



CONSENT FOR TREATMENT

UR:
Surname:
Given Names:
Date of Birth: Sex:

MAX ID LABEL HERE

Part A To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed ... and/or ... of his/her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risks of the following recommended operation/procedure(s).

Procedure/Reason for Admission: (Please print)

- Procedure site
Procedure side of body: Right Left Both Not Applicable
Patient does NOT consent to having a blood or blood products transfusion.
Interpreter used: Name of RHC accredited Interpreter: Language:
Sight Translated (NSW) Verbally Interpreted (NSW)

Treating RHC Accredited Practitioner / Doctor
Signature Print Name Contact Ph. No. Date

Part B To be completed by the PATIENT / Person Responsible

I acknowledge that:
Doctor ... and I have discussed the treatment of my / patients condition.

- I have consented to the Operation / Procedure as described above.
Ramsay employees will administer care / treatment under my treating Doctors direction, or in an emergency, medical and nursing care will also be delivered as required.
I understand the explanation the Doctor gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) as discussed by my Doctor above.
I have had the opportunity to ask questions and these have been answered in a way I understand by my Doctor above.
I have read / seen / heard and understand the following where applicable.
Information sheet(s)
Multimedia presentation(s)

Where applicable which explains the operation / procedure(s) and the risks involved.
I am able to withdraw this consent in writing at anytime prior to the commencement of treatment / procedures.

Patient / Responsible person(s) Signature Date
Print name of patient / person responsible
If person responsible signs, state relationship to patient eg: mother / father / husband

CONSENT FOR TREATMENT

RHC003

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.
Please PRINT clearly in block letters and return immediately to confirm your booking.

UR:

Surname:

Given Names:

Date of Birth: Sex:

AFFIX ID LABEL HERE

ADMISSION DETAILS

Specialist Surname: Specialist First Name:

Overnight: Yes No Do you know your admission date: Yes No Date of Admission: / /

Procedure / Reason for Admission:

Item Numbers (if known):

PATIENT DETAILS

Is the person completing the form the patient: Yes No

If No, Your Name: Your Phone No:

Title: Surname: Maiden / Other Name:

Given Names:

Residential Address:

Suburb: State: Postcode:

Postal Address: As above Different Details:

Suburb: State: Postcode:

Telephone (Wk/Day) (Home/AH) (Mobile/Other)

If there is a voice message service, may we leave a message? Yes No Allow SMS alert: Yes No

Email:

(Your email address is important as it is used to confirm to you that your admission form has been received and is NOT used for marketing purposes)

Date of Birth / / Gender: Male Female Indeterminant

Referring Doctor Surname: First Name:

(Specialist or GP who referred you to the admitting specialist)

Address:

Suburb: Postcode: Phone No:

General Practitioner (GP) Surname: First Name:

(if same as above write: "AS ABOVE")

Address:

Suburb: Postcode: Phone No:

Marital Status: Single Married De facto Separated Divorced Widowed Child

Employment: Employed Home Duties Other Retired Student Unemployed

Are you an Australian Resident? Yes No Country / State of Birth:

Are you of Aboriginal / Torres Strait Islander (TSI) descent?

No Aboriginal TSI both Aboriginal & TSI Not Stated/Unknown

Are you of Australian South Sea Islander (SSI) descent? No SSI Not Stated/Unknown

Religion:

Do you consent to the Hospital disclosing your personal information to the following visiting officials (if they are available)?

Chaplain Visit: Yes No Veteran Organisation Representative: Yes No

Language spoken at home: Interpreter Required: Yes No

CONTACT PREFERENCES (indicate your preferred contact option) Mobile Phone SMS Post Email

NEXT OF KIN Relationship to patient:

Title: Surname: Given Names:

Address: Same as patient Different from patient

Suburb: State: Postcode:

Telephone (Wk/Day) (Home/AH) (Mobile/Other)

PERSON TO NOTIFY Relationship to patient:

Title: Surname: Given Names:

Address: Same as patient Different from patient

Suburb: State: Postcode:

Telephone (Wk/Day) (Home/AH) (Mobile/Other)

Preadmission Patient RHC100.16

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ADMISSION DETAILS

RHC001

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.
Please PRINT clearly in block letters and return immediately to confirm your booking.

UR:

Surname:

Given Names:

Date of Birth: Sex:

AFFIX ID LABEL HERE

ENDURING POWER OF ATTORNEY

Do you have a current Advance Health Directive? Yes No

Do you have enduring power of attorney – health and medical guardian? Yes No

Name: Relationship: Phone:

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Self Next of Kin Workers Compensation DVA Third Party Other:

Title: Surname: Given Names:

Address: Suburb: State: Postcode:

Telephone (Work) (Home) (Mobile/Other)

MEDICARE DETAILS

Do you have a valid Medicare Number: Yes No

Medicare Number: Medicare Reference No: Valid Until:

PENSIONS / CONCESSIONS / HEALTH CARE CARD / SENIORS CARD / CONCESSIONAL PHARMACY BENEFITS

Do you have any type of pension/concessional benefits card?

No 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 Third Party Workers Compensation DVA Self Funded Public

Name of health fund: Type of Cover:

Membership No: Do you have an excess? Yes No Amount: \$

Have you changed your level of insurance cover in the last 12 months? Yes No

Public Hospital Name:

Workers' Comp Fund Name:

Address: Suburb: State: Postcode:

Claim No: Date of Accident: / /

Employer Name: Phone:

HR Manager: Fax No:

Third Party Name: Details: Policy No:

Serving Member of: DVA No: DVA Card Colour:

Details of cover (white card only)

ACCOMMODATION PREFERENCE (whilst every effort will be made to meet your preference, we cannot guarantee availability)

Room preference: Private room Shared room

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

Hospital Booklet Private Patient's Hospital Charter Your right to privacy under the Privacy Act

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 following conditions of admission:

Informed Financial Consent Payment Information

Person responsible for payment of accounts - Please provide your name, signature and today's date:

Name: Signature: Date:

Patient's Signature: Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ADMISSION DETAILS

RHC001

PATIENT HEALTH HISTORY - GENERAL

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.
Please PRINT clearly in block letters and return immediately to confirm your booking.

PATIENT TO COMPLETE

Patient Surname:

Given Names:

Date of Birth:

AFFIX ID LABEL HERE

Patient Completed C RHC100.11

DO NOT WRITE IN THIS BINDING MARGIN

Ver 3 - 12/12

PATIENT HEALTH HISTORY - GENERAL RHC002

ADMISSION INFORMATION **NURSING NOTES**

Is your admission to hospital for treatment of an injury? Yes No
 If Yes, please provide the date of injury: ___/___/___
 How did the injury occur? Car accident Work Sport Other
 Please specify:

Where did the injury occur? Roadway Home Work Sports area Other
 Please specify:

Could you be pregnant? Yes No Is the patient under the age of 18 years: Yes No
 If Yes, name of legal guardian of the child? Details:

Was the child born prematurely? Yes No Details:

Are the child's immunisations up to date: Yes No

	YES	NO	COMMENTS	NURSING NOTES
Have you had Xrays taken for this admission?			Where:	
Have you had blood tests for this admission?			When: Where:	
Have you donated your own blood for the purposes of this operation?			Where:	
Have any other doctors been consulted recently eg. cardiologist, physician			If yes, please write details below	
Doctor consulted:			Specialty:	
Doctor consulted:			Specialty:	
Doctor consulted:			Specialty:	
Doctor consulted:			Specialty:	

PREVIOUS HOSPITALISATIONS **NURSING NOTES**

	YES	NO	COMMENTS	NURSING NOTES
Have you been admitted to this hospital before				
Have you been admitted to any hospital within the last 7 days				
Have you been admitted to any hospital within the last 28 days				
Have you been admitted to a hospital outside WA in last 12 months (For WA residents only)				WA hospitals only
Reason for Admission:			Hospital Name:	

PREVIOUS SURGERY / PROCEDURES eg joint replacement, transplants, implants, colonoscopy

OPERATION	APPROX YR	SURGEON	NURSING NOTES

MEDICATIONS (including puffers, eye drops etc) **NURSING NOTES**

	YES	NO	COMMENTS	NURSING NOTES
Do you take anti-coagulant or blood thinning therapy (Warfarin, Coumadin, Plavix, Iscover, Aspirin)			Still take? <input type="checkbox"/> Yes <input type="checkbox"/> No Date to be ceased:	
Do you take steroids, anti-inflammatory drugs, cortisone tablets/injections				
Do you take herbal supplements or complementary therapies e.g. fish oil				
Have you received advice from your specialist rooms regarding taking/ceasing your medications prior to admission?				

NOTE: Please list all medications including those above in the following section

PATIENT HEALTH HISTORY

- GENERAL

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MEDICATION	FOR TREATMENT OF	FREQUENCY	DAILY DOSE	CESSATION INSTRUCTIONS	DATE CEASED	NURSING NOTES
						Patient own stock?

- Pt med drawer
- Schedule 8 store
- Sent home

ALLERGIES / ALERTS	YES	NO	DETAILS / REACTIONS	<input type="checkbox"/> Alert sticker
Do you have adverse reactions to anaesthetic eg malignant hyperthermia				
Family member with adverse reaction to anaesthetic				
Foods excluded from diet				
Do you have allergies to medications, food, sticking plaster, latex / rubber (e.g. balloons, gloves) or other substances			If yes, please list details below.	
Do you have a medical dietary restriction? (e.g. diabetic, Coeliac Disease, Lactose Intolerance)				
Do you require a special diet? (e.g. Vegetarian, Vegan, Kosher etc)				

ALLERGY INCLUDING FOOD ALLERGIES	YES	NO	DETAILS / REACTIONS	<input type="checkbox"/> Alert sticker

LIFESTYLE	YES	NO	COMMENTS	NURSING NOTES
Height (cms):			Weight:	Check BMI > 35
Have you recently lost weight unintentionally				
Have you ever smoked			Daily Amount:	
			Ceased:	
Do you drink alcohol			Daily Amount:	
Do you use recreational drugs			Daily Amount:	
			Type:	
Do you exercise regularly eg 3 times per week				
Do you have chronic pain				

RHC002 PATIENT HEALTH HISTORY - GENERAL

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT HEALTH HISTORY - GENERAL

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

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PATIENT TO COMPLETE

Patient Surname:

Given Names:

Date of Birth:

AFFIX ID LABEL HERE

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

CARDIOVASCULAR	YES	NO	COMMENTS	<input type="checkbox"/> Cardiac risk
Elevated cholesterol, triglycerides				
Blood pressure problems eg. low, hypertension				
Cardiac conditions eg. heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina				
Cardiac irregularities eg. palpitations, irregular heart beat, heart murmur, Atrial Fibrillation				
Cardiac surgery eg. pacemaker, implants/devices, prosthetic heart valve, grafts, stents, angioplasty, bypass or any other heart condition.				Year:
				Model:
Vascular disease eg. carotid disease, aortic aneurysm, peripheral vascular disease.				
Family history of cardiac disease				
ENDOCRINOLOGY	YES	NO	COMMENTS	NURSING NOTES
Diabetes			Type:	
			Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets	
Blood glucose levels normally greater than 10 mmol/L				
Thyroid problems, hypothyroidism, goitre				
GASTROINTESTINAL	YES	NO	COMMENTS	NURSING NOTES
Hiatus hernia, gastrointestinal ulcers, reflux				
Liver disease, hepatitis (eg A, B, C), jaundice				
Bowel problems/habits, stoma or bowel disease eg Crohns, IBS				
GENITOURINARY	YES	NO	COMMENTS	NURSING NOTES
Kidney disease, dialysis, renal impairment				
Bladder problems or habits, stoma, incontinence, urinary retention				<input type="checkbox"/> Falls risk screen
HAEMATOLOGY & ONCOLOGY	YES	NO	COMMENTS	NURSING NOTES
Ever had a blood transfusion			Any reaction:	
			Year Transfused:	
Blood Type:				
Diagnosed with cancer			Type:	
			Body Site:	
			Treatment:	
			Date of Diagnosis:	
Blood clot in lung / legs (DVT / PE)				
Blood disorders eg anaemia				
Bleeding disorders or problems				
MUSCULOSKELETAL	YES	NO	COMMENTS	NURSING NOTES
Arthritis eg rheumatoid arthritis, osteoarthritis				
Back or neck injury or problems				

PATIENT HEALTH HISTORY - GENERAL RHC002

Patient Completed C: RHC100.11

PATIENT HEALTH HISTORY

- GENERAL

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

Please PRINT clearly in block letters and return immediately to confirm your booking.

NEUROLOGY	YES	NO	COMMENTS	NURSING NOTES
Neuromuscular diseases eg MS, myasthenia , dystrophies, parkinsons.				
Stroke, mini stroke, TIA			Date: Impairment:	
Speech problems or swallowing problems eg coughing when eating or drinking				
Limb paralysis or weakness			Left / right side or both	
Difficulties with attention span, understanding and/or problem solving				<input type="checkbox"/> Falls risk screen
Epilepsy, fits, blackouts, funny turns				
Other neurological problems eg migraine, polio, meningitis				
Short term memory loss or dementia				
Previous confusion in hospital				<input type="checkbox"/> Falls risk screen
PROSTHETICS / AIDS / OTHER	YES	NO	COMMENTS	<input type="checkbox"/> Brought by Patient
Visual aids - glasses, contact lenses, visual impairment				
Hearing aids, hearing appliance or hearing impairment, cochlear implant				
Dentures, caps, crowns, loose teeth, implants, veneers				
Other aids for daily living - e.g. artificial limbs				
RESPIRATORY	YES	NO	COMMENTS	NURSING NOTES
Asthma, Pneumonia, Hay Fever, Asbestosis, Chronic Obstructive Pulmonary disease (COPD) e.g. bronchitis, Emphysema.				
Shortness of breath eg walking more than 50m, climbing stairs/inclines				
Sleep Apnoea, disturbed sleep, snoring			Treatment	
Do you use a CPAP machine?			Please bring your CPAP	Brought by patient
Other lung problems eg tuberculosis				
OTHER	YES	NO	COMMENTS	NURSING NOTES
Depression, other mental illness				
Lymphoedema				
Any other medical conditions				
FALLS RISK	YES	NO	COMMENTS	<input type="checkbox"/> Falls risk screen
Do you have a fear of falling, are unsteady on feet or have fallen in last 6 months				
Do you use mobility aids eg walking stick, frame etc			Distance without aids	
Have you experienced fainting, dizziness in last 6 months				

RHC002 PATIENT HEALTH HISTORY - GENERAL

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INFECTION RISK	YES	NO	COMMENTS	<input type="checkbox"/> Infection risk
Have you travelled to a country with a health alert in last 7 days				
Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose				
Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms				
Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms				
Have you ever had MRSA, VRE or ESBL				
Do you have any wounds or breaks on your skin				
Do you have any other conditions or infections				
Have you had vomiting & diarrhoea in the past 48 hours?				
Are you having an operation on your: brain, pituitary gland, spinal cord, nerve root ganglia, retina, optic nerve or having facial maxillary surgery. If you are unsure please tick YES.				

If yes, please answer the following 6 questions otherwise continue on to the next section

To find out more about cCJD please go to the following URL - <http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf>

1. Do you think you may have cCJD			
2. Do you have a first degree relative with cCJD			
3. Have you an unexplained progressive neurological illness of less than 12 mths			
4. Have you a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)			
5. Have you previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)			
6. Have you been involved in a look back for cCJD or have a "medical-in-confidence" letter regarding your risk for cCJD			

DISCHARGE PLANNING	YES	NO	COMMENTS	<input type="checkbox"/> Discharge Planner
Do you live alone				
Do you have someone to look after you after discharge or concerns after discharge			Name of person: Contact Number: Relationship:	
Are you solely responsible for the care of another person at home				
Do you currently receive community support and/or nursing services				
Do you require assistance or have concerns with any aspects of day to day living				
Where do you plan to go after discharge				
Do you have escorted transport from hospital				

I confirm that the information completed in this Patient Health History form is correct.

Signature _____

Patient Name _____ (please print) Date _____