RHC100.16 Patient Adm Details

Ramsay Health Care

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 Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

ADMISSION DETAILS

Specialist Surname:..... Specialist First Name:.....

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

Reason for Admission:..... (If unsure leave blank

Item Numbers (if known):.....

Is admission due to an injury? ☐ No ☐ Yes Date of injury: ..... /...../..... ☐ My Health Record Opt Out

How did the injury occur?: ☐ At work, going to/from work or as a result of being at work ☐ Motor Vehicle Accident ☐ Sport

Other (please specify):.....

Where did the injury occur?: ☐ Roadway ☐ Home ☐ Work ☐ Sports area ☐ Other (please specify):.....

Is the person completing the form the patient: ☐ No ☐ Yes

If No, Your Name:..... **Your Phone No.:**.....

PATIENT DETAILS

Title:..... Surname:..... Maiden Name:.....

Given Names:..... Preferred Name:.....

Residential Address:.....

Suburb:..... State:..... Postcode:.....

Postal Address: ☐ As above ☐ Different Details:.....

Suburb:..... State:..... Postcode:.....

Telephone (Home/AH)..... (Work/Day)..... (Mobile/Other).....

Contact Preferences: (indicate your preferred contact option) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

If there is a voice message service, may we leave a message? ☐ No ☐ Yes

Email:.....

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

Date of Birth: ..... /...../..... Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single/Never Married ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Child (not at school) ☐ Employed ☐ Home Duties ☐ Retired ☐ Student ☐ Unemployed ☐ Other

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

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

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown ☐ Decline to Answer

Are you of Australian South Sea Islander (SSI) origin? ☐ No ☐ SSI ☐ Not Stated/Unknown ☐ Decline to Answer

Religion:.....

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

Chaplain Visit: ☐ No ☐ Yes Veteran Organisation Representative: ☐ No ☐ Yes

Language(s) spoken: ☐ English ☐ Other:..... (please detai

Are you able to read and understand English: ☐ No ☐ Yes Interpreter required: ☐ No ☐ Yes

MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ No ☐ Yes Medicare Number: ☐☐☐☐☐☐☐☐☐☐

Medicare Reference No:..... (number in front of your name) Medicare Expiry date (MM/YYYY):..... /.....

NEXT OF KIN

Relationship to patient:.....

Title:..... Surname:..... Given Names:.....

Address: ☐ Same as patient ☐ Different from patient .....

Suburb:..... State:..... Postcode:.....

Country:.....

Telephone (Home/AH)..... (Work/Day)..... (Mobile/Other).....

PERSON TO NOTIFY

☐ Same as next of kin Relationship to patient:.....

Title:..... Surname:..... Given Names:.....

Address: ☐ Same as patient ☐ Different from patient .....

Suburb:..... State:..... Postcode:.....

Telephone (Home/AH)..... (Work/Day)..... (Mobile/Other).....

BINDING MARGIN - DO NOT WRITE

Ver 5.2 - 07/21

Ramsay
Health Care

PATIENT ADMISSION DETAILS

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UR: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

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 (Home/AH) ..... (Work/Day) ..... (Mobile/Other) .....

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? ☐ No ☐ Yes Safety Net No: .....

HEALTH INSURANCE DETAILS

Do you have entitlement to free treatment under Australian Veteran's legislation? ☐ No ☐ Yes
(If yes, *select DVA as your Insurance Type and complete the DVA questions*)

Has your injury or condition occurred due to the negligence of a third party? ☐ No ☐ Yes
(e.g. workers compensation, motor vehicle accident, common law)

If yes, have you lodged a claim for compensation or damages? ☐ No ☐ Yes Damages ☐ Yes Compensation
(If yes, *select Workers Compensation as your Insurance type and answer Workers Comp questions*)

Did your injury or condition occur at work, going to or from work or as a result of being at work? ☐ No ☐ Yes

Insurance Type:

☐ Private health fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ ADF ☐ Self Funded ☐ Public ☐ Overseas Insurer

Name of Health Fund: ..... Type of Cover: .....

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

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

Workers' Comp Fund Name: ..... Claim No: .....

Employer: ..... HR Manager: .....

Phone: ..... Fax No: .....

Third Party Name: ..... Policy No.: .....

DVA No: ..... DVA Card Colour: ..... Details of cover (white card only) .....

ADF Service Branch: ..... Approval No.: ..... Entitled Personnel Identification No.: .....

ADF Medical Officer (MO) On-base: ..... MO Contact Number: .....

Overseas Insurance Name: ..... Policy No.: .....

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: .....

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 this booklet:

☐ Hospital information (including pre-admission, day of admission, general information about our hospital as well as about no responsibility accepted if you bring valuables to hospital)

☐ Private Patients' Hospital Charter

☐ Your right to privacy under the Privacy Act

By ticking 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

Signature: ..... Date: ... / ... / .....

PATIENT ADMISSION DETAILS

RHC31

Ramsay
Health Care

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.

UR: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

PROCEDURE / ADMISSION	NO	YES	If yes, please answer these questions If no, please progress to the next question	NURSING NOTES
1. Could you be pregnant?				
2. Is the patient under the age of 18 years?			Name of child's legal guardian: ..... Are the child's immunisations up to date: ☐ No ☐ Yes	
3. Have you had any of the following? Xray:			When / where:	
Blood tests:			When / where:	
MRI:			When / where:	
Scan:			When / where:	
4. Have any other doctors been consulted in relation to this admission? e.g. cardiologist, physician			Doctor consulted: ..... Specialty:	
PREVIOUS HOSPITALISATIONS	**NO**	**YES**	**If yes, please answer these questions**	**NURSING NOTES**
5. Have you been admitted to this hospital before				
6. Have you been admitted to any hospital within the last 28 days?			In the last 7 days In the last 28 days Reason for admission: .... Hospital name:	
7. For WA residents only – Have you been admitted to a hospital outside WA in last 12 months?			Reason for admission: .... Hospital name:	
PREVIOUS SURGERY / PROCEDURES	**NO**	**YES**		**NURSING NOTES**
8. Have you had any previous surgeries or procedures? e.g. joint replacements, transplants, implants, colonoscopy			**If yes, please complete table below**	

OPERATION	APPROX YEAR	OPERATION	APPROX YEAR	NURSING NOTES

MEDICATIONS	NO	YES		NURSING NOTES
9. Are you currently taking medications?			**If no, go to question 12. If yes, please answer the questions below**	
10. Have you received advice from Specialist rooms regarding taking/ceasing medications prior to admission?			Details:	
11. Do you take any of the following: • anti-coagulant or blood thinning therapy e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaban, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor • cortisone tablets/injections, anti-inflammatory drugs • regularly take fish oil, krill oil, garlic or ginkgo supplements			Still take? ☐ No ☐ Yes Date to be ceased: ..... Still take? ☐ No ☐ Yes Date to be ceased: ..... Still take? ☐ No ☐ Yes Date to be ceased:	

IMPORTANT: Please either complete the medication table on page 4 OR bring a profile or list to hospital of all medications including anti-coagulant or blood thinning therapy as well as other tablets, puffers, patches, injections, nebulisers, ointments, drops and including non-prescription medications and herbal supplements. IF STAYING OVERNIGHT: please bring medications in the original packaging

BINDING MARGIN - DO NOT WRITE

Ramsay
Health Care

Patient Health History – General

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UR: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

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

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY	NURSING NOTES
						Patient own stock?
						☐ Pt med drawer
						☐ Schedule 8 store
						☐ Sent home

LIFESTYLE	NO	YES	If yes, please answer these questions	NURSING NOTES
12. Do you have a medical required or special diet? e.g. diabetic, coeliac disease, lactose intolerance, vegetarian, vegan, kosher			Details:	
13. Have you ever smoked?			Daily amount: Ceased:	
14. Do you drink alcohol?			Daily amount:	
15. Do you use recreational drugs?			Daily amount: Type:	
16. What is your weight: ..... kg				
17. Have you lost weight unintentionally?				☐ *Malnutrition risk*
18. What is your height: ..... cm				☐ *Check BMI>30*

PROSTHETICS / AIDS	NO	YES	If yes, please answer these questions	NURSING NOTES
19. Do you use any prosthetics / aids? e.g. aids for vision and hearing loss, walking sticks, other aids for daily living			Details:	☐ *Falls risk screen*
20. Are you paraplegic or quadraplegic?			Details:	

DISCHARGE PLANNING	NO	YES	If yes, please answer these questions	NURSING NOTES
21. Where do you plan to go after discharge?				
22. Do you live alone or are solely responsible for the care of another person at home?			☐ I have someone to look after me after discharge ☐ I currently receive community support and/or nursing services. ☐ I require assistance with or have concerns with aspects of day to day living. ☐ I have concerns after discharge	
23. Do you have someone to take you home from hospital?			Name: Contact Number:	

ADVANCE HEALTH DIRECTIVE / POWER OF ATTORNEY	NO	YES	If yes, please answer these questions	NURSING NOTES
24. Do you have a current Advance Health Directive			Please bring copy with you on admission	
25. Do you have an enduring Power of Attorney – health & medical guardian?			☐ Same as next of kin Name: Relationship: Phone:	

PATIENT HEALTH HISTORY – GENERAL

RHC415

RHC100.11 Patient Health History

BINDING MARGIN - DO NOT WRITE

Ramsay Health Care

Patient Health History – General

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UR: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS

26. Do you have any ALLERGIES? (see conditions below) ☐ No ☐ Yes

If No, go to question 27. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ You or a family member has had an adverse reaction to anaesthetic e.g. malignant hyperthermia or post operative nausea and vomiting	☐ You ☐ Family member Details:	
☐ Allergies or sensitivities including medications, latex, sticking plaster, iodine, xray dyes, food (e.g. seafood, nuts, gluten), food additives (e.g. salicylates, amines) or insects (e.g. bees, dust mites)	☐ You: Please list details below ☐ Family member Details:	

ALLERGY INCLUDING FOOD ALLERGIES	DETAILS / REACTIONS	☐ *Alert sticker*

27. Do you have/had any CARDIOVASCULAR problems? (see conditions below) ☐ No ☐ Yes

If No, go to question 28. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Elevated cholesterol, triglycerides		
☐ Blood pressure problems e.g. low, high, hypertension		
☐ Cardiac conditions or irregularities, e.g heart attack, congestive heart failure, rheumatic fever, angina, palpitations, heart murmur		
☐ Cardiac surgery e.g. pacemaker, implants/devices, prosthetic heart valve, grafts, stents		Year: Model:
☐ Vascular disease e.g. carotid disease, aortic aneurysm, peripheral vascular disease		

28. Do you have/had DIABETES? (see conditions below) ☐ No ☐ Yes

If No, go to question 29. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Type 1 diabetes	Controlled by: ☐ Diet ☐ Insulin ☐ Tablets	
☐ Type 2 diabetes		
☐ Gestational diabetes		
☐ Unsure		

29. Do you have/had any GASTROENTEROLOGY OR UROLOGY problems? (see conditions below) ☐ No ☐ Yes

If No, go to question 30. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Hiatus hernia, gastrointestinal ulcers, reflux		
☐ Liver disease, hepatitis (e.g. A, B, C), jaundice, cirrhosis		
☐ Bowel problems/habits, stoma or bowel disease e.g. Crohns, IBS		
☐ Kidney disease, dialysis, renal impairment		
☐ Bladder problems or habits, stoma, incontinence, urinary retention		☐ *Falls risk screen*

Ramsay Health Care

Patient Health History – General

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Surname: _____

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(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS

30. Do you have/had any BLOOD OR CANCER problems? (see conditions below) ☐ No ☐ Yes

If No, go to question 31. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Ever had a blood transfusion	Any reaction: Year Transfused:	
☐ History of cancer	Type: Body Site: Treatment: Date of Diagnosis:	
☐ Blood clot in lung / legs (DVT / PE)		
☐ Blood or bleeding disorders e.g. anaemia		

31. Do you have/had any MUSCULOSKELETAL conditions? (see conditions below) ☐ No ☐ Yes

If No, go to question 32. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Arthritis e.g. rheumatoid arthritis, osteoarthritis		
☐ Back or neck injury or problems		

32. Do you have/had any NEUROLOGY problems? (see conditions below) ☐ No ☐ Yes

If No, go to question 33. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Neuromuscular diseases e.g. MS, myasthenia, dystrophies, parkinsons		
☐ Stroke, mini stroke, TIA	Date: Impairment:	
☐ Limb paralysis or weakness		☐ *Falls risk screen*
☐ Fear of falling, unsteady or fallen in last 6 months		☐ *Falls risk screen*
☐ Epilepsy/fits, faints, blackouts, dizziness		☐ *Falls risk screen*
☐ Speech or swallowing problems e.g. coughing when eating / drinking		
☐ Difficulties with problem solving, attention span, understanding, post surgery confusion		☐ *Cognitive risk screen*
☐ Other neurological problems e.g. meningitis, migraine, polio, short term memory loss, dementia, Alzheimers		☐ *Cognitive risk screen*

33. Do you have/had any BREATHING problems? (see conditions below) ☐ No ☐ Yes

If No, go to question 34. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Asthma, pneumonia, hay fever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary Disease (COPD)		
☐ Shortness of breath e.g. when walking more than 50m, climbing stairs/inclines		
☐ Sleep apnoea, disturbed sleep, snoring		
☐ Use a CPAP machine	Please bring CPAP to hospital	
☐ Other lung problems e.g. tuberculosis		☐ *Falls risk screen*

34. Do you have/had any OTHER conditions? (see conditions below) ☐ No ☐ Yes

If No, go to question 35. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Chronic pain		
☐ Depression, other mental illness		
☐ Lymphoedema		
☐ Thyroid problems, hypothyroidism, goitre		
☐ Any other medical conditions		

PATIENT HEALTH HISTORY – GENERAL

RHC415

BINDING MARGIN - DO NOT WRITE

Ramsay
Health Care

Patient Health History – General

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(Affix Patient Identification label here, if available)

MEDICAL CONDITIONS continued

35. Are you susceptible to possible INFECTION ISSUES?? (see conditions below) ☐ **No** ☐ **Yes**

If No, go to question 36. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Ever had MRSA, VRE, CRE or ESBL		
☐ I have had other infection issues previously		
☐ In the last 12 months have you been treated, admitted or worked in a healthcare facility overseas, including a nursing home or aged care facility		

36. Are you being admitted in the next 7 days? ☐ **No** ☐ **Yes**

If No, go to question 37. If Yes, please tick the relevant conditions below.

☐ Do you currently have any wounds or breaks on your skin? **In the last 3 weeks have you:** ☐ Travelled to a country or area with current health alerts (if known) ☐ Travelled to areas of high prevalence for acute respiratory infections/illnesses ☐ Had contact with anyone with an acute respiratory infections/ illnesses ☐ Had a fever or respiratory symptoms e.g. cough, sore throat, runny nose ☐ Had vomiting and/or diarrhoea		

37. Are you having an operation on your brain, spinal cord, pituitary gland, nerve root ganglia, retina, optic nerve or having maxillary or dental surgery? ☐ **No** ☐ **Yes**

If No, please go to the next section. If Yes, please tick the relevant conditions below.

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ I think I may have Creutzfeldt-Jakob Disease (CJD)		
☐ I have had two or more first or second-degree relatives with CJD		
☐ I have an unexplained progressive neurological illness of less than 12 mths		
☐ I have a history or receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)		
☐ I have previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)		
☐ I have been involved in a look back for CJD or have a "medical-in-confidence" letter regarding your risk for CJD		
☐ I am not sure		

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

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

Patient Name (print): .....

Signature: ..... Date: .....

BINDING MARGIN - DO NOT WRITE