

Cliveden

Welcome, and thank you for choosing Epworth Cliveden Hospital.

"At Epworth, doctors and staff work in partnership to provide care and services equal to the world's best for patients, their families and the community".

Please complete the relevant documents and return in the envelope provided to;

Booking Office
Epworth Cliveden Hospital,
29 Simpson Street,
East Melbourne 3002

The hospital will attempt to telephone before and after your hospital stay to confirm information.

If you have any queries please telephone the hospital (03) 9419 7122.

Admission Date: _____

Admission Time: _____



Epworth Cliveden Hospital,
29 Simpson Street,
East Melbourne 3002
Tel: 03 9419 7122
Fax: 03 9419 0347
Melway Ref: Map 2G/F4
www.epworth.org.au

PATIENT INFORMATION

Welcome to Epworth Cliveden Hospital.
We are dedicated to making your stay with us as pleasant and relaxed as possible. The following information is provided to assist you.

Pre-Admission

To assist with prompt return of the completed pre-admission forms, an envelope has been enclosed for your convenience. For patients admitted at short notice the completed pre-admission forms can be faxed directly to the booking office on 9419 0347 or email: admin@cliveden.com.au. If using the fax or email method, please bring the original forms with you on the day of admission.

Admission and Operation Times

Your surgeon organizes the admission times for your surgery.

Due to the number of patients on some lists, you may have several hours to wait prior to your surgery. It is suggested that you bring reading material, audio devices, crosswords etc.

The hospital will contact you the week prior to your surgery to discuss admission times and costs by letter or phone.

What to Bring

- Night attire - including dressing gown and slippers (If staying overnight)
- Personal toiletries
- Current medications in original packaging
- X-rays, if applicable
- If you are staying one night or more and you have previously used Anti-embolic stockings (e.g: Ted's), please bring them with you
- Other articles to help your stay more comfortable, e.g. Books, walkman, magazines

Valuables

It is recommended that you leave all valuable and jewellery items at home. We cannot accept responsibility for loss or damage of any item brought into the hospital.

Accommodation

Epworth Cliveden Hospital offers patients staying overnight or longer, both private and shared accommodation equipped with television and telephone . Every effort will be made to accommodate

you in the room of your choice. However, if your preference is not available, we will endeavor to accommodate your needs as soon as possible. All patients undergoing day surgery will be accommodated in our Day Recovery Unit.

Visiting Hours

Visitors are welcome between the hours of 2.00 pm and 8.00 pm. However, special arrangements can be made with the nursing staff for visitors outside of these hours.

No visitors are allowed in the Day Recovery Unit with the exception of a Parent/Guardian of a school age child.

Patient Rights And Responsibilities

Epworth Cliveden Hospital is committed to providing the best in patient care and in doing so we provide the patient with information that helps them make informed decisions about their treatment and health care.

A comprehensive statement of your rights and responsibilities as a patient is available at your bedside. We highly recommend that you take time to read this.

As a healthcare service we strive for continuous quality improvement and our quality management system is accredited through ISO 9001:2008. There is a quality policy available on request.

Discharge

Information regarding wound care, pain relief and follow-up appointments with your surgeon will be given to you prior to discharge. If any problems arise following discharge, please contact your surgeon.

Discharge time for overnight patients is between 9.00 am and 10.00 am, please arrange for your escort to collect you during this time.

Any Tax Invoice received for Pharmacy items on discharge is payable directly to the Pharmacy.

Accounts

It is advised that you contact your insurance company prior to admission to confirm your level of coverage for your hospitalization. You should provide your insurance company with your length of stay and item numbers for the procedure you will be having. Patients hospitalized within 12 months of joining a health fund must pay the total hospital account on admission. Any patients who are Self Insured should contact the Hospital to confirm the costs. All out of pocket costs are to be settled on admission, our receptionist will endeavour to contact you prior to admission to confirm any costs involved with your hospitalization.

Payment can be made by Credit card (visa, mastercard or bankcard)

Cash or EFTPOS (eftpos payments cannot exceed \$800).

No personal or business cheques accepted. Bank Cheque ONLY.

Patient Satisfaction Evaluation

We are keen to ensure we meet the needs of all our patients and that your stay in hospital is a pleasant one. The completion of a Patient Satisfaction Evaluation questionnaire which will be provided

to you upon admission allows us to make improvements where needed. We appreciate your co-operation in completing this questionnaire.

Dietary Requirements

The Hospital caters for Patients with special dietary needs. If you require a special diet please contact the Hospital prior to your admission so that we can make arrangements for your catering requirements.

Special Instructions

- We suggest loose/comfortable clothing to be worn.
- Please do not wear makeup or nail polish.
- Do not smoke 12 hours prior to your surgery.
- Do not eat or drink anything (including water) after midnight prior to morning surgery or after 7.00am prior to afternoon surgery, unless otherwise instructed.
- Patients are advised not to drive a car, operate machinery, drink alcohol or sign important documents for 48 hours following surgery.
- Unit staff will advise you of discharge time to assist you with contacting your escort.
- Please arrange for a responsible person to escort you home.
Do not drive yourself to or from the Hospital.

If you have any queries regarding your admission, bookings staff can be contacted on 9419 7122.



- Please tick which Epworth site you are being admitted to:
- Richmond
 - Brighton
 - Freemasons Clarendon Street
 - Freemasons DPC
 - Freemason Maternity
 - Cliveden
 - Eastern
 - Camberwell

Unit Record Number: Adm. Number:

Surname.....

Given Name.....

D.O.B..... Age..... Sex.....

Medical Officer.....

Affix Patient Identification Label

ADMISSION DETAILS

(Doctors Secretary to complete - MUST BE COMPLETED)

Admission Date: _____ Admission Time: _____

Admitting Dr: _____ Dr Phone: _____

Procedure: _____ Provisional Item Number(s): _____

Estimated Length of Stay: _____ days Day Case Overnight Case

MATERNITY DETAILS

Estimated Date of Delivery: / / Obstetrician:

PATIENT DETAILS

Have you been a patient at Epworth Richmond/Brighton/Eastern/Freemasons/Camberwell/Cliveden? Yes No

Have you stayed in any hospital within the last month? Yes No If Yes, Hospital name: _____

Title: Mr Mrs Miss Ms Master Other: _____

Surname: Previous Surname:

Given Names: Sex: Male Female Date of Birth / /

Country of Birth: Marital Status: Preferred Language:

Residential Address:

Suburb / Town: State: Postcode:

Postal Address: Tick if as per above

Contact No: Home: Business: Mobile:

Aboriginal or Torres Strait Islander: Yes No Religion: Tick if No Religion

Medicare Number: Number beside name on card Exp Date: / /

Pension / Concession No: Exp Date: / /

PBS Entitlement Card No: HealthCare Card No:

NEXT OF KIN / CONTACT PERSON

ADDITIONAL CONTACT PERSON

Surname: <input type="text"/>	Surname: <input type="text"/>
Given Name: <input type="text"/>	Given Name: <input type="text"/>
Relationship to Patient: <input type="text"/>	Relationship to Patient: <input type="text"/>
Address: <input type="text"/>	Contact No: Home: <input type="text"/> Work: <input type="text"/>
Suburb / Town: <input type="text"/> Postcode: <input type="text"/>	Mobile: <input type="text"/>
Contact No: Home: <input type="text"/> Work: <input type="text"/>	
Mobile: <input type="text"/>	

Do you have a nominated Medical Power of Attorney?

No Yes, please bring a copy of documents to the hospital

If we are unable to contact you directly, we may need to contact your above nominated next of kin to provide information relating to your admission.

GP DETAILS

Name of regular Dr: <input type="text"/>	OFFICE USE ONLY
Dr Address: <input type="text"/> State: <input type="text"/> Postcode: <input type="text"/>	Is this the Admitting Medical Officer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dr Phone: <input type="text"/> Fax: <input type="text"/> Email: <input type="text"/>	

We routinely send information about your hospitalisation to your local Dr. If you do not consent to this please tick this box

MR1

June 2010

ADMISSION DETAILS

MR1

PERSON RESPONSIBLE FOR ACCOUNT (if not self)

Surname: [] Given Name: []
Home Address: [] State: [] Postcode: []
Contact No: Home: [] Work: [] Mobile: []

INSURANCE / CLAIM DETAILS – please tick relevant box

You are advised to contact your health fund to confirm your level of cover prior to this admission, as co-payments or an excess may apply. If you do not have adequate cover or are NIL insured, you are required to pay all costs on admission. MATERNITY PATIENTS - nil insured patients must pay all costs prior to admission.

Privately Insured Fund: [] Membership No: [] Level of Cover: []
 Nil Insured Overseas Patient DVA – Card No: [] Gold Card White Card

WORKCOVER / TAC – please attach claim acceptance letter

OFFICE USE ONLY
EMU Yes No

Approval of your application is necessary prior to your admission. Workcover / TAC will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and accepted liability for your hospitalisation, treatments and other associated costs.

Workcover TAC Claim No: []
Date of Injury: [] / [] / [] Name of Insurance Company: []
Employer's Name: []
Employer's Address: [] State: [] Postcode: []
Contact Person: [] Contact No: [] Fax No: []

Please be advised that Workcover, Veteran Affairs and Transport Accident Commission patients are accommodated in shared rooms only - single room charges apply.

REHABILITATION PATIENTS

Rehabilitation Diagnosis: []
Medical Diagnosis: [] Subgroup: []
 ABI: [] days Cardiac: [] days Medical: [] days
 Neurological: [] days Orthopaedic: [] days Pain Management: [] days
 Reconditioning: [] days Respiratory: [] days

SIGNATURE OF BOOKING OFFICER: []

EPWORTH HEALTHCARE CORRESPONDENCE

From time to time Epworth HealthCare and the Epworth Medical Foundation provide patients with information, newsletters and appeals. Please let us know if you do not wish to receive this information.

I do not wish to receive additional information from Epworth HealthCare or the Epworth Medical Foundation.

DECLARATION

I agree that the information provided within this form is true and correct to the best of my ability.

Signature: [] Name: [] Date: []



MR3



- Please tick which Epworth site you are being admitted to:
- Richmond Eastern
 - Brighton Camberwell
 - Freemasons Clarendon Street
 - Freemasons DPC
 - Freemason Maternity
 - Cliveden

Unit Record Number: Adm. Number:
Surname.....
Given Name.....
D.O.B..... Age..... Sex.....
Medical Officer.....
Affix Patient Identification Label

PART A To be completed by the TREATING MEDICAL PRACTITIONER

I have informed....., of the:
Print name of patient/ person responsible

- Reason and nature of his/her admission

OR

- Nature, likely results and risks of the planned procedure

Planned operation/ procedure including side and site

Patient does not consent to having a blood or blood products transfusion

Interpreter used. Language

Treating Medical Practitioner
Signature Print name Date

PART B To be completed by the PATIENT / person responsible

Doctor and I have discussed treatment of my condition
Print name of Treating Medical Practitioner

I acknowledge that I have consented to this admission to Epworth for:

Reason for admission/ procedure consented to(side and site if applicable)

I understand that:

- The administration of medicine / anaesthetic / blood transfusion may be needed in association with this admission/procedure and that these carry some risks.
- Epworth staff administer care under the treating doctor's direction, or in an emergency, medical and nursing care is administered as required.
- I may withdraw the consent I gave to my doctor at any time.

I acknowledge that:

- I listened to the explanation the doctor gave me as to the need, benefits, risks and complications related to this admission or procedure.

I have had the opportunity to ask questions and these have been answered in a way I understand.

.....
Signature patient Date

.....
Print name of patient If person responsible signs, state relationship to patient

PART C Involvement of Specialist Trainees: Applicable Not Applicable (please delete)

Epworth HealthCare is committed to training the next generation of medical specialists. Specialist trainees are fully qualified and registered medical practitioners who are undergoing advanced training in their chosen medical speciality but they do not have the same level of experience as your treating specialist.

Under the direct supervision of your treating specialist, a specialist trainee may participate in your surgery/procedure and may perform some of your operation/procedure as part of their training. Your specialist will always be present in the operating theatre during the operation or during your procedure.

I agree / do not agree to the involvement of the specialist trainee in my operation / procedure.

I understand and acknowledge consent that

Print name of Speciality Trainee

.....
Signature patient Date

.....
Print name of patient If person responsible signs, state relationship to patient

REQUEST FOR MEDICAL TREATMENT OR OPERATION/PROCEDURE

June 2010

MR3



Epworth HealthCare

PATIENT HEALTH HISTORY

Unit Record No _____

Surname _____

Given Names _____

D.O.B. _____ Doctor _____

ATTACH PATIENT I.D. LABEL

Date: ____ / ____ / ____

Patient wishes to be addressed as: _____

Primary Language: _____

Needs Interpreter: No Yes

Has blood tests/pathology been taken for this admission?

Have X-rays been taken for this admission?

HEALTH INFORMATION

What is your Height Weight

Blood group(if know, please bring document)

High/Low Blood Pressure No Yes

Diabetes: Type 1/Type 2 No Yes

Do you smoke? No Yes, frequency.....

Have you ever smoked? No Yes, frequency.....

Reason for current admission to hospital (in patient's own words).

SURGICAL HISTORY

Please list any previous operations and dates

Do you have any wounds or breaks to your skin currently? No Yes

Location: _____

HEALTH BEHAVIOURS

Do you drink alcohol? No Yes

State average daily intake _____

Short of breath or chest pain while exercising? No Yes

Specify _____

Do you require a special diet? No Yes

Specify _____

ALLERGIES/REACTIONS

None known Yes – specify below

Anaesthetic: Specify drug & reaction: _____

Lotions/Tapes: Specify lotion/tape & reaction: _____

Foods: Specify food and reaction _____

Drugs: Specify drug & reaction: _____

Blood Product: Specify product & reaction: _____

Chemotherapy: If you have experienced a sensitivity reaction during a chemotherapy infusion, please state drug & specify reaction

PAST MEDICAL HISTORY please tick

	No	Yes
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Strokes/Mini-Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker: Make: _____ Model: _____	<input type="checkbox"/>	<input type="checkbox"/>
Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Cough at present; Type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases eg. HIV	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis; State what type _____	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders/Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcer/Bowel Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Location _____	<input type="checkbox"/>	<input type="checkbox"/>
1° diagnosed: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
2° Location: _____ diagnosed: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness/Anxiety Attacks	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis: Location: _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Fits	<input type="checkbox"/>	<input type="checkbox"/>
Vision Impairment (glasses?)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment (hearing aid?)	<input type="checkbox"/>	<input type="checkbox"/>
Speech/Swallow Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Recent Cortisone Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any medical conditions indicated, or if any other medical conditions, give further details:

MEDICATIONS: Medicines taken Prior to Presentation to Hospital (Prescribed, over the counter, complementary)Own medications brought in? Y N Administration Aid (specify) _____

Medication	Dose & Freq.	Duration	Medication	Dose & Freq.	Duration
GP: _____			Community Pharmacy: _____		

Medicines usually administered by: _____

Have you been instructed to stop any medications prior to your admission? No Yes**CREUTZFELDT JAKOB DISEASE QUESTIONS**Have you had a dura mater graft between 1972 and 1989? No YesDo you have a family history of two or more relatives with Creutzfeldt Jakob Disease or other unspecified neurological disorders? No YesHave you received human pituitary hormones (growth hormone or gonadotrophins) prior to 1985? No YesHas the patient suffered a recent progressive dementia (physical or mental), the cause of which has not been diagnosed? No Yes**PASTORAL CARE**During your hospital stay would you like Pastoral care support or counselling? No Yes

Please list any religious requirements: eg. Communion: _____

PLANNING FOR DISCHARGEDo you live alone?: No Yes Do you live in a : House Flat / Residential Care: High Level Low Level

Other: _____

As a result of this admission are you likely to have problems managing at home: No Yes

If yes, please specify: _____

How long do you expect to be in hospital? _____ Do you expect to go to a Rehab. facility? No Yes**THIS SECTION IS TO BE COMPLETED ON ADMISSION BY NURSING STAFF**

REFERRALS	Referral Date & Initial	Review Date & Initial		Referral Date & Initial	Review Date & Initial
Dietitian			Discharge Coordinator		
Diabetes Educator			Stomal Therapist		
Physiotherapy			Breast Care Nurse		
Social Worker			Occupational Therapist		
Pastoral Care			Other:		

PERSONAL BELONGINGS:

	No	Yes	Dispensed to whom
Money/Credit Card			
Jewellery/Watch			
Dentures/Bridges			
Glasses/Contacts			
Hearing aid			
Assistive devices			
Other:			

Must be completed for all patients on admission

I am aware that any jewellery or valuables kept on me or in the ward are my responsibility and I understand that the hospital is not accountable for any loss.

Signature _____

Date ____/____/____

Health assessment information was collected from: _____

(eg. Patient, family, significant other) – Please ask this person to sign.

I declare that the above information is true and accurate to the best of my knowledge

Signature _____ Name _____ Date ____/____/____

Admitting Nurse

Signature _____ Name _____ Designation _____ Date ____/____/____