Pacific
PRIVATE HOSPITAL

ADMISSION GUIDE

In order to confirm your admission, it is essential the hospital receives the completed pages 7 to 14 **no later than 48 hours prior to your admission.**

Admission Date:

Admission Time:

Operating Doctor:

Nil by mouth from:

Healthscope

Pacific PRIVATE HOSPITAL

Pacific Private Day Surgery
Level 1, 123 Nerang Street
Southport QLD 4215

Postal Address:
PO Box 2180
Southport QLD 4215

PH: 07 5556 6222 (business hours)
PH: 07 5556 6205 (extended hours)
FAX: 07 5556 6234

Pacific Private Oncology
Level 3, Suite 6, 123 Nerang St
Southport QLD 4215

Oncology Contact
PH: 07 5556 6200
FAX: 07 5556 6210

Patient Parking is available underneath the building
via Cougal St. No token is required

Please show this document to the parking attendant to acknowledge your appointment.

DAY SURGERY/ONCOLOGY ADMISSION INFORMATION

Your hospital admission will be arranged by your doctor who will inform you of the day and the time you need to come to hospital. On your admission day, please go to the admissions desk on level 1, Pacific Private Hospital or level 3 for Oncology. After your admission has been registered by our reception team you will be transferred to an appropriate admission area.

CAR PARKING

We recommend that you travel to and from the hospital with a carer, friend or relative (unless you are having a local anesthetic). Parking is available underneath our building and in the streets surrounding.

SMOKING

Smoking is not permitted in our facilities. Avoid smoking 24 hours prior to your surgery.

FEES & CHARGES

Insured patients

Details of your health insurance should be provided prior to your admission. Depending on your type of cover, you may need to pay an excess or co-payment on the day of your admission. Health fund policies require members to serve waiting periods before they will provide cover, and some levels of cover have excluded services. We strongly recommend that you contact your health fund to confirm your cover prior to your admission.

Uninsured patients

If you do not have private health insurance, you must pay the estimated cost of your admission fee. There is no rebate from Medicare for these fees.

Workcover/Third Party Insurance

If your admission is a result of a workcover/worksafe, third party or public liability claim, the hospital will require prior written approval for your admission from the relevant insurance company.

Payment methods

We accept all major credit cards, cash and EFTPOS. Check with your bank regarding any daily limit, most financial institutions have a daily limit of $1000. Please be aware that when paying by credit card, surcharges will apply.

Visa/MasterCard - 1.5 %

Amex - 3 %

(We do not accept personal cheques or Diners credit cards)

You will also receive separate accounts from your Doctor, Anaesthetist and/or pathology.

INTERPRETER SERVICES

An accredited interpreter service can be arranged where deemed necessary. Charges may apply.

MEDICATIONS

It is very helpful if you can bring a list of current medications. Knowing what medications you are taking is important information for people providing your care.

Ask your doctor if you should take your regular medication on the morning of surgery or cease any of your medications any earlier prior to surgery. If you are on insulin or asthma inhalers please bring these with you.

PATIENT FEEDBACK

Patient feedback is important to us and we encourage all patients to tell us how they feel about our level of customer service, our facilities and our staff. To know where we do well is great, but to learn where we could do things better is far more important if we are to improve the service we offer for future patients. We do provide feedback surveys but if you have a question or observation please ask the nurse caring for you, or the Nurse Manager.

PATIENT RIGHTS AND RESPONSIBILITIES

Healthscope feels it is important that you understand your rights and responsibilities as a patient. Patients must respect the privacy and confidentiality of other patients. Therefore we do not allow relatives into the discharge lounge area. It is illegal to disclose any information about another patient's presence in the hospital or their treatment. This includes verbal and digital communications as well as the use of photographs, videos etc. and information published online and/or via any social media platform.

INFORMATION FOR DAY SURGERY PATIENTS ONLY

PERSONAL EFFECTS

While you are undergoing your procedure, your personal effects may be locked away and returned to you prior to discharge. Patients are strongly advised not to bring valuables. Please ensure all jewellery is left at home. **This hospital does not accept responsibility for loss or damage to personal property.**

CLOTHING

Dress sensibly, be comfortable. No high heels, make-up, or nail polish. Please wash/shower prior to your admission. Some patients may be asked to use a surgical wash. Do not apply talcum powder, deodorant or apply make up or moisturisers following the shower.

FASTING

Prior to your procedure do not eat, drink, chew gum or smoke as per your Doctors or the hospital's instructions. Some procedures may not include fasting, be sure to check with your Doctor. If you do not follow these instructions it is likely your procedure will be cancelled.

INFORMATION FOR DAY SURGERY PATIENTS ONLY

CHILDREN / PAEDIATRIC PATIENTS AND THEIR PARENTS

As a parent or carer, we would encourage you to remain with your child during their hospitalisation. The hospital will provide details re facilities available during your child's stay.

MEALS AND DIETARY REQUIREMENTS

Please advise if you have special dietary needs as this is very important. You will be offered some light refreshments after your procedure. If you have specific requirements you may bring your own light refreshments in a sealed container. This will be kept in the fridge for after your procedure.

X-RAYS

X-rays remain the property of the patient and are to be taken home by the patient on discharge. The hospital does not keep x-ray films/scans and does not accept responsibility for these following a patient's discharge.

DISCHARGE

Patients must have a responsible adult accompany them home and stay with them overnight after discharge (unless you are having a local anaesthetic).

We will be able to advise you at the time of admission of the approximate time that you will be ready for discharge/ready to leave hospital. This is usually 2-3 hours from the time of admission.

The hospital will call the person that will be taking you home half an hour before you are ready to leave.

Your escort must present to the discharge lounge for collection.

For the first 24 hours after leaving hospital, please **DO NOT:**

- Use any dangerous machinery and tools
- Sign any legal documents
- Drink alcohol
- Activities that require coordination or a high level of alertness
- Drive a motor vehicle. Motor vehicle insurance policies may be void in the event of an accident
- You should not be on your own for the first 24 hours post surgery

Please be advised we do not have overnight facilities.
If required, please discuss with your Doctor.

WHAT TO BRING- YOUR ADMISSION CHECKLIST

We may need to sight the items listed below only if the details on the admission forms is incomplete

Health fund membership card	☐
Veteran Affairs Card	☐
Medicare Card	☐
Workers compensation claim forms	☐
A list of current medications	☐
All relevant x-rays / scans (Day surgery patients only)	☐
Notes / letters / reports from your Doctor (Day surgery patients only)	☐
Spectacles & case	☐
Credit Card / EFTPOS / Cash – if required	☐
Mobility / walking aid if used	☐

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Attach patient's identification label

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

PART A: PROVISION OF INFORMATION (To be completed by specialist)

I, Doctor ..... have discussed with my patient (named above) /patient's guardian of the nature, likely results, and material risks of the recommended operation / procedure and/or treatment.

The agreed operation / procedure and treatment is:
The agreed operation date is:

(Insert name of operation / procedure and/or treatment)

Preferred Language: **Specify Language**

English? **Yes** ☐ **No** ☐ **If No** →

☐Left side ☐Right side ☐Not applicable

Interpreter required? **Yes** ☐ **No** ☐ **If Yes,**

Medical Practitioner's Signature

Interpreter's Signature

DATE: / /

DATE: / /

PART B: PATIENT CONSENT (TO BE COMPLETED BY PATIENT)

The treating doctor whose name appears in Part A (above) and I have discussed my / my child's / my charge's present condition and the various ways in which it might be treated. The doctor has recommended the operation / procedure / treatment in Part A.

The doctor has told me that:

- The operation / procedure/treatment carries some risks and complications may occur.
- Anaesthetics, medicines, and/or blood transfusion may be needed and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected.
- The procedure / treatment may not give the expected results even though the procedure / treatment will be performed with due professional care.

I understand the nature of the procedure / treatment and that undergoing the procedure / treatment carries risks. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. I understand that I may withdraw my consent at any time prior to the procedure / treatment. I **request, understand and consent** to the procedure / treatment as outlined in Part A. I agree to additional anaesthetics, medicines or procedures / treatments being carried out if required, provided they are related to the procedure / treatment outlined in Part A. I also consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV, should contamination of any staff member or myself occur during my hospital stay.

Do you consent to a blood transfusion if needed? **Yes** ☐ **No** ☐

....

Signature of patient/parent/guardian

Signature of witness of signatory

....

Date

Date

....

Print name of patient/Parent/Guardian

Print name of witness of signatory

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TO BE COMPLETED BY SPECIALIST

Patient Details (A patient label may be attached here if it contains the appropriate information)

Surname ..... First Name .....

Address .....

Date of Birth ..... Male ☐ Female ☐

ADMISSION DETAILS

Admitting Doctor .....

Date/Time of Admission .....

CMBS item Number (if known) .....

Planned procedure/operation .....

Admission Diagnosis .....

Clinical Summary/History and Examination:

Special Requirements:

Allergies:	Adverse Reaction:
Allergies:	Adverse Reaction:

Doctors Signature .....

Date .....

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REGISTRATION FORM (PATIENT TO COMPLETE)

Please complete & return to the hospital completed pages 7-14 no later than 48 hours prior to admission

ADMITTING DOCTOR: .....

ADMISSION DATE: .....

PERSONAL DETAILS

PATIENT SURNAME: ..... TITLE: .....

GIVEN NAME(S): ..... PREVIOUS NAME: .....

KNOWN AS: .....

DATE OF BIRTH: .....GENDER: Male ☐ Female ☐

RESIDENTIAL ADDRESS: .....

SUBURB: ..... POST CODE: .....

HOME TELEPHONE: ( ) ..... WORK: ( ) .....

MOBILE: ( ) ..... FAX: ( ) .....

EMAIL ADDRESS: .....

COUNTRY OF BIRTH: ..... OCCUPATION: .....

RELIGION: ..... AUSTRALIAN RESIDENT? Yes ☐ No ☐

MARTIAL STATUS: Single □ Married □ De facto □ Separated □ Divorced □ Widowed □

WEIGHT: ..... (Mandatory for anaesthetic purposes prior to admission) HEIGHT: .....

Are you of Aboriginal/Torres Strait Islander Descent? Yes ☐ No ☐

MEDICARE CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐ ☐ EXPIRY: ...../.....

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PRIVATE HEALTH INSURANCE	DEPARTMENT OF VETERANS AFFAIRS
Company:	Member Number:
Member Number:	Card Colour Gold □ Orange □ Blue□ White □
Do you have an excess or co-payments? Yes ☐ No ☐ If yes, how much $	Expiry Date:

WORK COVER	SELF FUNDED/UNINSURED
Insurance Company:	Please be aware that Medicare does not provide a rebate on your uninsured theatre fee.
Membership Number:	Have you been quoted a Theatre Fee? □ yes □ no
Approval Number:	Theatre Fee Estimate: $

CONCESSION CARDS	
Pension Number:	Healthcare Card:
Safety Net Number:	Senior Pharmacy Card:

GENERAL PRACTITIONER DETAILS	REFERRING DOCTOR DETAILS
Name: Practice:	Name: Practice:
Ph: Fax:	Ph: Fax:
Address: _____ _____	Address: _____ _____

NEXT OF KIN	EMERGENCY CONTACT
Name:	Name:
Ph:	Ph:
Address: _____ _____	Address: _____ _____
Relationship to patient:	Relationship to patient:

Pacific PRIVATE HOSPITAL **MEDICAL QUESTIONNAIRE**	**123 Nerang Street Southport QLD 4215 Ph: (07) 555 66 222**	***Attach patient's identification label***
PERSONAL MEDICAL HISTORY		
Have you been admitted to any hospital in the last 28 days? If Yes, please provide details:	**Yes ☐ No ☐**	Date: _____ Hospital: _____ Reason:
Have you had previous operations?	**Yes ☐ No ☐**	Operation(s): _____ Dates:
Do you have any allergies? (e.g. Medications, sticking plasters or other substances)	**Yes ☐ No ☐**	Allergies: _____ _____ _____ _____ Reactions: _____ _____ _____
Have you, or any of you blood relatives, had a reaction to anaesthetic?	**Yes ☐ No ☐**	Details: _____ _____
Are you currently taking ANY medications? (if the list is extensive, please attach a separate medications list)	**Yes ☐ No ☐**	Medications List: _____ _____ _____ _____ _____ _____ _____
Are you currently taking any Vitamins, supplements or herbal preparations?	**Yes ☐ No ☐**	_____ _____ _____ _____
Could you be pregnant?	**Yes ☐ No ☐**	How many weeks?
Do you smoke?	**Yes ☐ No ☐**	How many per day?
Do you drink alcohol?	**Yes ☐ No ☐**	How many glasses per day?
Have you had a recent cold or flu?	**Yes ☐ No ☐**	Details:
Do you have high blood pressure?	**Yes ☐ No ☐**	Details:
Do you have Diabetes?	**Yes ☐ No ☐**	**Type 1 ☐ Type 2 ☐**
Do you have Asthma or wheezing?	**Yes ☐ No ☐**	Details:
Do you suffer from sleep apnoea?	**Yes ☐ No ☐**	Details:

Pacific PRIVATE HOSPITAL **MEDICAL QUESTIONNAIRE**	123 Nerang Street Southport QLD 4215 Ph: (07) 555 66 222	*Attach patient's identification label*
DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?		
Chest pain or angina?	**Yes** ☐ **No** ☐	Details: _____
Do you suffer from Asthma/Bronchitis/Emphysema/ shortness of breath on exertion/Pneumonia/ SARS, Avian influenza/undiagnosed acute respiratory illness?	**Yes** ☐ **No** ☐	Details: _____
Muscle weakness?	**Yes** ☐ **No** ☐	Details: _____
Anaemia?	**Yes** ☐ **No** ☐	Details: _____
Epilepsy/fits?	**Yes** ☐ **No** ☐	Details: _____
Deep vein thrombosis?	**Yes** ☐ **No** ☐	Details: _____
Heart attack/coronary? Have you had bypass surgery/stents/pacemaker?	**Yes** ☐ **No** ☐	Details: _____
Palpitations/irregular heart beat/heart murmur?	**Yes** ☐ **No** ☐	Details: _____
Tendency to bleed/blood clots/bruise easily?	**Yes** ☐ **No** ☐	Details: _____
Arthritis?	**Yes** ☐ **No** ☐	Details: _____
Impairment? Eg. Vision, hearing, mobility? Have you had a fall/trip in the last 12 months?	**Yes** ☐ **No** ☐	Details: _____
HIV/Hepatitis?	**Yes** ☐ **No** ☐	Details: _____
Any concerns about your anaesthetic?	**Yes** ☐ **No** ☐	Question: _____

Pacific PRIVATE HOSPITAL **MEDICAL QUESTIONNAIRE**	123 Nerang Street Southport QLD 4215 Ph: (07) 555 66 222	*Attach patient's identification label*

CREUTZFELD-JAKOB DISEASE (CJD)

What is CJD?- CJD is a rare, fatal brain disorder, which causes rapid, progressive dementia. It can take from 2-40 years before the onset of the disease.

Do you or any members of your family have a history of CJD?
(Two or more blood relatives- mother, father, sister or brother)
If you have a family history of CJD you would know and have undergone genetic studies identifying if you carry the Gene that pre-disposes you to CJD. **Yes** □ **No** □

Have you had a recent onset of progressive Dementia?
The person will have suffered from a sudden progressive Dementia over the last few days, the cause of which has not been diagnosed. **Yes** □ **No** □

Have you received Human Pituitary Hormone (Growth, Gonadotrophin - for infertility?)
A national register of those people who have received pituitary hormone exists. Therefore all of these patients know and have received their follow up counselling **Yes** □ **No** □

Have you received a Dura Mater Graft between 1972 and 1989? (for Brain surgery)
A person will know if they have received a Dura Mater Graft **Yes** □ **No** □

DISCHARGE PLANNING		If Yes, please provide details:
Do you require assistance with any aspect of day-to-day living?	**Yes** ☐ **No** ☐	Details: _____
Do you have multiple health problems?	**Yes** ☐ **No** ☐	Details: _____
Do you live alone?	**Yes** ☐ **No** ☐	Details: _____
Do you any sole caring responsibilities for other/children when you go home after surgery?	**Yes** ☐ **No** ☐	Details: _____ _____ _____ _____
Would you like us to inform your GP of your admission?	**Yes** ☐ **No** ☐	Details: _____

Print Name: _____ Patient Signature: _____ Date: / /

Checked by: _____ RN Signature: _____ Date: / /

Comments: _____

Skin Integrity: Waterlow Score: **At Risk 10+** ☐ **At High Risk 15+** ☐ **At Very High Risk 20+** ☐

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PRIVACY / CONSENT TO USE INFORMATION (PATIENT TO COMPLETE)

We acknowledge our obligations to you under the Privacy Act 1988 (as amended).
I understand that the hospital will need to confirm details of my health fund membership;
I understand that the Health Insurance Commission may be asked to release my Medicare details;
I hereby consent to the use of my personal information for the purposes indicated below;

(Please tick either 'yes' or 'no' for each of the statements listed)

Yes ☐	**No** ☐	To inform my local Doctor and healthcare professionals
Yes ☐	**No** ☐	To my health fund in the event of an audit
Yes ☐	**No** ☐	To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent necessary to my treatment when I am not able to provide such consent
Yes ☐	**No** ☐	To assist other healthcare professionals and facilities who are involved in my care and who may treat me in the future, but only to the extent necessary to treat the particular condition in this episode of care
Yes ☐	**No** ☐	Are you happy to receive a Patient Satisfaction Survey?

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

_____

Signature: _____ Date: _____

I certify that information provided on this form is true and accurate to the best of my knowledge.

Patient or Guardian's Signature: _____

Guardian's full name (if applicable) _____