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 Names: .....
Date of Birth:..... Sex:.....

RHC100.16
Preadmission Patient

DO NOT WRITE IN THIS BINDING MARGIN

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:..... (If unsure leave blank)
Item Numbers (if known): .....
Is admission due to an injury? ☐ Yes ☐ No Date of injury: ..... / ..... / .....
How did the injury occur?: ☐ Work ☐ Car 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: ☐ Yes ☐ No
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 (Wk/Day).....(Home/AH).....(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? ☐ Yes ☐ No Allow SMS alert: ☐ Yes ☐ No
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 ..... / ..... / ..... Gender: ☐ Male ☐ Female
Marital Status: ☐ Single/Child ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed
Employment: ☐ Child (not at school) ☐ 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 name 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

MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ Yes ☐ No 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: .....
Telephone (Wk/Day).....(Home/AH).....(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 (Wk/Day).....(Home/AH).....(Mobile/Other) .....

PATIENT ADMISSION DETAILS
RHC001
Ver 3 - 05/14

Ramsay
Health Care

PATIENT ADMISSION DETAILS

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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 (Wk/Day)..... (Home/AH)..... (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? ☐ Yes ☐ No Safety Net No: .....

HEALTH INSURANCE DETAILS

Insurance Type: ☐ Private health fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ ADF ☐ 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

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

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

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

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

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

Third Party 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
☐ Charter of Healthcare Rights
☐ Privacy Policy

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

RHC001

DO NOT WRITE IN THIS BINDING MARGIN

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.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

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: ☐ Yes ☐ No	
3. Have you had Xrays or blood tests taken for this admission			When: Where:	
4. Have any other doctors been consulted recently eg. 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 YR	OPERATION	APPROX YR	NURSING NOTES

MEDICATIONS	NO	YES	If yes, please answer these questions		NURSING NOTES
9. 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? Date to be ceased: Still take? Date to be ceased: Still take? Date to be ceased:	☐ No ☐ Yes ..... ☐ No ☐ Yes ..... ☐ No ☐ Yes	
10. Have you received advice from Specialist rooms regarding taking/ceasing medications prior to admission.			Details:		

***IMPORTANT:** Please either complete the medication table below or bring a profile OR list to hospital of all medications especially 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*

***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

Patient Completed C RHC100.11

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT HEALTH HISTORY – GENERAL RHC002

Ver 4 - 09/14

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.

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

PROSTHETICS / AIDS	NO	YES	If yes, please answer these questions	NURSING NOTES
18. 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*

DISCHARGE PLANNING	NO	YES	Please answer these questions	NURSING NOTES
19. Where do you plan to go after discharge				
20. 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	
21. Do you have escorted transport from hospital?			Name: Contact Number:	

ADVANCE HEALTH DIRECTIVE / POWER OF ATTORNEY	NO	YES	If yes, please answer these questions	NURSING NOTES
22. Do you have a current Advance Health Directive				
23. Do you have an enduring power of attorney - health & medical guardian			Name: Relationship: Phone:	

MEDICAL CONDITIONS

24. Do you have any Allergies (see examples below) ☐ **No** ☐ **Yes**
*If No, go to question **25**. 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 eg 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)	Please list details below	

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

DO NOT WRITE IN THIS BINDING MARGIN

RHC002 PATIENT HEALTH HISTORY – GENERAL

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.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

RHC100.11

Patient Completed C

DO NOT WRITE IN THIS BINDING MARGIN

MEDICAL CONDITIONS continued

25. Do you have/had any Cardiovascular problems (see examples below) ☐ **No** ☐ **Yes**
*If No, go to question **26**. If Yes, please tick the relevant conditions below.*

If yes please tick relevant conditions following	DETAILS	NURSING NOTES
☐ Elevated cholesterol, triglycerides		
☐ Blood pressure problems eg. low, high, 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.		Year: Model:
☐ Vascular disease eg. carotid disease, aortic aneurysm, peripheral vascular disease.		

26. Do you have/had Diabetes (see examples 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
☐ Type 1 diabetes	Controlled by: ☐ Diet ☐ Insulin ☐ Tablets	
☐ Type 2 diabetes		
☐ Gestational diabetes		
☐ Unsure		

27. Do you have/had any Gastroenterology or Urology problems (see examples 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
☐ Hiatus hernia, gastrointestinal ulcers, reflux		
☐ Liver disease, hepatitis (eg A, B, C), jaundice, cirrhosis		
☐ Bowel problems/habits, stoma or bowel disease eg Crohns, IBS		
☐ Kidney disease, dialysis, renal impairment		
☐ Bladder problems or habits, stoma, incontinence, urinary retention		☐ *Falls risk screen*

28. Do you have/had any Blood or Cancer problems (see examples 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
☐ 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 eg anaemia		

29. Do you have/had any Musculoskeletal conditions (see examples 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
☐ Arthritis eg rheumatoid arthritis, osteoarthritis		
☐ Back or neck injury or problems		

PATIENT HEALTH HISTORY – GENERAL RHC002

Ver 4 - 09/14

Ramsay
Health Care

PATIENT HEALTH HISTORY – GENERAL

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.
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MEDICAL CONDITIONS continued

30. Do you have/had any Neurology problems (see examples 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
☐ Neuromuscular diseases eg 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 eg coughing when eating / drinking		
☐ Difficulties with problem solving, attention span, understanding, post surgery confusion		
☐ Other neurological problems e.g. meningitis, migraine, polio, short term memory loss, dementia, Alzheimers		

31. Do you have/had any Breathing problems (see examples 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
☐ Asthma, pneumonia, hay fever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary disease (COPD)		
☐ Shortness of breath e.g. walking more than 50m, climbing stairs/inclines		
☐ Sleep apnoea, disturbed sleep, snoring		
☐ Use a CPAP machine	Please bring CPAP to hospital	
☐ Other lung problems eg tuberculosis		

32. Do you have/had any Other conditions (see examples 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
☐ Chronic pain		
☐ Depression, other mental illness		
☐ Lymphoedema		
☐ Thyroid problems, hypothyroidism, goitre		
☐ Any other medical conditions		

33. Are you susceptible to possible Infection Risk (see examples 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
☐ Ever had MRSA, VRE, CRE or ESBL		
☐ Any wounds/ breaks on your skin		
☐ Other conditions or infections		
☐ If you are being admitted in the next 7 days, have you: * travelled to a country with a health alert * travelled to areas of high prevalence for acute respiratory infections or acute respiratory illness * had a fever and/or respiratory symptoms, eg cough, sore throat, runny nose * had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness * had vomiting and diarrhoea		

RHC002 PATIENT HEALTH HISTORY – GENERAL

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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.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

RHC100.11

Patient Completed C

DO NOT WRITE IN THIS BINDING MARGIN

MEDICAL CONDITIONS continued

34. 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 questions following	DETAILS	NURSING NOTES
☐ I think I may have CJD		
☐ I have a first degree relative 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 cCJD 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.

Signature _____

Patient Name _____ Date _____
(please print)

PATIENT HEALTH HISTORY – GENERAL RHC002

Ver 4 - 09/14

Ramsay
Health Care

PATIENT HEALTH HISTORY – GENERAL

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NURSE USE ONLY

RISK SCREENING	NO	YES	Completed	Signature	*Refer to Facility Policy*
Fall risk screen required					*Refer to Facility Policy*
Infection risk screen required					*Refer to Facility Policy*
Pressure injury risk screen required					*Refer to Facility Policy*
Delirium/Dementia risk screen required					*Refer to Facility Policy*
Malnutrition risk screen required					*Refer to Facility Policy*

Confirmation that Patient history form reviewed by Preadmission Staff ☐ No ☐ Yes			*Refer to Facility Policy*
Name of Preadmission nurse:	Signature:	Date:	
Designation:		Time:	
Confirmation that Patient history form reviewed by Admitting Nurse ☐ No ☐ Yes			*Refer to Facility Policy*
Name of admitting nurse:	Signature:	Date:	
Designation:		Time:	
Confirmation that Patient history form reviewed by DSU / Ward Staff ☐ No ☐ Yes			*Refer to Facility Policy*
Name of DSU / Ward nurse:	Signature:	Date:	
Designation:		Time:	

CLINICAL / PRE-ADMISSION NOTES

DO NOT WRITE IN THIS BINDING MARGIN