St John of God Murdoch Hospital
100 Murdoch Dve
MURDOCH WA 6150
Ph: 9366 1111
Fax: 9366 1139
Country: 1800 640 300

ST JOHN OF GOD
Murdoch Hospital

St John of God Health Care Inc.
(Limited Liability) Incorporated in Western Australia
ABN 21 930 207 958

PATIENT ADMISSION INFORMATION

MRN

Admitting Dr Derek Chen Admission Date _____ Time _____

Dr's Phone No 9312 1888 Anaesthetist _____

ADMISSION TYPE: (please tick)
☐ Daycase
☐ Inpatient

To CONFIRM your admission, please complete this form and either post or deliver it to the Hospital at your earliest convenience. It must be received no later than **7 days prior to admission.** If this is not possible, please contact our Admission Office by telephone with the details.

PART A — PATIENT / GUARDIAN TO COMPLETE

PATIENT DETAILS

Surname | Given Names | **NB: Surname and given names must match Medicare details**

Preferred Name | Title | Sex | Marital Status | Date of Birth

Ethnic Origin (eg. Asian, Aboriginal, Caucasian, TSI) | Country / State of Birth | Preferred Spoken Language | Religion

Are you of Aboriginal or Torres Strait Island Origin? Yes ☐ No ☐

I am happy to be visited by a hospital approved representative of my religious denomination during my stay. Yes ☐ No ☐

Residential Address | Postcode

Postal address (if different from above) | Postcode

Phone No: Home | Other Contact / Mobile No: | Phone No: Work | Email address

Preferred Contact Phone No/Time: _____ ☐ Morning ☐ Afternoon ☐ Evening

Employment Status ☐ Employed full-time ☐ Employed part-time ☐ Retired
☐ Unemployed ☐ Student ☐ Home Duties ☐ Pensioner

Name of GP / Medical Centre | Address

Your General Practitioner may be notified of your hospitalisation. Do you agree to this? Yes ☐ No ☐

PART B — PATIENT / GUARDIAN TO COMPLETE

NEXT OF KIN

Next of Kin | Relationship | Phone No: Home | Phone No: Mobile | Phone No: Work

Residential Address | Postcode

PART C — PATIENT / GUARDIAN TO COMPLETE

HOSPITAL PAYMENT DETAILS

Please Tick		NAME OF HEALTH FUND	LEVEL OF COVER	MEMBERSHIP NUMBER	LENGTH OF MEMBERSHIP
☐	INSURED				
	OR				
☐	WORKERS COMP / MVIT	If Workers Comp or MVIT, please complete Part D (over page)			
	OR				
☐	UNINSURED	Please note uninsured patients are required to pay the full estimated fee on admission.			

CARD DETAILS

☐ PENSION — HEALTH CARE CARD

☐ MEDICARE — DATE OF EXPIRY

Individual patient number (to the left of name on card)

Medicare
6000 555553
1 JOHN F CITIZEN
2 MARY G CITIZEN
VALID TO 05/2008

☐ VETERAN'S AFFAIRS — CARD COLOUR

I CONSENT TO BE VISITED BY A REPRESENTATIVE OF THE EX-SERVICE ORGANISATION'S YES ☐ NO ☐

☐ SAFETY NET — DATE OF ISSUE

PHARMACY

PLEASE BRING ALL YOUR CARDS WITH YOU TO THE HOSPITAL.

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

YES ☐ NO ☐ If Yes, which hospital? _____ If you were hospitalised, please state discharge date _____

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

TYPE OF ACCOMMODATION PREFERRED: PRIVATE ROOM ☐ SHARED ROOM ☐

Whilst every effort will be made to meet your preferred accommodation we can not guarantee availability on the day of admission and you will be charged for the room which you occupy. Please note that private room fees are higher than those for shared. It is recommended that you check your level of insurance prior to admission.

PART D — PATIENT / GUARDIAN TO COMPLETE

PAYMENT/INSURANCE DETAILS

WORKERS COMPENSATION

Date of Accident _____

Claim Number _____

Employer Name _____

Address _____

_____ Postcode _____

Insurance Co. - Name _____

Address _____

_____ Postcode _____

MOTOR VEHICLE

Date of Accident _____

Claim Number _____

Is this a W.A. Claim Yes ☐ No ☐

If NO, which State? _____

_____

Solicitor _____

Address _____

_____ Postcode _____

WORKERS COMPENSATION / MVIT INSURANCE COVERS SHARED ACCOMMODATION ONLY. A REQUEST FOR A PRIVATE ROOM WILL INCUR AN EXTRA CHARGE WHICH IS THE RESPONSIBILITY OF THE PATIENT.
You are required to provide details of your claim/approval to your doctor prior to a booking being made at the Hospital. If the Hospital is unable to confirm that your claim has been accepted by the relevant third party, you will be required to pay your estimated account in full at the time of admission and to finalise the account upon discharge. If your claim has been accepted by the appropriate agency, you will only be covered for a shared room. If you choose to be accommodated in a private room you will be responsible for the difference between the shared and private room rates.

PART E — DIET

DIET

SPECIAL DIETARY REQUIREMENTS (if so, please tick box below) ☐ No special diet required

☐ Kosher ☐ Halal ☐ Vegetarian ☐ Antenatal ☐ Diabetic ☐ Gluten Free (Coeliac) ☐ Other (specify)_____

Allergy: ☐ Nut ☐ Dairy ☐ Egg ☐ Soy ☐ Shellfish / Fish ☐ Other (specify)_____

PART F — PATIENT / GUARDIAN TO READ

GENERAL

- Please bring any X-rays and Doctors' letters with you on the day of admission.
- Please bring Medicare card and all Health Insurance cards, Pharmaceutical Benefits Entitlement cards or Veterans' Affairs cards.
- St John of God Health Care Murdoch has a "No Lift Policy" and aids will be used where necessary to move patients.
- Our Hospital is a smoke free area and smoking is only permitted in designated outdoor areas.
- 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.
- You are urged NOT to drive or operate machinery for at least 24 hours following an anaesthetic or procedure using sedation so please arrange for a family member or support person to collect you.

PART G — PRIVACY - FOUNDATION AND MARKETING

PRIVACY

St. John of God Foundation:
Do you consent to us passing on your contact details to St. John of God Foundation Inc. in order that it may contact you at a later date in relation to fund raising activities which are outlined in the Privacy Guide for Patients? **YES** ☐ **NO** ☐

St. John of God Marketing:
Do you consent to being contacted by St. John of God Health Care in relation to direct marketing initiatives? **YES** ☐ **NO** ☐

PART H — PATIENT / GUARDIAN TO COMPLETE

DECLARATION

I hereby:

a) acknowledge having received, read and understood a copy of the St John of God Health Care Privacy Guide for Patients, which explains how the Hospital will handle my personal information.

b) declare the information provided by me in this form is true and correct.

c) authorise St John of God Murdoch Hospital to act as my agent for the purposes of claiming pharmaceutical benefits for the period of my hospitalisation.

d) If Day case patients are required to stay overnight, inpatient fees (including accommodation charges) will apply.

e) **Hospitalisation / Transfer:** During your hospitalisation should a situation arise where a clinical service is unavailable within a clinically appropriate time frame, or your care is to be progressed at another facility, you may require transfer using the service of St John Ambulance. Ambulance fees do not form part of your medical expenses and you will be charged directly by St John Ambulance in accordance with their fee structure.

f) I acknowledge that I am familiar with the type and level of health cover I hold and that I will disclose information relating to any associated restrictions etc prior to my admission. I understand I am ultimately responsible for the costs associated with my hospitalisation and that I will provide information regarding my ability to pay such costs and will ensure that my financial obligations are fulfilled as promptly as possible.

Patient/Guardian Signature X _____ DATE ☐☐ ☐☐ ☐☐☐☐

Witness Signature X _____ DATE ☐☐ ☐☐ ☐☐☐☐

PLEASE CONTINUE OVER PAGE

ST JOHN OF GOD
Murdoch Hospital

CLINICAL INFORMATION

Please use patient ID label when available

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX
DOCTOR'S NAME Derek Chen	

PATIENT / GUARDIAN TO COMPLETE

CLINICAL INFORMATION REQUIRED FOR ADMISSION

PATIENT HISTORY

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

YES	NO		SPECIFY
☐	☐	Medication Allergy	
☐	☐	Other Allergies (including Latex, Lotion allergy, Food)	
☐	☐	Heart problems (chest pain, heart attack)	
☐	☐	Blood pressure problems	
☐	☐	Bleeding/clotting problems	
☐	☐	Diabetes	
☐	☐	Breathing problems(shortness of breath, sleep apnoea)	
☐	☐	Asthma	
☐	☐	Current skin infection	
☐	☐	Epilepsy/fits	
☐	☐	Hepatitis	
☐	☐	Kidney problems	
☐	☐	Back or neck problems	
☐	☐	Psychiatric problems (anxiety, depression)	
☐	☐	Dementia	
☐	☐	Do you have a pacemaker?	
☐	☐	Cortisone / Steriods	
☐	☐	Recent sore throat, cold or flu in the last 2 weeks	
☐	☐	Problems with an anaesthetic in the past	
☐	☐	Other history / other condition	
☐	☐	Do you drink alcohol?	Specify daily intake
☐	☐	Do you smoke? / Have you ever smoked?	Specify number per day or when ceased

MEDICATIONS

Please list your current medications and dosage

TYPE	DOSAGE

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

YES	NO		DATE CEASED
☐	☐	Aspirin	
☐	☐	Warfarin	
☐	☐	Steroid/Cortisone/Prednisolone	
☐	☐	Insulin	

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

YES	NO		YES	NO	
☐	☐	Contact Lenses	☐	☐	Crutches
☐	☐	Glasses	☐	☐	Prosthesis
☐	☐	Dentures	☐	☐	Walking Frame
☐	☐	Hearing Aid	☐	☐	Walking Stick
			☐	☐	Wheelchair

ST JOHN OF GOD
Murdoch Hospital

CONSENT TO PROCEDURE AND ADMINISTRATION OF ANAESTHESIA

Please use patient ID label when available

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX
DOCTOR'S NAME Derek Chen	

I, _____
Name

hereby consent to the procedure of _____
No abbreviations, please print

_____

being performed on _____
If not self, state patient's name and relationship

the nature, benefits, risks, options and purpose of which has been explained to me by

_____
Medical Practitioner's name

Procedure Date: _____ **CMBS Number:** ☐☐☐ ☐☐☐ ☐☐☐

Estimated Length of Stay: _____ ☐☐☐ ☐☐☐ ☐☐☐

Is this procedure Elective Cosmetic surgery? **Yes** ☐ **No** ☐

I acknowledge that my Doctor has advised me about any prosthesis, medical devices or high cost drugs planned to be used in my procedure and whether I'll have to pay a gap. I understand the hospital will charge me for any gap payment required, and that I will be liable to pay that charge.

CONSENT TO BLOOD PRODUCT ADMINISTRATION ☐ N/A

The risks associated with the administration of blood products has been explained to me by my Doctor.

☐ I consent to the administration of blood products

☐ I do not consent to the administration of blood products (complete Refusal for Blood Transfusion HR123)

CONSENT TO BLOOD TEST - ACCIDENTAL INJURY TO STAFF

During your procedure, there is a possibility of a staff member or doctor being injured and contaminated with your blood. Should this situation arise, we request your consent for blood to be collected and tested for infectious agents, including Hepatitis B, Hepatitis C and HIV antibody.

I understand and agree 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 Doctor and 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 CONSENT

I acknowledge that my Doctor has explained the medical condition, the procedure and the risks associated with it. He / She has also explained the prognosis and risk of not having the treatment. I understand that if immediate life-theatening events occur during my procedure they will be treated accordingly.

PATIENT/GUARDIAN SIGNATURE X _____ DATE ☐☐ ☐☐ ☐☐☐☐

MEDICAL PRACTITIONER'S CONFIRMATION

I authorise the use of my standing orders. **YES** ☐ **NO** ☐

I confirm that I have explained to the patient/guardian the nature, benefits, risks, options and purpose of this procedure

MEDICAL PRACTITIONER'S SIGNATURE X _____ DATE ☐☐ ☐☐ ☐☐☐☐

DIAGNOSTIC TESTS (MEDICAL PRACTITIONER TO COMPLETE THIS SECTION)

PATHOLOGY **YES** ☐ **NO** ☐ _____
RADIOLOGY **YES** ☐ **NO** ☐ _____
E.C.G. **YES** ☐ **NO** ☐ _____

ARE THESE TESTS REQUIRED:
PRIOR TO ADMISSION ☐
ON ADMISSION ☐

ICU REQUIREMENT Please tick: ☐ Will require ICU post-op ☐ May require ICU post-op ☐ Will not require ICU post-op

MEDICAL PRACTITIONER'S INSTRUCTIONS

POTENTIAL CREUTZFELDT - JAKOB DISEASE (CJD) RISK

For pre-operative patients undergoing neurosurgical and ophthalmological (posterior segment) procedures

☐ Is the patient at risk? If YES please contact Infection Control for further advice.

Advice sought from: _____

Date: _____

MEDICAL PRACTITIONER'S SIGNATURE _____ DATE ☐☐ ☐☐ ☐☐☐☐

This form is also available separately as a one-sided form - HR120 Consent to Procedure and/or Administration of Anaesthesia)