BURNSIDE HOSPITAL

SECTION B:

Please complete this centre booklet and return to Burnside Hospital.

Forms for you to complete and return to the Burnside Hospital Prior to Admission

Please fill out this section as best you can, use **black** or **blue** pen and return to the Hospital
At least one week before admission (please allow for postal delays).
If you are unable to post this form to reach us in time, please email all relevant pages to:
admissions@burnsidehospital.asn.au

Please address the envelope
(no stamp required)

REPLY PAID 64813
ADMISSIONS OFFICE
BURNSIDE WAR MEMORIAL HOSPITAL
120 KENSINGTON ROAD
TOORAK GARDENS SA 5065

For Sleep Centre patients

If you are unable to post this form to reach us in time, please fax all relevant pages to Fax No. **8331 7152**
OR email to: sleepadmin@burnsidehospital.asn.au (at least one week prior to admission)
For queries patients should contact the Sleep Centre reception on **8202 7272** during business hours.

Please address the envelope
(no stamp required)

REPLY PAID 64813
ADMISSIONS OFFICE
BURNSIDE WAR MEMORIAL HOSPITAL
120 KENSINGTON ROAD
TOORAK GARDENS SA 5065

Patient Admission Form

This section will provide Burnside Hospital with your general contact and payment information.

Your Health Assessment

It is important that we have this information before your pre-admission call.
This information provides the doctors and nurses / midwives caring for you with an overview of your general health to enable us to provide you with the safest and best possible care and to help us organise any tests/instructions you may require on, or prior to admission.

Please complete the forms in this section as best you are able.

If you have any queries, contact your General Practitioner, admitting specialist or the Hospital on **8202 7222** during business hours.

Please attach your GP Health Summary if available.

ACCOUNT RESPONSIBILITY: *The account is the responsibility of the patient.*

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 your 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 his/her 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 a maternity admission must be paid within 7 days 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 Worker's Compensation or Third Party Claim, then we will provide an estimate of the total cost of your hospitalisation. **If you are uninsured, the estimated fees must be paid prior to admission. Any shortfall between the estimated and actual fees for your hospitalisation must be paid on discharge.**

CERTIFICATE (*to be completed by patient or parent (guardian) if patient is a minor or otherwise impaired*)

I, ...
(Name in full)

Of, ...
(Address in full)

certify to the best of my knowledge and belief the particulars set out in this form are correct. I am aware of the fees chargeable for the above-mentioned patient's hospitalisation and understand the payment conditions.

I ACCEPT PERSONAL RESPONSIBILITY FOR THE PAYMENT OF THE HOSPITAL'S ACCOUNT.

Date: / / Signature: .....

Privacy Consent

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 the Burnside Hospital Privacy Statement (Pages A:8 - A:10). I have read and understood the information in the Privacy Statement.

I understand that Burnside Hospital's Personal Information Management (Privacy) Policy is also available at hospital reception.

Date: / / Signature: .....

I have completed the Health Assessment and understood the details included in this guide. I confirm that I have arranged for a responsible adult to accompany me home upon discharge and to stay overnight with me if I am a same day surgery patient.

Date: / / Signature: .....

Marketing and Fundraising

In compliance with the *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.

I consent to Burnside Hospital using the information it holds about me to send me information about the:

Hospital's services and facilities: ❑ Yes ❑ No

Activities of the Burnside Hospital Foundation ❑ Yes ❑ No

Date: / / Signature: .....

In the interests of good health, we are a non-smoking hospital

For office use only: Date Rec'd: Processed by: Time: MRN:

PATIENT ADMISSION INFORMATION

Personal Details: - *Please complete this form in BLOCK LETTERS*

ELECTIVE ☐ EMERGENCY ☐ INPATIENT ☐ SHORT STAY PATIENT ☐ (Day Surgery) BOARDING PARENT ☐ (of child aged 12 years & under)

Admission Date: Arrival Time: am/pm

Reason for Admission:
(if the reason for admission is caused by an injury, please state its cause and the place of its occurrence)

Title: Gender:

Surname: Former Surname: *(if applicable)*

Given Name(s): Preferred Name:

What are your Personal Pronouns:

At birth, you were recorded as: Male ☐ Female ☐ Another Term ☐

Address:

State: Post Code:

Phone: *(Home)* Phone: *(Bus)* Mobile:

(Email)

Date of Birth: Age: Religion: *(Optional)*

Country of Birth: Occupation:

Ethnicity: Caucasian ☐ Asian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other

(Required by Department of Health for Statistical Purposes only)

Emergency Contact:

(Full Name)

Address:

State: Post Code:

Phone: *(Home)* Phone: *(Bus)* Mobile:

Other Contact Person: *(Full Name)*

Phone: *(Home)* Phone: *(Bus)* Mobile:

General Practitioner's Name: Phone:

Address: State: Post Code:

Admitting Doctor/Specialist's Name:

continued on next page...

PATIENT ADMISSION INFORMATION *(Continued)*

Have you been a patient in any hospital within the last 7 days?: No ☐ Yes ☐

Name of Hospital: Admitted: Discharged:

Have you previously been admitted to Burnside Hospital?: No ☐ Yes ☐ If "YES", when?

HOSPITAL INSURANCE DETAILS: Fund Name:

Membership No.: Table:

Contributor Name: *(Please Print)*

Length of Membership: Over 12 Months ☐ Less than 12 months ☐

Medicare No.: Number before Patient's name on card: Valid to: _ _ / _ _ _ _

DVA Member No.: S Card Colour: Safety Net No.:

Health Care Card No.: Expiry Date:

Pensioner Concession Card No.: Expiry Date: SA Ambulance Member No.:

COMPLETE ONLY IF THERE IS A CLAIM FOR WORKER'S COMPENSATION OR THIRD PARTY

(Please ✔ appropriate box): Worker's Compensation ☐ Third party ☐

Date of Accident: Claim No:

Work Cover Insurer:

Work Cover Insurer's Address:

Employer's Name:

Address:

State: Post Code:

Solicitor acting on behalf of Patient: *(Name)* Ph:

Address: State: Post Code:

If the admission relates to Public Liability, please contact our Accounts Staff on 8202 7201 to discuss payment.
Please note that if responsibility is not accepted through compensation, the patient is personally liable for payment

My Health Record: Opted in ☐ Opted out ☐

Health Assessment – Part 1 Medical / Surgical History

Please complete this form in BLOCK LETTERS

Medical / Surgical History

Tick the appropriate box.	**Further details**	**Staff Use Only: Initial actions**
Are you sensitive or allergic to: medicines, foods, tapes, metals, latex / rubber, antiseptics, other? ☐ No ☐ Yes	If yes, please list and describe reaction:	Record on alert sheet. Notify ward / OT of latex allergy
Have blood tests or other pathology tests been taken for this admission? ☐ No ☐ Yes	When: Where:	
Have X-rays / CT scan / MRI / Ultrasound been taken for this admission?(please bring your x-rays or scans with you) ☐ No ☐ Yes	If yes, they are ☐ With the surgeon ☐ With me	Films present
Are you pregnant or is there a possibility that you could be pregnant? ☐ N/A ☐ No ☐ Yes	Due date: / /	

*** Mandatory. Please Complete** *** Height:** cm *** Weight:** kg **BMI:**

Medications – 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.

Please note - some natural therapies eg 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).

Do you take or have your recently taken blood thinning medicines i.e. Aspirin (Astrix, Cartia, Aspro, Disprin etc), Warfarin (Coumadin, Marevan), Clopidogrel (Plavix, Iscover), or arthritis medication? ☐ No ☐ Yes	Name of medicine(s): Have you been asked to cease: ☐ No ☐ Yes Date last taken: / / Time last taken: / /	VMO notified if applicable
Have you taken any steroids or cortisone tablets or injections in the last 6 months? ☐ No ☐ Yes	Name of medicine: Date last taken: / / Time last taken: / /	VMO notified if applicable

Current Medications **Please list ALL Medications**

Medication	**Dose**	**How often taken**	**Reason for taking**	**Taken for how long?**

Continued over page

Health Assessment – Part 1 Medical / Surgical History *(Continued)*

Please complete this form in BLOCK LETTERS

Current Medications (continued)				
Medication	**Dose**	**How often taken**	**Reason for taking**	**Taken for how long?**
Non prescribed medications	**Dose**	**How often taken**	**Reason for taking**	**Taken for how long?**

Medical Contacts *Please list other professionals involved in your care, for example (Cardiologist, Psychiatrist)*

Name	**Specialty**	**Telephone number**	**Address**	**Date of last review**

Your Medical / Surgical History

Tick the appropriate box.	**Further details**	**Staff Use Only: Initial actions**
Have you or your family had any problems with an anaesthetic or surgery before? ☐ No ☐ Yes	If yes, please describe:	If yes, notify Anaesthetist
Have you had an anaesthetic in the last 5 years (including at the dentist)? ☐ No ☐ Yes	When:	
Do you have any questions or concerns about your anaesthetic? ☐ No ☐ Yes		
Have you ever smoked? ☐ No ☐ Yes Do you currently smoke? ☐ No ☐ Yes	How many per day: Date stopped: How many per day:	
Do you drink alcohol? ☐ No ☐ Yes	How often per week? How many units per day?	
Do you use recreational drugs (other than alcohol or tobacco)? ☐ No ☐ Yes	Type: Date of last use: Quantity / Frequency:	
Do you or have you had difficulty with pain management? ☐ No ☐ Yes	Specify:	
Do you have braces, capped, broken or loose teeth/dentures? ☐ No ☐ Yes	Specify:	Dentures brought into hospital
Do you have any of the following respiratory / sleep problems ...		
Asthma ☐ No ☐ Yes		
Cough ☐ No ☐ Yes		
Wheeze ☐ No ☐ Yes		
Bronchitis ☐ No ☐ Yes		
Emphysema ☐ No ☐ Yes		
COPD ☐ No ☐ Yes		
Pneumonia ☐ No ☐ Yes		
Hayfever ☐ No ☐ Yes		
Tuberculosis ☐ No ☐ Yes		
Shortness of breath ☐ No ☐ Yes		
Sleep problems ☐ No ☐ Yes		
Sleep apnoea /snoring / interrupted breathing ☐ No ☐ Yes		
Narcolepsy ☐ No ☐ Yes		
Do you use a CPAP /breathing device? Please ensure that you bring your machine (cleaned prior to admission) with you. ☐ No ☐ Yes		

Continued over page

Your Medical / Surgical History (continued)

Tick the appropriate box.			**Further details**	**Staff Use Only: Initial actions**
Do you have any of the following heart or circulatory conditions ...			Name of Cardiologist: Date of last consult:	
Heart attack	☐ No	☐ Yes		
Angina	☐ No	☐ Yes		
Chest pain	☐ No	☐ Yes		
Bypass	☐ No	☐ Yes		
Heart murmur	☐ No	☐ Yes		
Irregular heart beat	☐ No	☐ Yes		
High blood pressure	☐ No	☐ Yes		
Low blood pressure	☐ No	☐ Yes		
Elevated cholesterol / tryglcerides	☐ No	☐ Yes		
Family history of heart disease	☐ No	☐ Yes		
Rheumatic fever	☐ No	☐ Yes		
Congestive cardiac failure	☐ No	☐ Yes		
Coronary artery bypass	☐ No	☐ Yes		
Angiogram	☐ No	☐ Yes	Date:	
Coronary / vascular stent	☐ No	☐ Yes	Date:	
Artificial valve	☐ No	☐ Yes		
Blood clots	☐ No	☐ Yes	☐ legs ☐ lungs	
Pacemaker	☐ No	☐ Yes		
Valve replacement	☐ No	☐ Yes		
Implantable defibrillator manufacturer:	☐ No	☐ Yes		Notify Anaesthetic if implantable defibrillator
Do you have any of the following diabetes or endocrine conditions ...			Managed by: ☐ Diet ☐ Tablets ☐ Insulin	
Type 1 Diabetes	☐ No	☐ Yes		
Type 2 Diabetes	☐ No	☐ Yes		
Thyroid problems	☐ No	☐ Yes		
Do you have any of the following mental health problems or illnesses ...			Are you under the care of a Psychiatrist or Psychologist: ☐ No ☐ Yes If yes, name: date of last review:	
Depression	☐ No	☐ Yes		
PTSD	☐ No	☐ Yes		
Psychosis	☐ No	☐ Yes		
Anxiety	☐ No	☐ Yes		
Bipolar	☐ No	☐ Yes		
Substance abuse	☐ No	☐ Yes	Details:	
ADHD	☐ No	☐ Yes		
Other	☐ No	☐ Yes		

Your Medical / Surgical History (continued)

Tick the appropriate box.			**Further details**	**Staff Use Only: Initial actions**
Do you have any of the following neurological conditions ...			Date: Date of last seizure:	
Epilepsy	☐ No	☐ Yes		
Mini strokes / TIA	☐ No	☐ Yes		
Stroke	☐ No	☐ Yes		
Parkinsons	☐ No	☐ Yes		
Huntingtons	☐ No	☐ Yes		
Motor Neurone Disease	☐ No	☐ Yes		
Multiple Sclerosis	☐ No	☐ Yes		
Brain Injury	☐ No	☐ Yes		
Spinal injury	☐ No	☐ Yes		
Nerve stimulator implant	☐ No	☐ Yes		
Dementia	☐ No	☐ Yes		
Confusion	☐ No	☐ Yes		
Short term memory loss	☐ No	☐ Yes		
Delirium following surgery	☐ No	☐ Yes		
Fainting	☐ No	☐ Yes		
Dizzy spells	☐ No	☐ Yes		
Blackouts	☐ No	☐ Yes		
Intellectual disability	☐ No	☐ Yes		
Falls	☐ No	☐ Yes	If yes, please specify:	
Do you have any of the following kidney or bladder conditions ...				
Kidney disease	☐ No	☐ Yes		
Renal failure	☐ No	☐ Yes		
Nephrectomy (kidney removal)	☐ No	☐ Yes		
Bladder problems	☐ No	☐ Yes	details:	
Urostomy	☐ No	☐ Yes		
Catheter in situ	☐ No	☐ Yes		
Prostate problems	☐ No	☐ Yes		
On dialysis	☐ No	☐ Yes	last treatment: next treatment:	
Dialysis fistula	☐ No	☐ Yes		

Continued over page

Your Medical / Surgical History (continued)

Tick the appropriate box.			**Further details**	**Staff Use Only: Initial actions**
Do you have any of the following bone or joint conditions ...				
Arthritis	☐ No	☐ Yes		
Osteoporosis / low bone desity	☐ No	☐ Yes		
Limited neck movement	☐ No	☐ Yes		
Significant back or spinal injury	☐ No	☐ Yes	specify:	
Previous fractures	☐ No	☐ Yes	specify:	
Metal plate / pins	☐ No	☐ Yes	specify:	
Joint replacements	☐ No	☐ Yes	specify:	
Do you have any of the following gastrointestinal conditions ...				
Reflux	☐ No	☐ Yes		
Stomach ulcer	☐ No	☐ Yes		
Hiatus hernia	☐ No	☐ Yes		
Constipation	☐ No	☐ Yes		
Colostomy or / urostomy	☐ No	☐ Yes		
Gastric band	☐ No	☐ Yes	fluid (mls)	
Weight loss surgery	☐ No	☐ Yes	specify:	
Liver problems / disease	☐ No	☐ Yes		
Nausea / vomiting weightloss	☐ No	☐ Yes		
Swallowing difficulties	☐ No	☐ Yes		
Do you require assistance with eating	☐ No	☐ Yes	specify:	
Have you lost weight recently without trying? ☐ Yes (see below) ☐ No = 0 ☐ Unsure = 2 If yes to weight loss: ☐ 1-5kg = 1 ☐ 6-10kg = 2 ☐ 11-15kg = 3 ☐ >15kg = 4 Have you been eating poorly due to decreased appetite? ☐ Yes = 1 ☐ No = 0				Nutritional Assessment: score of **2** or more. Generate Med Alert & consider referral to Dietician
Special dietary requirements	☐ No	☐ Yes	If yes, please specify:	

Other Significant Medical History

Blood disorder / bleeding tendency or bruising	☐ No	☐ Yes		
Blood or tissue transfusion	☐ No	☐ Yes	If yes please provide details:	
Any form of cancer Did you have ... ☐ chemotherapy date: / / facility: ☐ radiatherapy date: / / facility:	☐ No	☐ Yes	If yes, site of cancer: Date diagnosed: / /	
Human organ or tissue transplant	☐ No	☐ Yes	If yes, name organ(s) or tissue(s):	

Your Medical / Surgical History (continued)

Tick the appropriate box.		**Further details**	**Staff Use Only: Initial actions**
Lymphoedema / Swelling	☐ No ☐ Yes	Where on body?	
Implantable Venous Access Devices (eg. Portacath, Infusaport, PICC Line)	☐ No ☐ Yes	Where on body?	
Do you have any difficulty with your vision?	☐ No ☐ Yes	☐ glasses ☐ contact lenses ☐ other	brought into hospital
Do you have any difficulty hearing?	☐ No ☐ Yes	☐ hearing aid ☐ lip reading ☐ other	
Have you had ...			
Fever, cold, cough or sore throat in the past 2 weeks	☐ No ☐ Yes		
Vomited in the past 2 weeks	☐ No ☐ Yes		
Diarrhea in the past week	☐ No ☐ Yes		
Flu like symptoms and recent overseas travel	☐ No ☐ Yes		
Any type of recent infection	☐ No ☐ Yes	When? Site of infection? Date of clearance: / /	
Have you been colonised/infected with any multi-resistant organisms, or superbugs *for example: Methicillin Resistant Staphyloccus Aureus (MRSA), Vancomycin Resistant Enterococci (VRE), Extended-Spectrum B-Lactamases (ESBL's).*	☐ No ☐ Yes	If yes, date of clearance: / /	

Creutzfeldt-Jakob Disease (CJD)

			Staff Use Only: Initial actions
Did you have spinal or brain surgery between 1972 and 1988?	☐ No	☐ Yes	If yes to any of these questions notify Infection Control Consultant immediately.
Have you ever received Human Pituitary Hormone (growth, gonadotrophin) prior to 1985?	☐ No	☐ Yes	
Is there anyone in your family that has had CJD?	☐ No	☐ Yes	
Have you had a dura mater graft prior to 1990?	☐ No	☐ Yes	
Have you suffered from a recent undiagnosed progressive dementia?	☐ No	☐ Yes	

Please list operations including the year that you had them.

Surgery	**Date**	**Health facility / hospital**	**Staff Use Only: Initial actions**

Other general health details	Staff Use Only: Initial actions

Your Medical History / Your Physical Health				Staff Use Only: Initial actions
Do you need help with the following activities? Please tick the appropriate box. **If you receive help please specify who helps (family, friend, carer, Community Nurse).**				
Getting in or out of bed or chair	☐ No	☐ Yes		
Dressing	☐ No	☐ Yes		
Showering	☐ No	☐ Yes		
Toileting	☐ No	☐ Yes		
Cleaning	☐ No	☐ Yes		
Shopping	☐ No	☐ Yes		
Taking medications	☐ No	☐ Yes		
Do you require mobility aides or assistance to walk?	☐ No	☐ Yes	Details:	
Have you suffered any falls recently?	☐ No	☐ Yes		
Planning your discharge? Please tick the appropriate box and add further information in the column on the right.				
Are you expecting to return to your current residential address following discharge?	☐ No	☐ Yes		
Do you live alone?	☐ No	☐ Yes		
Are you the primary carer of another adult or child?	☐ No	☐ Yes		
Do you live in residential aged care? *(eg. Nursing Home / Hostel)*	☐ No	☐ Yes	Name: Contact details:	
Do you have stairs / steps at your home?	☐ No	☐ Yes		
Who will take you home on discharge by or at 10am? *(Sleep Patients by 7:30 am)*				
Do you have someone to be of assistance to you 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	Name of escort: Telephone number:	
Do you currently use any community services? *(eg. home nursing, home help, meals on wheels)*	☐ No	☐ Yes	Service provider: Contact details:	
Do you have a current Aged Care Assessment Team (ACAT) status?	☐ No	☐ Yes		
Do you have an Advanced Health Directive?	☐ No	☐ Yes	If yes, please bring it with you.	
Do you have an Enduring Power of Attorney for Health Matters?	☐ No	☐ Yes		
Is there a Guardianship Order relating to you?	☐ No	☐ Yes		

I have completed and understood the details included in this Patient Admission Guide.

Date: _____ Signature: _____