THE MELBOURNE EASTERN
PRIVATE HOSPITAL
Independent Private Hospitals of Australia

157 Scoresby Road, Boronia, VIC 3155
(The Melbourne Eastern) Pty Limited

DAY CASE INTEGRATED PRE-ADMISSION FORM

Thank-you for choosing The Melbourne Eastern Private Hospital. Please complete all parts of this form and return it to the hospital as soon as possible, or at least 3 business days prior to your admission date.

In the week prior to your admission you will be contacted by an Admission Office team member. Our staff will check your details for accuracy and review your Private Health fund details with you. They will also inform you of any out-of-pocket expenses which will include a $100.00 pharmacy bond for all overnight admissions, a $25.00 ancillary fee and any insurance excesses that you will be required to pay upon admission.

Please advise our staff of any special needs that you have including the need for an interpreter, if required.

Day of admission: Please present to the admissions department at the scheduled time for check in to the hospital. We ask that you double check the accuracy of your details and make our staff aware of any allergies or special needs.

Day only patients: Please bring with you your Medicare card and if applicable your private health insurance card and pension card. Also bring all your usual medications **and** for your comfort please bring a dressing gown and slippers. It is also important to ensure you have organised return transportation with a support person for discharge.

Overnight patients: For your comfort please bring night attire, slippers, dressing gown and toiletries. Please also bring all your usual medications in its original packaging.

We welcome your feedback and ask that you take the time to complete our patient satisfaction survey at the end of your admission.

We discourage valuables and large amounts of money from being brought in to the hospital and if done so it is at your own risk.

We wish you the best during your hospital stay.

The Melbourne Eastern Private Hospital - A Total Quality Management Facility

(Please return this form intact to the hospital at least 3 business days prior to admission)
COMPLETED BY THE PATIENT

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Attach patient identification label

Patient Details
UR Number:.....
Surname:.....
Name:.....
Date of Birth:.....Gender:.....
Dr:.....

PATIENT DETAILS:

Admit Date | Procedure Date

Admission Time : am pm

Treating Doctor

Have you been a patient at this hospital before? Yes No If Yes, when?

Have you been a patient at any hospital in the past 7 days? Yes No

TITLE: Mr Mrs Miss Ms Child

Family Name:

Given Names:

Address:

Telephone No. - Private | Mobile

Business | MARITAL STATUS M S W Div Def

Sex M F | Date of Birth

Occupation | Religion

HEALTH INSURANCE & PHARMACEUTICAL BENEFITS

Medicare Card

Position on card | Expiry date

Name of Private Health Insurance Fund

Membership Number

Date Joined | Date Paid To | Table

Pharmaceutical Entitlement Card No / Safety Net No.

Pension No. | Expiry Date

Country of Birth | If Australia, which State

Are you of Aboriginal or T.S.I. descent? Yes No

NEXT OF KIN - Person for Notification

CONTACT 1 - Name

Relationship

Address:

Telephone No. - Private | Business / Mobile

CONTACT 2 - Name & Relationship

Telephone No. - Private | Business / Mobile

WORKCOVER CLAIM

Claim No. | Date of Accident

Employers Insurance Company

DEPARTMENT OF VETERAN AFFAIRS NUMBER

Gold Card Yes No

TAC CLAIM

Claim No. | Date of Accident

PAYMENT OF ACCOUNTS

All hospital out-of-pocket expenses are payable on admission.

INFORMED FINANCIAL CONSENT

I understand and agree to pay all hospital accounts notwithstanding any denial by - Health Insurance Funds, WorkCover, Transport Accident Commision or any other relevant body. I give permission for the hospital to contact my health fund regarding my membership status.

Signed - person responsible for the account

*Name *write 'as above' if same as patient

Given Names

Address:

OFFICE USE ONLY: Booking No. | UR No. | Episode No. | Room No.

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Surname:.....

Name:.....

Date of Birth:.....Gender:.....

Dr:.....

LOCAL DOCTOR'S (GP) DETAILS:	
Dr's Name:	Name and contact number of person picking you up:
Telephone:	Name:
Address:	Contact Number:
Do you have any religious / cultural needs? Yes ☐ No ☐	
Interpreter needed? Yes ☐ No ☐ Language spoken:	
Do you have difficulties with speech, hearing, touch or vision? Yes ☐ No ☐	

INFECTION CONTROL ASSESSMENT	YES	NO		YES	NO
Do you have a fever, cold cough or sore throat?	☐	☐	Have you ever had a Multi Resistant Organism, such as: - Multi / methicillin resistant staphylococcus (MRSA)? - Vancomycin resistant enterococci (VRE)? - Carbapenem Resistant Enterobacteriaccoc (CRE)?	☐ ☐ ☐	☐ ☐ ☐
Have you been exposed to / been in contact with someone who has had an infectious disease in the past two weeks? i.e chicken pox, shingles, measles, influenza?	☐	☐			
Do you ever / have you ever had a blood borne infection (e.g. Hepatitis B and C, HIV)?	☐	☐	For patients undergoing cystoscopy or prostate surgery, have you travelled to India, South East Asia or Greece in the past 12 months?	☐	☐
FALLS RISK ASSESSMENT	**YES**	**NO**		**YES**	**NO**
Have you fallen / tripped in the last 12 months?	☐	☐	Do you use a walking aid? (e.g. frame / stick)	☐	☐

MEDICATIONS

ALLERGIES	YES	NO	
Do you have any allergies to medications, foods (e.g peanuts), dressings or latex/rubber based products?	☐	☐	Specify allergy and reaction: .... Document on anaesthetic & Medical Record - Alert Sheet If latex allergy, follow latex policy.
Have you had any aspirin in the past week?	☐	☐	If Yes, how many and when:
Have you ever taken Warfarin or any other blood thinners?	☐	☐	

LIST CURRENT MEDICATION(S)	DOSE	FREQUENCY

ATTACH LIST IF NOT ENOUGH SPACE

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Name:.....

Date of Birth:.....Gender:.....

Dr:.....

HEALTH HISTORY

Please tick (✓) Yes or No to all of the following questions	YES	NO		YES	NO
GENERAL MEDICAL					
Do you suffer from bowel problems / disorders?	☐	☐	Do you suffer from reflux / stomach ulcer?	☐	☐
Do you suffer from kidney / bladder problems / incontinence?	☐	☐			
DENTAL					
Do you have crown, caps, dentures, braces or loose teeth?	☐	☐			
NUTRITION					
Do you have any eating difficulties or special dietary needs? (e.g. cultural / religious)	☐	☐	Have you lost weight in the last 6 months without trying?	☐	☐
DIABETES					
Do you have Diabetes? Type 1 ☐ Type 2 ☐	☐	☐			
HEART					
Have you ever suffered from chest pain / discomfort / heart attack? Year:..... Treatment:.....	☐	☐	Do you have a pacemaker or implantable defibrillator?	☐	☐
			Do you have palpitations / irregular heartbeat / heart murmur?	☐	☐
Do you have high blood pressure, high cholesterol AND/OR a family history of cardiac disease? Name of Cardiologist:.....	☐	☐	Have you ever had Rheumatic Fever?	☐	☐
AIRWAYS					
Do you suffer from Asthma / Bronchitis / Emphysema / shortness of breath on exertion / Pneumonia?	☐	☐			
NEUROLOGICAL					
Do you suffer from epilepsy / fits / seizures?	☐	☐			

SURGICAL HISTORY

PAST SURGICAL HISTORY (attach a list if insufficient space)
Have you ever had any previous operations? Please list operations and dates performed.

..... Date:.....

..... Date:.....

..... Date:.....

..... Date:.....

..... Date:.....

..... Date:.....

..... Date:.....

..... Date:.....

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CONSENT TO TREATMENT

MUST BE COMPLETED

Attach patient identification label

Patient Details

UR Number:.....

Surname:.....

Name:.....

Date of Birth:.....Gender:.....

Dr:.....

CONSENT TO OPERATIVE TREATMENT AND ADMINISTRATION OF ANAESTHETIC - SURGICAL
NOTE: CONSENT & CONFIRMATION MUST BOTH BE COMPLETED

CONSENT

I, (Given Name and Surname)

hereby consent to the following operations (specify operation(s))

being performed upon (Given Name and Surname)

The nature and effect of the above operation(s) have been explained to me by a Doctor

☐ I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) stated above and to require post-operative treatment.

BLOOD PRODUCTS CONSENT

I do ☐ or do not ☐ consent to the administration of blood or blood products and I have notified my doctor and am aware of the risks, benefits and alterative treatment options.

☐ In conjuction with the above stated operation(s), I consent to the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable with the exception of (state "none" or type of anaesthesia)

Dated this | Day of | Year

Signed | *Relationship to Patient

Signature of Witness

*Relationship to Patient - e.g. myself, my child

CONFIRMATION

I, (Name of Doctor)

have explained to the **patient/person legally responsible for the patient the nature and effect of the above mentioned operation(s) and anaesthetic(s). In my opionion, ***he/she understood this explanation.

Dated this | Day of | Year

☐ I am aware that this patient has refused administration of blood or blood products and I have advised the patient/person legally responsible for the patient of the risks, benefits & alternative treatments.

Signature of Doctor

CONSENT TO TREATMENT (NON-SURGICAL)

I, given Name and Surname)

hereby consent to and authorise the administration by qualified staff of the above named hospital, all treatment, examinations, tests and drugs as deemed necessary during this stay in hospital.

Notwithstanding the above, I reserve the right to refuse in writing any specific treatment, examination, test or drug.

Dated this | Day of | Year

Signed | *Relationship to Patient

Signature of Witness

*Relationship to Patient - e.g. myself, my child

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Dr:.....

PRE ANAESTHETIC HEALTH INFORMATION

What is your **Height:** ..... **Weight:** ..... Body Mass Index (if known) ..... Temp:..... Pulse:.....

Respiration:.....Blood Pressure.....Last food / drink (date and time:.....

ORIENTATION TO DAY SURGERY

Call Bell ☐ Light ☐ Toilet ☐

Please tick (✓) Yes or No to all of the following questions	YES	NO		YES	NO
Have you or any family member had any reactions / side effects to anaesthetic? (e.g. malignant hyperthermia)	☐	☐	Have you ever had jaundice / liver problems or disease?	☐	☐
Do you or have you ever smoked?	☐	☐	Have you ever had any blood tests / autologous blood or other pathology taken for this admission?	☐	☐
Do you suffer from blood disorders / anaemia / bleeding problems / bruise easily?	☐	☐	Have ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission?	☐	☐
Have you ever had a blood clot in your legs or lungs (i.e. DVT or PE)?	☐	☐	Have you ever had a blood transfusion? Any reaction?	☐ ☐	☐ ☐
Do you drink alcohol? Socially ☐ Daily ☐	☐	☐	Do you have any implants / prosthesis? e.g. joint replacements, cardiac valves or stents)	☐	☐

DISCHARGE ASSESSMENT *Answering these questions will assist us in planning your discharge from hospital.*	YES	NO	Provide details if requested below
1. Are you aged 75 years or over?	☐	☐	
2. Do you live alone?	☐	☐	
3. Do you have any caring responsibilities for other?	☐	☐	Provide details

LEGAL DOCUMENTATION *Have you completed any of the following?*	YES	NO		Nursing Staff Use ONLY
Enduring Power of Attorney (Financial Decisions)	☐	☐		Note on Alert Sheet if patient indicates Yes
Enduring Power of Guardianship (Personal Decisions)	☐	☐		
Medical Power of Attorney (Medical Decisions)*	☐	☐		
Anticipatory Directive* (SA) Advanced Care Directive (all other states)	☐	☐		
Are you registered with the Australian Organ Donor Register?	☐	☐		
If Yes to any of the above marked with a star (*), please provide a copy to the hospital.				

The Melbourne Eastern Private Hospital feels it is important you understand your rights and responsibilities as a patient. Our *Rights and Responsibilities* brochure is available on the internet and in the reception at the hospital.

To the best of my knowledge, the above details are true and correct. **Date:...../...../.....**

Patient Signature: X..... **Print Name:** .....

R.N. . E.N. Signature (as checked):.....**Initial:**.....

Print Name: .....