones, gonadotrophins) prior to 1985?	N	Y
Have you suffered from a recent, progressive dementia the cause of which has not been identified?	N	Y
Have you been involved in a "look-back" for CJD or received an "In Medical Confidence" letter notifying you of a potential exposure to CJD	N	Y

Prosthetics / Aids / Other

			N/A	Kept at own risk	Ward Storage	Taken home by: (Signature)	Dietary Requirements
Visual aids	N	☐ Glasses ☐ Contact lenses ☐ Sight impaired ☐ Eye Prosthesis	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
Hearing aids	N	☐ Left ☐ Right	☐ ☐	☐ ☐	☐ ☐		Do you have a special diet? ☐ No ☐ Diet office contacted ☐ Yes If Yes, Specify ....
Walking aids	N	☐ Y Specify	☐ ☐	☐ ☐	☐ ☐		
Dentures	N	☐ Upper ☐ Partial ☐ Full ☐ Lower ☐ Partial ☐ Full	☐ ☐	☐ ☐	☐ ☐		
Other	N	☐ Y Specify ..... ☐ Left Right	☐	☐	☐		

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Please document any known allergies or sensitivities eg. medications, latex plants, tape

Allergies & Sensitivities

Allergies	Sensitivities	Reaction

Food Allergy

Staff only

☐ Red Allergy Band Applied

☐ Alert Sheet

☐ Diet Office Contacted

Your current Medications

Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. *Consult your GP or surgeon if you are unsure of any details about your medications or which medications should be ceased prior to your surgery.* ***Bring to the hospital all current medication you are taking, in their original individual packaging (ie. not in Webster or Doset packs)***

Prescription Medication	Strength	Dose & Frequency (ie, how much / how often)	For Long Stay pts only Last taken Brought in by Pt.

If you are taking any non-prescription medication eg. Complementary therapies, natural therapies, herbal preparations or vitamins, please specify
NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)

Non- Prescription Medication	Strength	Dose & Frequency	Purpose	*Last taken*	*Brought in by Pt.*

Has patient brought own stock (including complementary therapies) to hospital? Yes ☐ No ☐ N/A ☐

If Yes ☐ Sent home ☐ Schedule 8 cupboard ☐ Patient medication drawer

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Height and weight details

Height ..... Weight .....

BMI ..... $\frac{\text{Weight}}{\text{height x height}}$

Infection Risk Screen

Previous history of Multi-resistant Organisms (MRO) Infection or colonisation (eg. MRSA, VRE) ?		Swab Result ☐ Yes ☐ No ☐ N/A
Wound/Ulcer site + Description		Please inform infection control co-ordinator ☐ Notified
Wound / Ulcer Dressing		

DISCHARGE PLANNING (for Day Patients Only)

Who will be taking you home and be with you for 24 hours?

Name	Relationship
Best contact phone no.	Or mobile no.

Discharge Planning Discharge Time is 10 am

Estimated date of Discharge : ___ /___ /___

Person responsible for taking patient home : .....

Do you have problems caring for yourself at home	☐ Yes	☐ No
Do you live alone	☐ Yes	☐ No
Do you care for someone else?	☐ Yes	☐ No
Do you receive community services? If Yes, ☐ Nurses ☐ Home Care ☐ Meals of Wheels	☐ Yes	☐ No

If yes to any question refer to your Nurse Unit Manager

☐ Notified

VALUABLES (Staff Only)

Whilst all care will be taken TSPH does not accept responsibility for valuables or personal belongings

Personal property ☐ N/A ☐ Kept at own risk ☐ Ward storage ☐ Taken home by .....(Sign)

Valuables ☐ N/A ☐ Kept at own risk ☐ Ward storage ☐ Taken home by .....(Sign)

Cash exceeding $100 placed in hospital safe Patient / Carer to Sign .....

Orientation to Ward (Staff Only)

Clinical Pathway / Core Plan ☐ Yes ☐ N/A

Patient Information Brochures given to patients ☐ Yes ☐ N/A

- ☐ Buzzer
- ☐ Bathroom
- ☐ No smoking policy
- ☐ Discharge time - 10.00am
- ☐ Customer satisfaction survey
- ☐ Lights
- ☐ News paper
- ☐ Visiting hours
- ☐ Meal times
- ☐ Hospital patients guide
- ☐ Patients Rights and Responsibilities brochure
- ☐ Check out at reception prior to discharge
- ☐ Telephone
- ☐ Complaint guide
- ☐ TV
- ☐ Pharmacy

SIGNATURE

PATIENT/ CARER

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature .....

Date ...../...../.....

Form completed by :

Doctor...../Sign.
Patient ...../Sign.
Carer ...../Sign.
Pre Admission ...../Sign.
Admitting Nurse ...../Sign.

Patient History form reviewed by : (OT Nurse)

Signature ..... Print Name ..... Designation ..... Date / /

Patient History form reviewed by : (Ward Staff)

Signature ..... Print Name ..... Designation ..... Date / /

BINDING MARGIN – NO WRITING

Request for Surgical Operation, Procedure and / or Medical Treatment

ADMITTING DOCTOR	SURNAME CHRISTIAN NAMES
PATIENT HISTORY/Summary of Physical Exam	ADDRESS
1. ☐ **Healthy Patient**	POSTCODE
2. ☐ **Mild Systematic Disease – no functional limitations**	PHONE / D.O.B / SEX MALE ☐ FEMALE ☐
3. ☐ **Severe Disease with definite functional limitations**	DATE OF ADMISSION ...../...../..... / OPERATION DATE ...../...../..... / ESTIMATED STAY
4. ☐ **Severe Disease that is a constant threat to life**	LA ☐ GA ☐ Neurolept ☐
Other comments:	HEALTH FUND / MEMBERSHIP NUMBER
Relevant Infections MRSA ☐ VRE ☐ Hep B or C ☐ HIV ☐	

Known Allergies: .....

Provisional Diagnosis: .....

Other Conditions Present/History of Complications / ☐ Aspirin ☐ Non-Steroidal Antiflammatory

.....

Proposed Operation/Treatment: .....

.....

..... Item No. (if known) .....

Prostheses Required: ☐ Yes ☐ No Prostheses Informed Financial Consent given: ☐ Yes ☐ No

Specific Pre-Operative Instructions (incl Instrumentation) : ..... ☐ Chest X-ray

..... ☐ Pathology

..... ☐ ECG

Date ...../...../..... Medical Officer's Signature: .....

BINDING MARGIN – NO WRITING

Dear Doctor, please fax this completed page immediately to hospital
Fax - 9632 8480 or email holroyd.info@iphoa.com.au

I .....

of .....

request that the following operation / procedure .....

.....

be performed *upon me/upon .....

Following a discussion of *my/the patient's present condition, including the nature and likely results of the operation/procedure, I accept the professional opinion of Dr. ..... that this is the appropriate operation/procedure.

I also request and consent to the administration of anaesthetics, medicines, blood product transfusions or other forms of treatment normally associated with this operation/procedure. I understand that other unexpected operations/procedures may be necessary and request that these be carried out if required.

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

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

The possible complications, risks and benefits have been explained to me by Dr. .....

DAY SURGERY/ENDOSCOPY PATIENTS ONLY

I understand that if I am discharged on the same day as my anaesthetic/sedation and my surgery/procedure, I should not drive a motor vehicle or operate machinery or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours.

I also understand that I must be accompanied home by a responsible adult.

* Delete as required

....

SIGNATURE OF PATIENT/GUARDIAN/RELATIVE/ATTORNEY *SIGNATURE OF WITNESS *Witness to signature only

....

DATE FULL NAME OF WITNESS