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 **as soon as possible** (*no less than two weeks*) prior to admission.
If you are unable to post this form to reach us in time, please fax all relevant pages to:
Fax No. 8202 7237 / 1800 679 707 OR **email 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: sleep-lung@burnsidehospital.asn.au (no less than two working days 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
PATIENT SERVICES DESK
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

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.

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

In 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 to provide appropriate treatment and care, and also for administrative purposes.
I acknowledge that I have received 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 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 Inc.	Yes	No

Date: / / Signature: .....

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 yrs & 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)

Mr/Mrs/Ms/Miss/Master/Other: Male: ☐ Female: ☐

Surname: Former Surname: *(if applicable)*

Given Names:

Address:

Phone:

State: Post Code:

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

(Email)

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

Country of Birth: Occupation:

Marital Status: Single ☐ Married / Defacto ☐ Widowed ☐ Separated ☐ Divorced ☐

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

(Required by Department of Health for Statistical Purposes only)

Next of Kin: Relationship:

(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:

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.

Maternity Service patients only

Please complete this form in BLOCK LETTERS

First Day of last menstrual period *(if known)*: / /20 Baby's Due Date: / /20

Early Pregnancy Class: Yes ☐ No ☐

Antenatal Education Sessions: Yes ☐ No ☐

1. First-time parents: All day Saturday ☐ OR 3 evening sessions ☐
2. Previous parenting experience: 1 evening session ☐
3. Breastfeeding class? Yes ☐ No ☐ Day/Evening (please circle)

Please indicate the sessions you wish to attend. Both partners are welcome to attend all sessions.

Health Assessment – Part 1 Medical / Surgical History

Please complete this form in BLOCK LETTERS

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

Medical / Surgical History

Please circle the relevant condition(s) and 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		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		Films present
Are you pregnant or is there a possibility that you could be pregnant? ☐ N/A ☐ No ☐ Yes		

Medications – Please list **ALL** medicines and treatments that you currently take and attach a list if you require extra space. Include those medicines which you may have ceased already in preparation for your surgery, including vitamins, natural therapies and any over the counter medicines. 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 medicines 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 medicines in their **original labelled container** (not in a dosette).

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: 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
Are you taking any non-prescription or natural/ complementary medicines? (fish oil, vitamins, minerals, herbal remedies) ☐ No ☐ Yes	If yes, list below with your current medicines.	VMO notified if applicable

Medication (list all medications here - If there is insufficient space please attach)	**Strength Frequency**	**Reason for taking?**	**Taking for how long?**

Medical / Surgical History

Please circle the relevant condition(s) and 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, 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		
Do you or have you ever smoked? ☐ No ☐ Yes	How many per day: If stopped, when:	
Do you drink alcohol? ☐ No ☐ Yes	How often? How much per day?	
Do you use recreational drugs (other than alcohol or tobacco)? ☐ No ☐ Yes	Type: Quantity / Frequency:	
Do you or have you had difficulty with pain management? ☐ No ☐ Yes		
Do you have braces, capped, broken or loose teeth? ☐ No ☐ Yes		
Do you have dentures? ☐ No ☐ Yes	☐ upper ☐ lower ☐ partial	Dentures brought into hospital
Asthma / cough / wheeze / emphysema / bronchitis / shortness of breath on exertion / hayfever / pneumonia / tuberculosis ☐ No ☐ Yes		
Sleep problems / sleep apnoea ☐ No ☐ Yes		
Do you use a CPAP machine or home Oxygen? *Please ensure that you* bring *your machine (cleaned prior to admission) with you.* ☐ No ☐ Yes		CPAP brought into hospital
Hypertension (high blood pressure) ☐ No ☐ Yes		
Heart problems: heart attack / angina / chest pain / stent / heart murmur / irregular heart beat / bypass surgery / valve replacement surgery / pacemaker / implantable defibrillator (manufacturer) ☐ No ☐ Yes		Notify Anaesthetic if implantable defibrillator
Family history of heart disease ☐ No ☐ Yes		
High cholesterol ☐ No ☐ Yes		
Diabetes – Type 1 ☐ No ☐ Yes – Type 2 ☐ No ☐ Yes	Managed by: ☐ Diet ☐ Tablets ☐ Insulin	
Thyroid problems ☐ No ☐ Yes		
Strokes / mini strokes / epilepsy / fits / seizures / Motor Neurone Disease / multiple sclerosis / migraines ☐ No ☐ Yes	Any residual weakness?	
Faints / blackouts / dizziness ☐ No ☐ Yes		
Significant neck or back injury ☐ No ☐ Yes		

Medical / Surgical History

Please circle the relevant condition(s) and tick the appropriate box.	**Further details**	**Staff Use Only: Initial actions**
Depression / PTSD / anxiety / psychosis / other emotional or psychological disorder ☐ No ☐ Yes	Are you under the care of a Psychiatrist? If yes, name:	
Dementia / short term memory loss / confusion ☐ No ☐ Yes		
Speech / swallowing or eating difficulties ☐ No ☐ Yes		
Special dietary requirements *(eg. diabetic, gluten free, lactose free)* ☐ No ☐ Yes		
Gastric Reflux / indigestion / heart burn / hiatus hernia / stomach ulcer ☐ No ☐ Yes		
Nausea / vomiting / loss of appetite ☐ No ☐ Yes		
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 refer to dietician
Gastric band / surgical weight loss procedure ☐ No ☐ Yes		if yes, Anaesthetist notified
Problems passing urine or using your bowels ☐ No ☐ Yes		
Liver disease / hepatitis / jaundice ☐ No ☐ Yes		
Kidney disorder ☐ No ☐ Yes		
Blood disorder / bleeding tendency or bruising ☐ No ☐ Yes		
Blood clots in legs or lungs ☐ No ☐ Yes		
Blood transfusion ☐ No ☐ Yes	If yes please provide details:	
Arthritis / Osteoporosis ☐ No ☐ Yes		
Any form of cancer ☐ No ☐ Yes		
Organ transplant ☐ No ☐ Yes	If yes, name organ(s):	
Skin conditions / wounds / ulcers / cuts / bruises / pressure areas *(ulcer, broken or reddened skin)* ☐ No ☐ Yes		
Lymphoedema ☐ No ☐ Yes		
Implantable Venous Access Devices (eg. Portacath, Infusaport, PICC Line) ☐ No ☐ Yes		
Any type of current or recent infection? ☐ No ☐ Yes		
Have you been colonised/infected with any multi-resistant organisms, *for example: Methicillin Resistant Staphyloccus Aureus (MRSA), Vancomycin Resistant Enterococci (VRE), Extended-Spectrum B-Lactamases (ESBL's).* ☐ No ☐ Yes		
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	brought into hospital
Please list any other conditions or operations including the year that you had them. *(Please attach a list if required)*		

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