Day Surgery Admission Forms

Admission Date: ____________________________

Admission Time: ____________________________

Fasting Time: ____________________________

Please return the COMPLETED ADMISSION FORMS AT LEAST 5 DAYS PRIOR TO ADMISSION. (If posting – at least 10 days prior)
North Eastern Community Hospital

North Eastern Community Hospital
580 Lower North East Road
Corner of Lower North East Road and
Heading Ave
CAMPBELLTOWN SA 5074
Before Your Admission

Please return the COMPLETED ADMISSION FORMS AT LEAST 5 DAYS PRIOR TO ADMISSION. If posting, at least 10 days prior. This helps us to have the necessary paperwork completed prior to your admission.

YOUR ADMISSION

All admissions are arranged through your Doctor. Patients who are scheduled for surgery should arrive at the time arranged by your Doctor. If you have any other concerns about your time of arrival please contact our Hospital Admissions Office.

On Admission please bring with you:
- Relevant X-rays and Pathology reports
- Any letters from your Doctor
- Reading material, spectacles and case
- Medicare Card, Health Insurance Card and any Pension / Concession Cards.
- Confirmation of claim for Worker’s Compensation or other comparable admissions.
- Any current Medication you are taking in original container.
- Any personal attire and toiletries you may need.

VALUABLES AND MONEY

Please do not bring any valuables with you as the Hospital accepts no responsibility for stolen or lost items.

ADMISSION

Report to the Admission Desk on the 1st Floor. Enter via Car Park.

Please dress in comfortable clothing and footwear and wear no makeup or jewellery.

Your Doctor will advise of any special instructions such as fasting, taking medications and bowel preparation. An Anaesthetist will see you prior to your procedure.

FASTING

As instructed by your Doctor.

FAMILY / FRIENDS ACCOMPANYING PATIENT

Where appropriate, it is recommended that only one companion accompany you to the Hospital.

FOLLOWING PROCEDURE

You will be allowed to go home within 2-4 hours, but this may vary as your Doctor may need to see you before you go home and follow up appointments and tests may need to be arranged.

Immediately following the procedure, you will spend some time in the Recovery room and lounge. This will allow your progress to be monitored and ensure that you are ready to go home. You will also be given some light refreshments after the procedure.

Arrange for a responsible adult to:
- Collect you
- Remain with you overnight

If you have had sedation, you may be subject to drowsiness and dizziness in the first 24 hours. For safety and legal protection do not:
- Drink alcohol
- Drive a motor vehicle or operate machinery
- Make important decisions or sign a contract
- Do anything which requires co-ordination or for you to be alert during this time.

If you experience any excessive pain or are generally concerned about your condition, please contact your Doctor.
RIGHTS AND RESPONSIBILITIES

As a consumer of health care services you have the right to:

- Be informed about our facilities and services
- Quality care
- An explanation in every day language of your condition, proposed procedures, possible alternatives and likely effects, an informed consent must be given before any treatment is performed by any health care worker, whose identity and professional status you are entitled to know
- Be treated with respect and not be discriminated against
- Personal and information privacy
- Receive advice on how to make a complaint

Your responsibilities are to:

- Answer questions about your health honestly and completely
- Comply with prescribed treatments or inform your health profession if you do not intend to do so
- Be courteous, considerate and respectful towards others
- Respect the privacy of others
- Fulfil your financial obligations
- Raise concerns if you are unhappy with services
Day Surgery Admission Form

580 Lower North East Road Campbelltown SA 5074
Phone: (08) 83668111 Fax: (08) 83651139

Please complete this form and return to the Hospital at least 5 days prior to admission.
If posting – at least 10 days prior.

DATE OF ADMISSION: / / TIME:

PERSONAL DETAILS

<table>
<thead>
<tr>
<th>Title</th>
<th>Mr / Mrs / Ms / Miss / Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>Given Name(s)</td>
</tr>
<tr>
<td>DOB:</td>
<td>Sex: M / F</td>
</tr>
<tr>
<td>Address:</td>
<td>Marital Status:</td>
</tr>
</tbody>
</table>

Are you of Aboriginal or Torres Strait Islander origin? (for persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes)

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander

Religion: ________________
Country of Birth: ________________
Nationality: ________________
Language spoken at home: ________________
Occupation: ________________

Home Phone: ____________________
Work Phone: ____________________
Mobile Phone: ____________________

NEXT OF KIN

<table>
<thead>
<tr>
<th>Relationship Type:</th>
<th>Title:</th>
<th>Surname:</th>
<th>Given Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Home Phone:</td>
<td>Work Phone:</td>
<td>Mobile Phone:</td>
</tr>
</tbody>
</table>

EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Relationship Type:</th>
<th>Title:</th>
<th>Surname:</th>
<th>Given Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Home Phone:</td>
<td>Work Phone:</td>
<td>Mobile Phone:</td>
</tr>
</tbody>
</table>

ADMITTING DETAILS

<table>
<thead>
<tr>
<th>Admitting Doctor:</th>
<th>Admission Type:</th>
<th>Elective / Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Reason:</td>
<td>GP:</td>
<td></td>
</tr>
</tbody>
</table>

Previous admission to NECH: Yes ☐ No ☐
Previous name (if applicable): Approx. what year:
GP Address: ________________

Have you been in Hospital in the past 28 days? Yes ☐ No ☐ If yes, which Hospital

PRIVATE HEALTH INSURANCE?

<table>
<thead>
<tr>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Fund:</td>
</tr>
<tr>
<td>Table:</td>
</tr>
<tr>
<td>Aware of excess: Yes ☐ No ☐</td>
</tr>
<tr>
<td>Length of membership on this table: Over 12 Months ☐ Less than 12 months ☐</td>
</tr>
</tbody>
</table>

If excess is applicable: Excess must be paid at time of admission

BENEFIT DETAILS

<table>
<thead>
<tr>
<th>Medicare Number:</th>
<th>Expiry Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension Number:</td>
<td>Expiry Date:</td>
</tr>
<tr>
<td>Safety Net Number:</td>
<td>Expiry Date:</td>
</tr>
<tr>
<td>Veteran Affairs No:</td>
<td>Expiry Date:</td>
</tr>
</tbody>
</table>

WORKCOVER / THIRD PARTY

<table>
<thead>
<tr>
<th>Please circle:</th>
<th>Workcover / Third Party Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company:</td>
<td>Date of Injury/Accident:</td>
</tr>
<tr>
<td>Address of Insurance Company:</td>
<td></td>
</tr>
<tr>
<td>Claim Number:</td>
<td>Claim Manager:</td>
</tr>
<tr>
<td>Employer (WC only):</td>
<td>Expiry Date:</td>
</tr>
</tbody>
</table>

In consideration of admission of myself / husband / wife / child to NECH I agree to comply with the conditions outlined overpage. In the event of my claim being disallowed by the insurer I agree to pay the account personally on discharge.

PLEASE READ OVER PAGE
HOSPITAL CHARGES

Insured Patients
If you are an insured patient you should check with your Health Fund to confirm the following:

- That you are (or will be) covered for the Hospital charges in connection with your admission.
- What (if any) excess applies to your level of cover from the Health Fund as this is paid by you to the Hospital prior to or on admission.

Insured patients will be asked to sign a Certificate of Hospitalisation prior to discharge so that the account can be forwarded direct to the Health Fund for payment. Patients are responsible for any excess not covered by the fund and will be required to pay the excess prior to or on admission.

Self Insured Patients
Will be required to pay charges prior to or on admission. Our Accounts Department can inform patients of anticipated costs.

All patients are admitted on the understanding that they are personally liable for their own HOSPITAL ACCOUNTS. An estimate of the Hospital Account can only be provided by our Hospital Staff and a payment of the anticipated fee is payable on admission unless prior arrangements have been made.

WORKER’S COMPENSATION PATIENTS / THIRD PARTY INSURANCE PATIENTS
Patients are admitted on the condition that they, like all others, are personally responsible for payment of the Hospital’s account on presentation, notwithstanding any claims they have for compensation or damages. Accounts cannot be held in abeyance pending settlement of such claims. If any person or organisation (e.g. an employer or insurance company) has agreed to accept responsibility for payment on presentation of any account, the patient should arrange for that person or organisation to send to the Hospital, before admission date, a written undertaking to this effect. If no such undertaking is received, the patient will be regarded as personally responsible for prompt payment.

Financial Consent

In consideration of admission for myself to NECH I agree to comply with the conditions outlined.
In the event of my Health Fund claim being disallowed by the insurer, I agree to pay the total amount owing personally at the time of discharge.

Signature: ___________________________ Date: ___________________________

PRIVACY INFORMATION

North Eastern Community Hospital (NECH) acknowledges our obligation to you under the Privacy Act 1988 (as amended).

NECH requires you to provide personal information as a part of your admission. This normally includes your personal and contact information as well as details about your Health Insurer, your Hospital visit and your medical condition.

The Hospital uses your personal information to provide you with health services, verify your Health Insurance details, perform administrative tasks, comply with legislative and regulatory requirements and develop relevant services / and products. Without this personal information, the Hospital may be limited in its ability to provide you with appropriate, timely and safe medical and nursing care.

Our Personal Information Management Policy is available at reception and our Privacy Officer, who can be contacted by telephone through our reception is happy to answer any questions you may have concerning the policy. An information brochure is available from the Admission Clerk. A copy will be provided at your request.

By completing this Admission form and Patient Questionnaire, I acknowledge that I am providing personal information to NECH. I understand that this personal information is used by NECH in providing medical and nursing services to me in performing administrative tasks such as managing my Hospital account.

I (name) _______________________________ agree and consent to NECH collecting and using personal information about me for these purposes.

I acknowledge that I may have access to my personal information collected and held by NECH.

Signature: ___________________________ Date: ___________________________

Irrespective of any request received, I direct you NOT to provide my personal information to:
(please specify name / details)

I agree to my information being used for Marketing and/or Fundraising? Yes ☐ No ☐
Dear Patient,

We depend on you to provide accurate health screening information. To help us, you are requested to complete this questionnaire in BLOCK LETTERS and return with the admission form 5 days prior to admission.

Please state in your own words why you are being admitted to Hospital.

__________________________________________________________________________
__________________________________________________________________________

Do you suffer from Sleep Apnoea?  Yes ☐  No ☐  If yes, please bring your CPAP machine to hospital.

Weight: __________________________  Height: __________________________

Please attach a separate form if on multiple medications.

<table>
<thead>
<tr>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Have you had any problems with any anaesthetics?</td>
</tr>
<tr>
<td><strong>2.</strong> Are you taking any drugs or tablets? If so, please specify:</td>
</tr>
<tr>
<td><strong>3.</strong> Do you have a Pace Maker, artificial heart valve, hearing aid, prosthesis, contact lenses or body piercing?</td>
</tr>
<tr>
<td><strong>4.</strong> Have you any allergies:</td>
</tr>
<tr>
<td>To what: __________________________</td>
</tr>
<tr>
<td>Do you have a latex allergy?</td>
</tr>
<tr>
<td>Any special dietary needs?</td>
</tr>
<tr>
<td><strong>5.</strong> Have you had any problems with your heart, lungs, liver?</td>
</tr>
<tr>
<td><strong>6.</strong> Do you have an Advanced care Plan and other treatments – limiting orders?</td>
</tr>
<tr>
<td><strong>7.</strong> Have you had any problems with your blood pressure?</td>
</tr>
<tr>
<td><strong>8.</strong> Have you had trouble breathing or taken medication for a breathing problem?</td>
</tr>
<tr>
<td><strong>9.</strong> Do you smoke? How many per day:</td>
</tr>
<tr>
<td><strong>10.</strong> Do you have caps, crowns, dentures or loose teeth?</td>
</tr>
<tr>
<td><strong>11.</strong> Have you had a history of any bleeding tendencies?</td>
</tr>
<tr>
<td><strong>12.</strong> Have you had a blood/blood products infusion? Did you have an adverse reaction to the infusion?</td>
</tr>
<tr>
<td><strong>13.</strong> Do you have diabetes?</td>
</tr>
<tr>
<td><strong>14.</strong> Do you have any kidney disease?</td>
</tr>
<tr>
<td><strong>15.</strong> Have you had any other serious illnesses?</td>
</tr>
<tr>
<td><strong>16a.</strong> Do you have any pre-existing infectious diseases</td>
</tr>
<tr>
<td><strong>16b.</strong> Have you been unwell in the last 3 days?</td>
</tr>
<tr>
<td><strong>17.</strong> Do you have any physical disabilities?</td>
</tr>
<tr>
<td><strong>18.</strong> Have you recently been taking?</td>
</tr>
<tr>
<td>Aspirin or other blood thinning medication</td>
</tr>
<tr>
<td>Warfarin</td>
</tr>
<tr>
<td>Anti-inflammatory drugs</td>
</tr>
</tbody>
</table>

Date of last dose taken: __________________________
FOR MEDICAL STAFF

NURSING ASSESSMENT
(For Nursing Use Only)

<table>
<thead>
<tr>
<th>FASTED</th>
<th>PRE-OPERATIVE CHECKLIST</th>
<th>Admitting Nurse</th>
<th>Anaesthetic Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST VOIED:</td>
<td>ID Band Checked?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>FOOD Yes □ No □</td>
<td>Dr’s Standing Orders Checked?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Date: ___________</td>
<td>Consent?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Time: ___________</td>
<td>Yes □ N/A □</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>FLUIDS Yes □ No □</td>
<td>Piercing removed?</td>
<td>Yes</td>
<td>Yes N/A</td>
</tr>
<tr>
<td>Date: ___________</td>
<td>Yes □ N/A □</td>
<td>Yes</td>
<td>Yes N/A</td>
</tr>
<tr>
<td>Time: ___________</td>
<td>Makeup removed?</td>
<td>Yes</td>
<td>Yes N/A</td>
</tr>
<tr>
<td>Caps/crowns/dentures</td>
<td>Yes □ No □</td>
<td>Yes</td>
<td>Yes N/A</td>
</tr>
<tr>
<td>(upper/lower/partial)</td>
<td>X-Rays?</td>
<td>Yes □ N/A □</td>
<td>Yes □ N/A □</td>
</tr>
<tr>
<td></td>
<td>Sick certificate required?</td>
<td>Yes □ N/A □</td>
<td>Yes □ N/A □</td>
</tr>
<tr>
<td></td>
<td>Pressure Risk Level</td>
<td>L/M/H/E</td>
<td>L/M/H</td>
</tr>
<tr>
<td></td>
<td>Falls Risk</td>
<td>L/M/H</td>
<td>L/M/H</td>
</tr>
</tbody>
</table>

Signature of Admitting RN/EN: ________________________________
Signature of Anaesthetic Nurse: ________________________________

Post Procedure Progress Notes

Diet / Fluids:
___________________________________________________________

Observations: _____________________________________________

Specific Orders: ___________________________________________

SB Dr: ___________________________________________________

Discharge to: _____________________________________________

Additional Comments (when required):
___________________________________________________________

___________________________________________________________

PADSS D/C CRITERIA – Score 9 +

1. Vital Signs
   0 BP +/- 20 mmhg
   AND Pulse +/- 10 outside normal range
   1 BP +/- 20 mmhg OR
   Pulse +/- 10 outside normal range
   2 BP within 20 mmhg
   and pulse within 10 of normal range

2. Ambulation
   0 Unable
   1 Unsteady
   2 Steady

3. Nausea & Vomiting
   0 Severe
   1 Moderate
   2 Minimal

4. Pain
   0 Severe
   1 Moderate
   2 Minimal

5. Surgical Bleeding
   0 Severe
   1 Moderate
   2 Minimal

TOTAL /10

TIME:
___________________________________________________________

We thank you for your help. We look forward to caring for you.

Signature: ______________  Date: ______________