PATIENT ADMISSION FORM SECTION B

your **upcoming admission** at Burnside Hospital

Your Patient Admission Form

PLEASE COMPLETE AND RETURN YOUR ADMISSION FORM TO THE BURNSIDE HOSPITAL LOCATION WHERE YOU WILL BE ADMITTED AS SOON AS POSSIBLE.

To ensure a smooth admission process at Burnside Hospital, please complete and return this section of your patient admission form as soon as possible.

- Fill out this section using a **black** or **blue** pen.
- Return it to either **Toorak Gardens** or **Stepney** at least **one week before your admission**.
- If mailing, allow extra time for postal delays.
- If mailing won't reach us in time, scan and email all pages of this booklet to admissions@burnsidehospital.asn.au.

Please ensure your form is sent to the correct location where you will be admitted.
If you're unsure of your admission site, please check with your specialist.

Toorak Gardens

Reply Paid 64813
Admissions Office
Burnside Hospital - Toorak Gardens
120 Kensington Road
Toorak Gardens, SA 5065

Please allow for any postal delays
and note that a stamp is not required.

Stepney

Admissions Office
Burnside Hospital - Stepney
32 Payneham Road
Stepney, SA 5069

Please allow for any postal delays.

Sleep Centre Patients:

- All sleep centre admission forms should be sent to the Burnside Hospital Toorak Gardens site, noting the address details listed above.
- If mailing your admission form won't reach us in time, scan and email all pages of this booklet to sleepadmin@burnsidehospital.asn.au no less than one week before your admission. Alternatively, please scan and fax them through to our team on (08) 8331 7152.
- Any patient queries regarding an upcoming sleep study or sleep centre admission should be directed to (08) 8202 7272 during business hours (9am to 5pm), Monday to Friday.

Did you know our patient admission form is available online?
Simply scan the QR code to begin your electronic admission.

Your Consent. Your Rights & Responsibilities.

At Burnside Hospital, we are dedicated to providing you with exceptional care in a safe, respectful, and compassionate environment. Your patient admission is the first step in ensuring your care journey is smooth and tailored to your individual needs.

As part of this process, it's important for you to be informed of your rights and responsibilities. Your rights safeguard your access to high-quality care, protect your privacy, and ensure you are actively involved in decisions about your treatment. At the same time, your responsibilities help us maintain a safe and effective environment, allowing our healthcare team to deliver the best possible care to you and other patients.

By completing and returning this admission form, you acknowledge your understanding of these rights and responsibilities, which are integral to a successful and safe care experience.

If you have any questions or need assistance with completing this form, please do not hesitate to contact our admissions team on (08) 8202 7222.

Account Responsibility

Medicare does not cover any private hospital charges. Private health insurance will cover some or all of the private hospital charges, depending on your level of cover. Any health fund excess or gap, including that applying to basic cover, must be paid no later than the day prior to your admission. Any other amounts not covered by your health fund but payable by you must be paid upon discharge. Please check your cover and any excess payable with your fund.

It is vital that maternity patients have family cover before the birth of their baby, unless advised otherwise by your health fund. Family cover is required if your baby is required to be admitted to the nursery or is transferred to another hospital. In this event, the baby becomes a patient in their own right and in most cases, your health fund will charge an excess for your baby's care, unless otherwise advised. Any payments associated with maternity admission must be paid within 6 weeks of receiving your letter from the hospital. If you are self-insured, or have singles cover with a fund that does not recognise the newborn's status, then the charges associated with admission to the nursery are your responsibility and must be paid at the time of discharge.

If you do not have private health insurance, or an accepted Workers Compensation or Third-Party Claim, then we will provide an estimate of the total cost of your hospitalisation. If you are uninsured, the estimated total fees must be paid prior to admission. Any shortfall between the estimated and actual fees for your hospitalisation must be paid on discharge.

Acknowledgment of Payment Terms
(to be completed by patient or parent / guardian if the patient is a minor or otherwise impaired).

I,

(Name in full)

of,

(Address in full)

I am aware of the fees chargeable for this hospitalisation and understand the payment conditions. I also accept personal responsibility of the hospital's account.

Signature: Date: / /

If signed on behalf of the patient, please provide the following information:

Patient's Full Name: Relationship to Patient:

Office use only

RECEPTION			PREADMITTED		
Date received:	Processed by:	Time: AM/PM	Date received:	MRN:	Initials:
CLINICAL SIGN OFF		**ADMISSIONS ASSISTANT**			
Date received:	Initials:	Date received:	Sighted on adm. Yes ☐ No ☐	Theatre list consent: Yes ☐ No ☐	Initials:
MEDICAL RECORDS		**PREADMISSION NURSE**		**OTHER**	
Form bought forward: Yes ☐ No ☐	Initials:	Date:	Initials:		

Patient Admission Information.

My Upcoming Admission at Burnside Hospital.

Please complete this form in BLOCK LETTERS in either a black or blue pen.

This Hospital Visit

Elective ☐ Emergency ☐ Inpatient ☐ Short Stay ☐ (Day Surgery) Boarding Parent ☐ (of child 12 years and under) Sleep ☐

Day Oncology / Chemo ☐ Transfer from Public Hospital ☐ Maternity ☐ Other ☐

Please select your Hospital for admission:
If you are unsure of the Hospital location for admission, please check with your Surgeon.

Toorak Gardens ☐
120 Kensington Road
Toorak Gardens

Stepney ☐
32 Payneham Road
Stepney

Admission Date:

Procedure Date:

Reason for Admission:
(if caused by injury, please detail cause and place)

Preferred room type*: Private ☐ Shared ☐ No Preference ☐
* Whilst every effort will be made to accommodate the room type you have requested, this may not always be possible.

My Specialists Details

Admitting Doctor's Surname:

Admitting Doctor's First Name:

Previous Hospital Visits

Have you previously been a patient at Burnside Hospital? Yes ☐ No ☐

Have you been in any hospital within the past 28 days of your admission date? Yes ☐ No ☐

If you answered yes above, please provide the following: Name of Hospital:

Admission Date:

Discharge Date:

Is this latest admission related to the previous one? Yes ☐ No ☐

My Personal Details

Is the person completing this form the patient? Yes ☐ No, I am the patient's carer ☐

Patients Title:

Patients First Name:

Patients Middle Name:

Patients Surname:

Patients Preferred Name:

Patients Date of Birth:

Have you ever changed your name? No ☐ Yes ☐

Previous name(s):
Please state any previous name(s) including married or maiden name(s)

Patient sex (recorded at birth): Male ☐ Female ☐

Patient gender identity: Male/Man ☐ Female/Woman ☐ Non binary
Different Identity (please specify): ☐ Prefer not to answer ☐

Language spoken at home: English ☐ Another Language: (please specify) ☐

My Address & Contact Details

Building Name and/or Unit Number: Street Number: Street Name:

Suburb: State: Do you live overseas? No ☐ Yes ☐

Home Phone: Work Phone: Mobile Phone:

Preferred contact number: Home ☐ Work ☐ Mobile ☐

Email address:

Is your postal address the same as your residential address? No ☐ Yes ☐

If you answered no above, please include your postal address below:

Building Name and/or Unit Number: Street Number: Street Name:

Suburb: State: Do you live overseas? No ☐ Yes ☐

About Me

What is your country of birth?

Do you identify as Aboriginal or Torres Strait Islander? No ☐ Yes ☐ **If yes, please specify:** Aboriginal ☐ Torres Strait Islander ☐ Both ☐

Marital Status: Divorced ☐ Widowed ☐ Married / Defacto ☐ Separated / Single ☐ Not Specified ☐ Other Term ☐

Occupation: Religion:

My Healthcare Team

GP Full Name:

Practice / Clinic Name: Phone No:

GP Practice Address Details:

Street Number: Street Name: Suburb:

Postcode: State: Do you give us permission to upload your admission information to your My Health Record? No ☐ Yes ☐

Is this your regular GP? Yes: ☐ No: ☐

My Next of Kin

First Name: Surname:

Relationship to patient: Partner ☐ Carer ☐ Family ☐ Friend ☐
Parent ☐ Guardian ☐ Another term:

Same as patient address? No ☐ Yes ☐

If you answered no above, please include address below:

Building Name and/or Unit Number: Street Number: Street Name:

Suburb: State: Do they live overseas? No ☐ Yes ☐

Home Phone: Work Phone: Mobile Phone:

Email address:

Is this person your emergency contact / person to notify? No ☐ Yes ☐

My Emergency Contact

First Name: Surname:

Relationship to patient: Partner ☐ Carer ☐ Family ☐ Friend ☐
Parent ☐ Guardian ☐ Other:

Same as patient address? No ☐ Yes ☐

If you answered no above, please include address below:

Building Name and/or Unit Number: Street Number: Street Name:

Suburb: State: Do they live overseas? No ☐ Yes ☐

Home Phone: Work Phone: Mobile Phone:

Email address:

My Admission Payment

Who is paying for this admission? Private Health ☐ Uninsured ☐ Dept. of Veteran Affairs ☐

Work Cover ☐ Defence Force ☐ Public Patient ☐ Third Party or Motor Vehicle ☐

Clinical Trial ☐ Another party: (please specify)

This account is the responsibility of the patient.
Medicare does not cover any costs associated with private hospital care. Depending on your level of private health insurance, your health fund may cover some or all of your hospital expenses.

If your policy includes an excess or gap payment–including those applicable to basic cover - this must be paid no later than the day before your admission. Any additional costs not covered by your health fund will need to be settled upon discharge.

We strongly recommend checking with your health fund to confirm your level of cover and any out-of-pocket expenses you may be responsible for.

Please sign below to acknowledge that you have read and accept the above terms:

Signature: Date:

My Medicare Details

Medicare card number: ☐☐☐☐☐☐☐☐☐☐

Medicare ID No: Number to the left of patient's name on card ☐

Expiry Month & Year: ☐☐ / 2 0 ☐☐

I do not have a Medicare card ☐

Concessions & Entitlements

Other card type:	Pension card	☐	Health Care card	☐	Seniors card ☐
Other card number:			Other card expiry:		
PBS Safety Net type:	Safety Net Entitlement	☐	Safety Net Concession	☐	
PBS Safety Net card number:			If you have a current Prescription Record Form, please bring this with you to the Hospital as you may be eligible for benefits under the Medicare Safety Net Scheme.		

My Private Health Fund

Name of health fund:		Membership Number: Please ensure you detail your member number, not your health fund card number	
Card position number: Number to the left of patients name		Relationship of contributor to patient:	
Contributors title:	Given name(s):	Surname:	
Contributors preferred contact number:		Email address:	
Have you been in this fund / table for over 12 months?		No ☐	Yes ☐
Patients with less than 12 months membership in their fund / table may not be eligible for benefits. Please contact your health fund to validate cover charge for this.			
Have you transferred from another health fund?	No ☐ Yes ☐	If you answered yes, please include the name of your previous fund:	
Who will be responsible for the payment of any out of pocket expenses?		Self ☐ Other ☐	Next of kin ☐ Emergency contact ☐
Title:	Given name(s):	Surname:	
Contact number:		Email address:	

Worker's Compensation / Third Party Claims

Complete only if there is a claim for worker's compensation or third party.

Please tick appropriate box:	Worker's Compensation ☐		Third Party Claim ☐
Date of accident:	Claim number:		
Work Cover insurer:			
Work Cover insurer's address:		State:	Postcode:
Employer's name:		Phone:	
Employer's address:		State:	Postcode:

If the admission relates to Public Liability, please contact our Accounts staff on (08) 8202 7222 to discuss payment. Please note that if responsibility is not accepted through compensation, the patient is personally liable for payment.

My Ambulance Cover

Do you have ambulance cover?	☐	No ☐	Yes
Is your ambulance cover included in your private health insurance?	☐	No ☐	Yes
Name of cover provider (if different to private health fund):			
Member Number:			
Do you consent to being transported via ambulance if required?	☐	No ☐	Yes

National Private Hospital Claim Declaration (HC21)

The HC21 is a standardised form allowing your health fund to reassign your insurance benefits to the health provider who is providing the service. If you are not being admitted under a private health fund for this admission, the HC21 is still included in the event that there are changes to your insurance status prior to admission.

Do you have an entitlement to claim compensation or damages (including previous settlements?	No ☐	Yes ☐
Have you lodged a claim for compensation or damages?	No ☐	Yes ☐
Did the injury or condition occur at work, going to or from work, or as a result of being at work?	No ☐	Yes ☐
Did the hospitalisation result from a motor vehicle accident?	No ☐	Yes ☐
Did the hospitalisation occur from any other type of accident?	No ☐	Yes ☐
Does the patient have an entitlement to free treatment under Australian Veteran's legislation?	No ☐	Yes ☐
I understand that the financial implications of my hospital charges will be explained prior to my admission at Burnside Hospital.	No ☐	Yes ☐
Is the patient a full-time student dependant over 17 years and under 25 years?	No ☐	Yes ☐
If you answered yes, please include the name of educational institution:		

Date patient was first aware of symptoms:	Date patient first consulted doctor for symptoms:

Declaration

- I hereby declare and warrant that all of the above information provided in connection with this claim is true and correct.
- I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including the Critical Care Certificate, Day Only Certificate and Hospital Casemix Protocol Information as required by the Federal Government, to Medicare and/or the private health fund of which I am a member for the purpose of providing private health insurance in accordance with the fund's privacy policy.
- I authorise the health fund of which I am a member to pay benefits directly to the hospital and I agree to pay all private and shared room gaps relating to my level of private health insurance and other out of pocket expenses directly to the hospital.
- I assign my right to Medicare and private health insurance benefits directly to Burnside Hospital in respect of each professional service rendered in hospital for the treatment of the medical condition for which I was or will be admitted on the admission date specified above.
- I authorise Medicare and the private health insurance fund of which I am a member to contact the treating / referring practitioner if clarification of details on an account / receipt is required for assessment purposes.

I acknowledge / authorise the above declaration concerning my claim. No ☐ Yes ☐

My Legal & Care Directives

Do you have an Advanced Care Directive?		No ☐	Yes ☐	If yes, a copy of this document is required	
Have you appointed an Enduring Guardian?		No ☐	Yes ☐	If yes, a copy of this document is required	
First name:		Surname:			
Home phone:	Work phone:		Mobile phone:		
Email address:					
Have you appointed a Power of Attorney?		No ☐	Yes ☐	If yes, a copy of this document is required	
First name:		Surname:			
Home phone:	Work phone:		Mobile phone:		
Email address:					
Is there a Guardianship Order relating to you?		No ☐	Yes ☐	If yes, a copy of this document is required	

Health Assessment. Medical / Surgical History.

Please tick the appropriate box and complete this form in block letters.

Preadmission Tests & Info

			Staff Use Only Initial Actions
Have you had any blood tests or other swabs for this admission?	No ☐	Yes ☐	
If you answered yes, which pathology company did the test?			
Have you had any x-rays, scans or ultrasounds for this admission?	No ☐	Yes ☐	Films present
If you answered yes, where are the copies?	With me ☐	Doctor ☐	
Please bring your x-rays and / or scans with you on admission if you have them in your possession			
Are you pregnant, or is there a possibility that you are pregnant?	No ☐ N/A ☐	Yes ☐	
If you answered yes, when is your due date? / /			

Mandatory, please complete:

Height: ..... cm Weight: ..... kg BMI: .....

The Hospital can assist you to calculate if necessary

Allergies

Please document any known allergies, intolerances, reactions (including anaphylactic reactions or sensitivities e.g. medications, tape, latex / rubber, food, antiseptic, fragrances and/or other.			Staff Use Only Initial Actions
Have you had a bad reaction / allergy to any medication?	No ☐	Yes ☐	
Do you have any allergies, reactions or sensitivities?	No ☐	Yes ☐	
Are you allergic to latex?	No ☐	Yes ☐	
Are you allergic to adhesive tape?	No ☐	Yes ☐	
Please enter all allergy details below:			

Allergy	Type e.g. drug, food etc.	Reaction

Medication Summary

Are you taking any of these medications: Ozempic, Saxenda, Trulicity, Byetta, Mounjaro, Forxiga, Qtern, Jardiance, Glyxambi, Jardiamet, Xigduo XR, Steglatro, Segluromet, Steglujan, Wegovy and Invokana?		No ☐	Yes ☐
If you answered yes, please specify:			
Is your admitting doctor aware that you are taking this medication?		No ☐	Yes ☐
Have you been asked to cease use?	No ☐ Yes ☐	Date last taken:	
Are you on any medications to thin your blood e.g. Warfarin, asprin based medications?		No ☐	Yes ☐
If you answered yes, please specify:			
Is your admitting doctor aware that you are taking this medication?		No ☐	Yes ☐
Have you been asked to cease use?	No ☐ Yes ☐	Date last taken:	

Have you taken any steroids or cortisone tablets or injections in the last 6 months?	No ☐	Yes ☐
If you answered yes, please specify:		
Is your admitting doctor aware?	No ☐	Yes ☐
Have you been asked to cease use? No ☐ Yes ☐ Date last taken:		
Have you received any advice from your Doctor regarding taking / ceasing any other medication?	No ☐	Yes ☐
If you answered yes, please specify:		
Date last taken (or to be taken):		
Are you taking any medications or non-prescription medications, including tablets, capsules, puffers, nebulisers, patches, insulin, eye drops, vitamins, minerals, herbal remedies and infusions (including vitamin infusions)? Include in your answer any medications you have previously mentioned, as well as the dose and how often you take each medication.	No ☐	Yes ☐
Do you require assistance taking medications? i.e. dosette, crushed, webster packs?	No ☐	Yes ☐
If you answered yes, please specify:		

Please list all medications and treatments that you currently take and attach a list if you require extra space. Include those medications which you may have ceased already in preparation for your surgery, including vitamins, natural therapies and any over the counter medications.

Please check with your admitting doctor about when to cease all medications including vitamin and natural therapies prior to surgery / chemotherapy, as some natural therapies e.g. fish oil, St John's wort, weight loss products may interact with other medications and may also have an adverse effect on your post operative recovery (i.e. increased risk of bleeding).

Please bring with you all of your current medications in their original labelled boxes (**not a webster pack / dosette**).

Current Medications

Prescribed medication(s)	Dose	Frequency	Reason for taking	Duration

Current Medications Cont.

Non-prescribed medication(s)	Dose	Frequency	Reason for taking	Duration

Medical Contacts

Please list all other professionals involved in your care, for example Cardiologist, Psychiatrist etc.

Name	Specialty	Practice Name	Date of last review

Lifestyle

What is your smoking status?	Past smoker ☐	Smoker ☐	Non-smoker ☐
Daily amount?	Date ceased:		
Do you use an e-cigarette or vape?		No ☐	Yes ☐
Do you drink alcohol?		No ☐	Yes ☐
If you answered yes, how many days a week do you drink?			
How many standard drinks per day (on the days you drink)?			
Do you use recreational drugs (other than alcohol and tobacco)?		No ☐	Yes ☐
If you answered yes, please list drugs and frequency of use:			

Diet & Nutrition

Staff Use Only
Initial Actions

Assessment:
Scores of 2+
Generate Med Alert.
Consider referral to Dietician

Have you lost weight recently without trying?				No ☐	Yes ☐		
If yes, please specify:	1-5kg =1 ☐	6-10kg =2 ☐	11-15kg =3 ☐	>15kg =4 ☐			
Have you been eating poorly due to decreased appetite?				No =0 ☐	Yes =1 ☐		
Do you have any special dietary needs?							
If you have a food allergy, e.g. gluten, dairy products, or nuts, please enter this in the allergy section							
If yes, please specify:	Vegetarian ☐	Vegan ☐	Pureed ☐	Liquid ☐			
Gluten Free ☐	Dairy Free ☐	Soft Diet ☐	Religious (specify) ☐				
Other: (please detail)							
Do you require assistance with meals / eating?				No ☐	Yes ☐		
If yes, please specify:	Help eating ☐	Food cut ☐	Packets opened ☐	Special Utensils ☐			
Do you have an alternative way of receiving nutrition e.g. peg?				No ☐	Yes ☐		
If yes, please specify:							

Anaesthetic

			Staff Use Only Initial Actions
Have you or your family had problems with an anaesthetic or with surgery before? If yes, please specify:	No ☐ Self ☐	Yes ☐ Family ☐	If yes, notify anaesthetist
If yes, please detail:			
Have you had an anaesthetic in the last five (5) years (including at the dentist)? If yes, please specify when:	No ☐	Yes ☐	
Do you have any questions or concerns about your anaesthetic?	No ☐	Yes ☐	
If yes, please detail:			
Have you or a blood relative ever had malignant hyperthermia? If yes, please specify:	No ☐ Self ☐	Yes ☐ Family ☐	If yes, notify anaesthetist
If yes, please provide detail (where, when):			

Pain Management

				Staff Use Only Initial Actions
Do you have difficulty with pain management?		No ☐	Yes ☐	
Do you have chronic pain?		No ☐	Yes ☐	
Do you see a pain physician?	No ☐ Yes ☐	Name of physician:		
Do you go to a pain clinic?	No ☐ Yes ☐	Name of clinic:		
Have you been referred to palliative care?	No ☐ Yes ☐	Date referred: / /		
		Name of palliative care specialist:		

Infection Screening & Risk

				Staff Use Only Initial Actions
Do you currently have any symptoms of an acute illness or flu like symptoms e.g. vomiting, diarrhoea, fever, cough, sore throat, body aches, runny nose, rash?		No ☐	Yes ☐	
If yes, please detail:				
Have you recently been tested for COVID-19?		No ☐	Yes ☐	
If yes, when were you tested: / /				
Result:	Negative ☐ Positive ☐		Result pending ☐	
Have you been in an overseas hospital within the last 12 months?		No ☐	Yes ☐	
Have you ever had an infection with a Multi Resistant Organism?		No ☐	Yes ☐	
Multi / methicillin resistant staphylococcus aureus (MRSA)		No ☐	Yes ☐	
Vancomycin resistant enterococci (VRE)		No ☐	Yes ☐	
Date identified: / / Please detail site of infection:				
Have you had an infection after any surgery?		No ☐	Yes ☐	
Have you previously been identified or colonised with Carbapenem-resistant Enterobacteriaceae (CRE/CPE)?		No ☐	Yes ☐	
Have you been prescribed Vancomycin for a long period of time?		No ☐	Yes ☐	
Do you have two or more first or second-degree relatives with Creutzfeldt Jakob Disease (CJD)?		No ☐	Yes ☐	
Do you have an unexplained neurological illness of less than 12 months duration?		No ☐	Yes ☐	
Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)?		No ☐	Yes ☐ Year:	
Have you previously had surgery on the brain or spinal cord that include a dura mater graft (prior to 1990)?		No ☐	Yes ☐	
If you answered yes, what was the name of your surgeon:			Year:	
Have you been involved in a 'look back' for CJD or been shown a 'medical in confidence' letter regarding your risk for CJD?		No ☐	Yes ☐	

Heart & Circulatory Health

			Staff Use Only Initial Actions
Have you ever suffered from chest pain / angina?	No ☐	Yes ☐	
If yes, please specify: Chest pain ☐ Angina ☐			
Have you ever had a heart attack?	No ☐	Yes ☐	
If yes, please detail date(s):			
Do you suffer from high blood pressure / hypertension?	No ☐	Yes ☐	
Do you suffer from low blood pressure?	No ☐	Yes ☐	
Do you suffer from elevated cholesterol / triglycerides?	No ☐	Yes ☐	
Do you see a cardiologist?	No ☐	Yes ☐	
If yes, please detail the name of your cardiologist:			
Do you suffer from palpitations/ irregular heartbeat / heart murmur or AF (Atrial Fibrillation)?	No ☐	Yes ☐ If yes, please specify:	
Have you ever had rheumatic fever?	No ☐	Yes ☐ Year:	
Have you ever had congestive cardiac failure?	No ☐	Yes ☐	
Have you ever had cardiac surgery e.g. pacemaker, implants or devices, prosthetic heart valve, grafts or stents?	No ☐	Yes ☐	Notify anaesthetist if implantable defib
If yes, please specify details including year of procedure(s) and model of device(s):			
Do you have vascular disease e.g. carotid disease, aortic aneurysm, peripheral vascular disease?	No ☐	Yes ☐	
If yes, please specify:			

Respiratory & Sleep

			Staff Use Only Initial Actions
Do you have or have you ever had a lung condition or any obstructive breathing disease e.g. asthma, pneumonia, bronchitis, emphysema, lung cancer or COAD or COPD?	No ☐	Yes ☐	
If yes, please specify:			
Do you use: Oral steroids ☐ Nebulisers ☐ Inhalers ☐			
Are you receiving home oxygen treatment	No ☐	Yes ☐	
Do you experience shortness of breath with daily activities e.g. walking more than 50m, climbing stairs or inclines?	No ☐	Yes ☐	
If yes, please specify:			
Do you suffer from any other lung problems e.g. tuberculosis?	No ☐	Yes ☐	
If yes, please specify:			
Do you snore loudly or have you ever suffered from interrupted breathing or been diagnosed with sleep apnoea?	No ☐	Yes ☐	
If yes, please specify:			
Do you use, or have you used a CPAP machine or any other breathing device? If yes, please bring your machine with you on admission	No ☐	Yes ☐	
Do you have difficulties sleeping or suffer from any other sleep disorders?	No ☐	Yes ☐	
If yes, please specify:			

Blood History & Disorders

			Staff Use Only Initial Actions
Have you ever been diagnosed with anaemia?	No ☐	Yes ☐	
If yes, are you currently receiving treatment for this condition?	No ☐	Yes ☐	
Do you have or have you ever had any blood disorders or conditions such as Haemophillia?	No ☐	Yes ☐	
If yes, please detail the name of your condition:			
Have you ever had a blood clot in your legs or lungs (i.e. DVT or PE)	No ☐	Yes ☐	
If yes, please specify:			
Have you ever had a transfusion of blood or blood related products such as plasma or platelets?	No ☐	Yes ☐	
If yes, transfusion type			
Did you experience any reaction(s)?	No ☐	Yes ☐	
Please specify reaction type (if any):	Date last given: / /		
Have you ever had an iron infusion?	No ☐	Yes ☐	
Did you experience any reaction(s)?	No ☐	Yes ☐	
Please specify reaction type (if any):	Date last given: / /		
If recommended by your doctor, would you be willing to have a blood transfusion?	No ☐	Yes ☐	

Mental Health

Do you have any of the following mental health conditions / illnesses?					Staff Use Only Initial Actions
Anxiety	No ☐	Yes ☐	Depression	No ☐ Yes ☐	
PTSD	No ☐	Yes ☐	Psychosis	No ☐ Yes ☐	
Bipolar	No ☐	Yes ☐	ADHD	No ☐ Yes ☐	
Substance Abuse	No ☐	Yes ☐	Other (please detail):		
Are you under the care of a psychiatrist or psychotherapist?				No ☐ Yes ☐	
If yes, please specify:		Name of practitioner:			
		Date of last review: / /			

Neurological Health

Do you suffer from any of the following neurological conditions?					Staff Use Only Initial Actions
Mini Strokes / TIA	No ☐	Yes ☐	Stroke	No ☐ Yes ☐	
If you answered yes to any of the above, please provide details including type of residual weakness (if any):					
Multiple Sclerosis	No ☐	Yes ☐	Motor Neurone	No ☐ Yes ☐	
Parkinsons	No ☐	Yes ☐	Another condition (please detail):		
Do you / have you experienced any unexplained fainting or dizzy spells?				No ☐ Yes ☐	
Dizziness/ fainting from Meniere's, Vertigo or other?				No ☐ Yes ☐	
If yes, please specify:					
Do you suffer from epilepsy, fits or seizures?				No ☐ Yes ☐	
Date of last seizure: / /					
Do you have difficulties with problem solving, attention span, understanding, short term memory loss, dementia, Alzheimer's?				No ☐ Yes ☐	
If yes, please specify:					

Neurological Health Cont.

			Staff Use Only Initial Actions
Do you have speech / swallowing difficulties?	No ☐	Yes ☐	
If yes, please specify:			
Do you have any infection or inflammation of the brain or nervous system such as meningitis?	No ☐	Yes ☐	
If yes, please specify:			
Do you suffer from delirium following surgery?	No ☐	Yes ☐	
Do you have an intellectual disability?	No ☐	Yes ☐	
Do you suffer from falls or peripheral neuropathy?	No ☐	Yes ☐	
Do you suffer from any other neurological condition?	No ☐	Yes ☐	
If yes, please specify:			
Do you have a shunt?	No	Yes	

Bone & Joint Health

Do you suffer from any of the following bone or joint conditions:						Staff Use Only Initial Actions
Arthritis	No ☐	Yes ☐	Please specify:			
Osteoperosis / low bone density	No ☐	Yes ☐	Please specify:			
Limited neck movement	No ☐	Yes ☐	Please specify:			
Significant back or neck injury	No ☐	Yes ☐	Please specify:			
Back, neck or jaw problems	No ☐	Yes ☐	Please specify:			
Hip, knee or shoulder replacements	No ☐	Yes ☐	Left Hip ☐	Right Hip ☐		
			Left Knee ☐	Right Knee ☐		
			Left Shoulder ☐	Right Shoulder ☐		
Metal plates or pins	No ☐	Yes ☐	Please specify:			
Do you have mobility issues as a result of your condition?	No ☐	Yes ☐	Please specify:			

Gastrointestinal Health

Do you suffer from any of the following gastrointestinal illnesses or conditions:						Staff Use Only Initial Actions
Reflux / stomach ulcer	No ☐	Yes ☐	Please specify:			
Hiatus hernia	No ☐	Yes ☐	Please specify:			
Constipation	No ☐	Yes ☐	Please specify:			
Any bowel conditions such as Chron's disease, Ulcerative Colitis, Diverticulitis or IBS	No ☐	Yes ☐	Please specify:			
Colostomy or ileostomy	No ☐	Yes ☐	Please specify:			
Do you have fistulas or stomas?	No ☐	Yes ☐	Please specify:			
Have you had weight loss surgery?	No ☐	Yes ☐	Surgery type:	Gastric banding ☐		
				Gastric balloon ☐		
Procedure date: / /	Is the band deflated?		No ☐ Yes ☐	Gastric sleeve ☐		
Any other gastrointestinal problems?	No ☐	Yes ☐	Please specify:			
Have you ever had liver problems or liver disease e.g. jaundice, hepatitis, cirrhosis?	No ☐	Yes ☐	Please specify:			

Kidney & Bladder Health

										Staff Use Only Initial Actions
Do you have any of the following kidney or bladder illnesses or conditions:										
Kidney disease	No ☐	Yes ☐	Please specify:							
Renal failure	No ☐	Yes ☐	Please specify:							
Nephrectomy	No ☐	Yes ☐								
Incontinence	No ☐	Yes ☐	Bladder ☐	Bowel ☐						
Urostomy	No ☐	Yes ☐								
Catheter in place	No ☐	Yes ☐								
Prostate problems	No ☐	Yes ☐								
Bladder problems	No ☐	Yes ☐	Frequency ☐	Nocturia ☐	Neobladder ☐	Cancer ☐				
			Urinary Tract Infection (UTI) ☐	Retention ☐	Pad use ☐					
Are you receiving dialysis?	No ☐	Yes ☐	Last treatment: / /							
			Next treatment: / /							
Do you have a dialysis fitsula?	No ☐	Yes ☐	Please detail:							

General Health

										Staff Use Only Initial Actions
Skin Health										
Do you have any skin problems							No ☐	Yes ☐		
Where are they located:			Skin problems:				Cuts ☐	Frail skin ☐		
							Sores ☐	Psoriasis ☐		
							Wounds ☐	Eczema ☐		
							Tears ☐			
Do you have or have you ever had any skin injuries or pressure injuries?							No ☐	Yes ☐		
Type:			Location:				Size:			
Dental Health										
Do you have any of the following:										
Dentures							No ☐	Yes ☐		
Limited jaw movement							No ☐	Yes ☐		
Caps							No ☐	Yes ☐		
Crowns							No ☐	Yes ☐		
Loose or broken teeth							No ☐	Yes ☐		
Braces and / or wires							No ☐	Yes ☐		
Additional dental problems and/or implants?							No ☐	Yes ☐		
If yes, please specify:										
Aids, Impairments and Mobility										
Do you have any impairment of vision (including glasses or contact lenses?							No ☐	Yes ☐		
Visual aids / impairments: (please select)										
Glasses ☐	Contact lenses ☐		Sight impaired ☐		Eye prosthesis ☐					
Glaucoma ☐	Eye lens ☐		Anther impairment: (please specify)							
Do you have impairment of hearing?							No ☐	Yes ☐		
Hearing aids:	Left ☐	Right ☐	Cochlear implant ☐							
Have you had a fall in the last 12 months or do you fear falling or feel unsteady on your feet?							No ☐	Yes ☐		
Please specify if you have had repeated falls and/or were injured:										

General Health Cont.

Aids, Impairments and Mobility Cont.					Staff Use Only Initial Actions
Do you have impairment of mobility?			No ☐	Yes ☐	
Mobility aids: Wheelchair ☐	Crutches ☐		Other:		
Do you use a walking aid?			No ☐	Yes ☐	
If yes, please specify:					
Any other aids?			No ☐	Yes ☐	
If yes, please specify:					

Other Significant Medical History

Cancer History				Staff Use Only Initial Actions
Have you, or do you currently have cancer?			No ☐ Yes ☐	
If yes, date of initial diagnosis: / /				
Type and site of cancer:				
Please specify treatment:	Surgery ☐	Chemotherapy ☐	Immunotherapy ☐	
	Radiotherapy ☐	Bone strengthening ☐	No treatment ☐	
	Other: (please detail)			
Date of last treatment: / /		Specialist(s) name:		
Access type:	PICC line ☐	Portacath ☐	POC line ☐	
	Hickman's Catheter ☐			
Is your cancer treatment current or complete?		Current ☐	Complete ☐	
Are you currently involved in a clinical trial?		No ☐	Yes ☐	
If yes, what?		Trialing for:		

General History				
Do you suffer from lymphoedema?			No ☐ Yes ☐	
If yes, please specify:				
Do you have any transplant(s)?			No ☐ Yes ☐	
If yes, please specify:				
Have you seen a physician recently?			No ☐ Yes ☐	
If yes, please detail physicians name and specialty:				

Other general health information or detail we may need to be aware of ahead of your admission at Burnside Hospital:

Please detail below and attach a separate piece of paper if required

Surgical History

	Staff Use Only Initial Actions
Have you had surgery previously? No ☐ Yes ☐	
If yes, please list any operations you had had, including the year that you had them below.	

Surgery type	Doctors name (not essential)	Year	Hospital

Getting You Home Again. Discharge Planning.

Please tick the appropriate box and complete this form in block letters.

							Staff Use Only Initial Actions
Do you need help with any of the following activities:							
Getting in or out of bed / chair	No ☐	Yes ☐	Showering	No ☐	Yes ☐		
Toileting	No ☐	Yes ☐	Cleaning	No ☐	Yes ☐		
Taking medications	No ☐	Yes ☐	Shopping	No ☐	Yes ☐		
Transport (e.g. to appointments)	No ☐	Yes ☐	Meal preparation	No ☐	Yes ☐		
Do you live alone?				No ☐	Yes ☐		
Do you have any caring responsibilities for others?				No ☐	Yes ☐		
Please provide details:							
Are they being cared for while you are in hospital?				No ☐	Yes ☐		
Have you been assessed by ACAT (Aged Care Assessment Team)?				No ☐	Yes ☐		
Level of care:	Date of assessment: / /						
ACAT Number:	MAC Number:						
Do you currently require assistance with daily activities?				No ☐	Yes ☐		
Please check all appropriate:	Spouse / family support ☐		Domestic duties ☐				
	Community meal services ☐		Home nursing service ☐				
	Personal care (e.g. showering) ☐		Respite / care program ☐				
	Community care (e.g. shopping) ☐						
Further details / other assistance / service provider details: (if applicable)							
Have you been referred to palliative care?				No ☐	Yes ☐		
If yes, where and when:							
Do you have any concerns regarding how you will manage at home after your discharge from hospital?				No ☐	Yes ☐		
If yes, please provide details:							
Would you like to discuss your needs before your hospital admission?				No ☐	Yes ☐		

							Staff Use Only Initial Actions
Home Environment							
Are you expecting to return to your current residential address following discharge?					No ☐	Yes ☐	
Do you live in residential aged care? (e.g. nursing home, hostel)					No ☐	Yes ☐	
Do you have stairs / steps at your home?					No ☐	Yes ☐	
Do you have any of the following fittings or equipment in your home:							
Bath ☐	Shower over bath ☐	Shower recess ☐					
Shower or bath rails ☐	Toilet rails ☐	Seat over toilet ☐					
Can you walk independently?					No ☐	Yes ☐	
Do you / will you require the assistance of an aid to walk?					No ☐	Yes ☐	
If yes, please specify:	Walking frame ☐	Walking stick ☐					
	Crutches ☐	Another aid: (please detail)					
Your Discharge from Hospital							
Who will take you home on discharge **(before 10am*)**?		* Sleep patients, discharge is strictly before 7.30am					
Name:	Contact Number:						
Do you have someone at home to be of assistance when you are discharged?					No ☐	Yes ☐	
Short Stay Procedure (Day) Patients: Have you arranged for a responsible adult to stay with you overnight?					No ☐	Yes ☐	
Will you require a medical certificate?					No ☐	Yes ☐	

Confirmation of Discharge Requirements

Patient Acknowledgment and Consent	I agree	Initial
I understand that Burnside Hospital has a strict 10am patient discharge time.	☐	
I acknowledge that I am responsible for making the necessary arrangements in preparation for my discharge from Burnside Hospital and accept full responsibility for coordinating my transport, ongoing care, and any additional support I may require after leaving the hospital.	☐	
Short Stay (Day) Surgery Patients Only: I confirm that I have arranged for a responsible adult to accompany me home upon discharge and stay overnight with me as I am a same day surgery patient.	☐	

Declaration

I declare that I have completed and understood the details included in this Patient Admission Form and that the information provided is true and correct to the best of my knowledge.

Patient full name:

Patient signature: Date: / /

If signed on behalf of the patient:

Full name: Relationship to patient:

Signature: Date: / /

Understanding Your Fees

At Burnside Hospital, we are committed to providing transparency around medical costs so that you can make informed decisions about your care.

Doctor's Fees and Out-of-Pocket Costs

Before your admission, your treating doctor(s) should discuss their professional fees with you. For all treatments and procedures, we recommend that this information be provided in writing to ensure clarity and informed decision-making. If you have any questions regarding your doctor's fees, gap payments, or out-of-pocket expenses, we encourage you to contact their office directly.

If fee information is not proactively provided, you have the right to request it before proceeding with treatment. You can ask your doctor or their office staff for a breakdown of expected costs. In emergency situations (e.g., an emergency caesarean birth), treatment will always take priority, and fee details will be provided at the time of care or as soon as possible afterward.

Please note that any fees charged by your doctor are independent of the hospital's admission fees. These are billed in accordance with your doctor's fee schedule and must be paid directly to your doctor. Burnside Hospital does not set, manage, or accept responsibility for these charges.

Hospital Fees and Payment Responsibilities

Patients are responsible for the payment of their hospital account. Medicare does not cover private hospital charges but does contribute towards medical specialist fees. Invoices for specialist services, such as surgeons and anaesthetists, are separate from your hospital account.

- **Private Health Insurance** – If you are a private health fund member, Burnside Hospital staff will submit your claim on your behalf. Your private health insurance may cover some or all of the hospital charges, depending on your level of cover. Any excess or gap payment, including those applicable to "Basic Cover" policies, must be paid prior to or upon arrival. Upon discharge, you are required to pay any outstanding balance between the hospital account and the health fund benefit.
- **Self-Funded Patients** – If you do not have private health insurance, an approved Worker's Compensation claim, or a Third-Party Claim, our Accounts staff will provide an estimate of the total cost of your hospitalisation. This estimated amount must be paid before admission. Any shortfall between the estimated and actual costs must be paid on discharge. Please note that personal cheques are not accepted, and payments can be made via credit card or direct debit.

Additional Medical Fees

During your stay at Burnside Hospital, additional medical costs may apply beyond your hospital admission fees. These may include:

- **Specialist Fees** – Charges from surgeons, surgical assistants, anaesthetists, paediatricians and other medical specialists involved in your care / treatment.
- **Diagnostic Services** – Pathology tests (e.g., blood or tissue samples) and diagnostic imaging (e.g., X-rays), which are billed separately by third-party providers.
- **Medications** – Any medications dispensed during your hospital stay or upon discharge, which may incur separate pharmacy costs.

Obstetric Patients

All newborns at Burnside Hospital are automatically referred to a Paediatrician by your Obstetrician.

Whether your baby is admitted to the nursery or remains with you, they must be under the care of a Paediatrician, and associated medical fees will apply. These fees are billed separately by the Paediatrician.

Additionally, any tests or procedures ordered by the Paediatrician, including pathology, diagnostic imaging, or other investigative tests may incur additional costs. For more information regarding these fees, we recommend discussing them directly with your Paediatrician during your post-birth consultation.

Your Right to Fee Information

We encourage all patients to be proactive in understanding their medical costs. If you have any concerns about specific charges, please speak with your treating doctor, their office staff, or the relevant third-party provider to ensure you are fully informed.

If you need further assistance, our Burnside Hospital accounts team is available on (08) 8202 7222 during business hours, Monday to Friday to help guide you through the process.

Patient Acknowledgment and Consent	I agree
I acknowledge that I have read and understood the information provided regarding medical fees, hospital charges, and payment responsibilities at Burnside Hospital.	☐
I understand that Medicare does not cover private hospital charges, and specialist fees are billed separately from my hospital account.	☐
I understand that if I have private health insurance, I am responsible for any excess or gap payments not covered by my policy.	☐
I understand that if I am a self-funded patient, I must pay the estimated cost of my hospitalisation before admission and settle any outstanding balance upon discharge.	☐
I acknowledge and accept that additional fees may apply for specialist services, diagnostic tests, and medications, which may be billed separately by third-party providers.	☐
In emergency situations, I understand and accept that treatment will be prioritised, and fee information will be provided at the time, or as soon as possible.	☐
I accept responsibility for ensuring payment of all applicable fees and understand that Burnside Hospital does not manage or accept responsibility for charges billed by third-party providers or my treating doctors.	☐
Obstetric patients only: I understand that my newborn will automatically referred to a Paediatrician, and any fees related to their care will apply.	☐

Signature: Date: / /

Informed Consent & Your Rights

By seeking treatment at Burnside Hospital, you provide general agreement for medical care related to your condition. However, certain procedures such as surgery, anaesthesia, and specific diagnostic tests require your written consent before proceeding.

You have the right to receive a clear and understandable explanation of any proposed procedure or operation. Your doctor should discuss the risks, possible complications, and expected outcomes in a way that you fully comprehend.

Before signing a consent form, ensure you understand the nature of the procedure, what it involves, and any associated fees and charges.

You are entitled to:

- **Information about your condition** – including the proposed treatment, alternative options, and expected outcomes.
- **Refuse treatment** – including surgery or any medical procedure, if you choose.
- **Seek a second opinion** – discuss this option with your doctor if desired.
- **Know your healthcare team** – you may ask for the name and professional status of any person involved in your care and their role in your treatment.

If you have an Enduring Power of Attorney (Medical Treatment) or an Advanced Directive, please bring a copy with you to the hospital. This document will be included in your medical record to ensure all caregivers are aware of your healthcare preferences.

Patient Acknowledgment and Consent	I agree
I acknowledge that I have read and understood the information provided regarding my rights, informed consent, and medical treatment at Burnside Hospital.	☐
I understand that I have the right to receive clear explanations about my condition, proposed treatments, and alternative options.	☐
I understand that I may refuse any treatment or procedure if I choose.	☐
I understand that I have the right to seek a second opinion regarding my treatment.	☐
I understand that I may request information about the healthcare professionals involved in my care.	☐

Signature: Date: / /

Privacy Consent

Burnside Hospital is committed to providing individuals with the highest standards of health care and service. This includes respecting and upholding their rights to privacy protection in compliance with the Privacy Amendment (Enhancing Privacy Protection) Act 2012, Australian Privacy Principles (APPs) which amends the Privacy Act 1988.

At Burnside Hospital we collect personal information from patients so that we can provide appropriate treatment and care, and for administrative purposes. This may include name, date of birth, next of kin, address, telephone number(s), occupation, religion, health information (which may sometimes be provided by others associated with their health care), treating specialist and general doctor practitioner/referring doctor.

We also hold transaction details associated with services we have provided, and any other information given to us, including through patient surveys.

Personal information is used or disclosed by Burnside Hospital to enable us to:

- Provide optimal medical treatment and care in conjunction with the patient's health care team.
- Help individuals with their enquiries and administer the services we provide.
- Deal with private health funds/insurers concerning the treatment of patients.
- Share information with Medical Practitioners, Registered Nurses / Midwives service providers such as pathologists and radiographers, and allied health professionals who provide necessary follow-up treatment and ongoing care.
- Participate in quality assurance, accreditation and audit programs.
- Benchmark and report patient care data to hospital committees.
- Meet Statutory/State Government reporting requirements.
- Render accounts and collect payment from patients and service providers.
- Notify relevant Disease Registers.
- Advise Debt recovery agencies.
- Inform future health care providers.

Individuals may request access to personal information held by Burnside Hospital, and ask us to supplement or correct information they believe is incorrect, incomplete or inaccurate. These requests must be made in writing. We may charge a fee to cover the cost of searching for and providing access to information we hold. In circumstances in which access is restricted, the reasons for denying access will be explained.

Individuals can request that their health information held by us, be made available to another health service provider.

Burnside Hospital will not disclose personal information about patients to any person except on a confidential basis to agents used in the ordinary operation of our business, such as for data processing, printing or mailing.

To view the Burnside Hospital Privacy Statement, please visit our website: burnsidehospital.asn.au/privacy

Patient Acknowledgment and Consent	I agree
I consent to Burnside Hospital collecting personal information about me, including information about my health and health services provided, or to be provided to me. I understand that the purpose of collecting this information is to enable Burnside Hospital and other healthcare teams to provide appropriate treatment and care, and also for administrative purposes.	☐
I acknowledge that I have read and understood the Burnside Hospital Privacy Statement.	☐
I understand that Burnside Hospital's Personal Information Management (Privacy) Policy is also available at hospital reception.	☐

Signature: Date: / /

Marketing & Fundraising

In compliance with Australian Privacy Principles and the Privacy Act 1988 (as amended), we require your prior consent to use your personal information for marketing and fundraising purposes. You are not obliged to provide such consent.

By signing below, you acknowledge and consent to Burnside Hospital using the information it holds about you to send you information about the hospital's services and facilities and the activities of the Burnside Hospital Foundation either via email or mail.

Signature: Date: / /

Thank you for taking the time to complete your patient admission form. We appreciate your effort in providing the necessary details to help us prepare for your stay.

Now that the hard work is done, we kindly request that you please:

- Return it to either **Toorak Gardens** or **Stepney** at least **one week before your admission**.
- If mailing, allow extra time for postal delays.
- If mailing won't reach us in time, scan and email all pages of this booklet to admissions@burnsidehospital.asn.au
- **Please ensure your form is sent to the correct location where you will be admitted.** If you're unsure of your admission site, please check with your specialist.

Toorak Gardens

Reply Paid 64813
Admissions Office
Burnside Hospital - Toorak Gardens
120 Kensington Road,
Toorak Gardens, SA 5065

Please note that a stamp is not required.

Stepney

Admissions Office
Burnside Hospital - Stepney
32 Payneham Road
Stepney, SA 5069

Sleep Centre Patients

- All sleep centre admission forms should be provided to the **Burnside Hospital Toorak Gardens** site, noting the address details listed above. If mailing, please allow extra time for postal delays.
- If able, scan and email all pages of this booklet to sleepadmin@burnsidehospital.asn.au at least **one week before your admission**. Alternatively, please scan and fax them through to our team on (08) 8331 7152.
- Any patient queries regarding an upcoming sleep centre admission should be directed to (08) 8202 7272 during business hours, Monday to Friday.

BURNSIDE
HOSPITAL

Exceptional care, always.

120 Kensington Road, Toorak Gardens SA 5065
32 Payneham Road, Stepney SA 5069
(08) 8202 7222 | burnsidehospital.asn.au