Patient Admission Form

BURNSIDE HOSPITAL

Please complete this booklet and return to Burnside Hospital Stepney 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: stepneyadmissions@burnsidehospital.asn.au

Please address the envelope:

Admissions Office
Burnside Hospital Stepney
32 Payneham Road
Stepney SA 5069

Your Health Assessment

This section will provide Burnside Hospital with your general contact and payment information. It is important that we have this information before your pre-admission call. This information provides the doctors and nurses 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 **08 8130 1100** during business hours. Please attach your GP Health Summary if available.

Office use only

Admin

Date rec:	Processed by:	Time:
MRN:	Preadmitted:	

Admissions

Date rec:	Signature:	Sighted on adm: ☐ Yes ☐ No
Preadmission appt: ☐ Yes ☐ No	Consent on theatre list: ☐ Yes ☐ No	Initials:

Medical records

Form bought fwd: ☐ Yes ☐ No	Staff initial:	Patient initial:

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.

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 and understood the Burnside Hospital 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:

Patient Admission Information

Please complete this form in **BLOCK LETTERS**

☐ Elective

☐ Emergency

☐ Inpatient

☐ Short Stay Patient (Day Surgery)

☐ Boarding Parent (or child aged 12 years and 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 pronouns:

At birth, you were recorded as:

Male ☐ Female ☐ Another term ☐

Address:

State: Postcode:

Phone (home):

Phone (business):

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: Postcode:

Phone (home):

Phone (business):

Mobile:

Other contact person (full name):

Phone (home):

Phone (business):

Mobile:

General Practitioner's name:

Phone:

Address:

State: Postcode:

Admitting Doctor/Specialist's name:

Have you been a patient in any hospital within the last 7 days?

- ☐ Yes
- ☐ No

Name of Hospital:

Date Admitted:

Date Discharged:

Have you previously been admitted to Burnside Hospital?

- ☐ Yes
- ☐ No

If 'yes' when?

Hospital Insurance Details

Fund name:

Membership No:

Contributor name:

Length of membership:

- ☐ over 12 months
- ☐ less than 12 months

Medicare No:

Number before patient's name on card:

Valid to: / /

DVA Member No:

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:

- ☐ Worker's compensation
- ☐ Third party

Date of Accident:

Claim No:

Work cover insurer:

Work cover insurer's address:

Employer's Name:

Address:

State: Postcode:

Solicitor acting on behalf of patient (name):

Phone:

Address:

State: Postcode:

If the admission relates to Public Liability, please contact our Accounts Staff on 08 8130 1100 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**

			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?	☐ No ☐ Yes	Due Date:	
* Mandatory. Please Complete:	Height:	Weight:	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 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(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?

Non prescribed medications

Medication	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	Phone Number	Address	Date of last review

Medical / Surgical History (continued)

			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		
Do you have any questions or concerns about your anaesthetic?	☐ No ☐ Yes		
Have you ever smoked?	☐ No ☐ Yes	How many per day: Date stopped:	
Do you currently smoke?	☐ No ☐ Yes	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

Medical / Surgical History (continued)

Staff Use Only:
Initial actions

Do you have any of the following heart or circulatory conditions?

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	
Coronary / vascular stent	☐ No	☐ Yes	
Artificial valve	☐ No	☐ Yes	
Blood clots	☐ No	☐ Yes	
Pacemaker	☐ No	☐ Yes	
Valve replacement	☐ No	☐ Yes	
Implantable defibrillator Manufacturer:	☐ No	☐ Yes	Notify Anaesthetic if implantable defibrillator

Name of Cardiologist: Date of last consult:

Do you have any of the following diabetes or endocrine conditions?

Type 1 Diabetes	☐ No	☐ Yes	Managed by: ☐ Diet ☐ Tablets ☐ Insulin
Type 2 Diabetes	☐ No	☐ Yes	Managed by: ☐ Diet ☐ Tablets ☐ Insulin
Thyroid problems	☐ No	☐ Yes	Managed by: ☐ Diet ☐ Tablets ☐ Insulin

Do you have any of the following mental health problems or illnesses?

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	

Are you under the care of a Psychiatrist or Psychologist:	☐ No	☐ Yes If yes, name: Date of last review:

Do you have any of the following neurological conditions?

Epilepsy	☐ No	☐ Yes Date of last seizure:
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

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?	☐ No = 0	☐ Yes = 1
Special dietary requirements	☐ No	☐ Yes Specify:

Nutritional Assessment: score of 2 or more. Generate Med Alert & consider referral to Dietician.

Other Significant Medical History

Blood disorder / bleeding tendency or bruising	☐ No	☐ Yes
Blood or tissue transfusion	☐ No	☐ Yes Details:
Any form of cancer	☐ No	☐ Yes Site of cancer: Date diagnosed:
Did you have chemotherapy?	☐ No	☐ Yes Date: Facility:
Did you have radiotherapy?	☐ No	☐ Yes Date: Facility:
Human organ or tissue transplant	☐ No	☐ Yes Name organ(s) or tissue(s):

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	Brought into hospital
Have you had a fever, cold, cough or sore throat in the past 2 weeks?	☐ No	☐ Yes	
Have you vomited in the past 2 weeks?	☐ No	☐ Yes	
Have you had 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 Specify: Date of clearance:	
Creutzfeldt-Jakob Disease (CJD)			
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	
Have you ever received Human Pituitary Hormone (growth, gonadotrophin) prior to 1985?	☐ No	☐ Yes	

Operations

(Please list operations including the year that you had them)

Surgery	Date	Health facility/hospital

Other general health details

Staff Use Only:
Initial actions

Your medical history / your physical health

Do you have any of the following neurological conditions?
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?	☐ No	☐ Yes Details:
Have you suffered any falls recently?	☐ No	☐ Yes

Planning your discharge?

Are you expecting to return to your current residential address following discharge?	☐ 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?		
Do you have someone to assist 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: Phone number:
Do you currently use any community services? (eg. home nursing, home help, meals on wheels)	☐ No	☐ Yes Service provider: Contact detials:
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: