



**Epworth
HealthCare**

Eastern

Welcome, and thank you for choosing Epworth Eastern 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,

**Bookings Office
Epworth Eastern Hospital,
1 Arnold Street,
Box Hill, 3128**



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) 8807 7100.

Epworth Eastern Hospital

1 Arnold Street

Box Hill 3128

Tel: 03 8807 7100

Fax: 03 8807 7676

Melway Ref: Map 47, C8

www.epworth.org.au

Admission Date: _____

Admission Time: _____

What you need to do before admission

To confirm your admission we ask that you complete the following forms:

- Hospital Admission Details form
- Medical Treatment Consent form
- Patient Health History form

Forward the completed forms to the hospital in one of the following ways:

- **By mail** using the return paid self-addressed envelope attached as soon as possible, allow 7 working days for the post
- **In person** to main Reception Desk on Level 1, 1 Arnold Street, Box Hill
- **By fax 8807 7676** Please remember to bring the original forms with you on the day of your admission.

Your doctor / doctor's secretary will also inform you of the day and time of your planned admission and any special preparation that may be required.

If you have private health insurance it is important to check with them the following prior to your admission:

- whether the cost of your procedure and hospitalisation will be covered by the health fund
- any excess and/or copayment that may apply on your level of cover is payable by admission

Self funded patients are required to pay the estimated amount of the procedure by the time of admission.

Every effort has been made to provide an accurate estimate of expenses. However, additional costs are sometimes incurred during your stay. If this occurs, you will be asked to pay the balance at the time of discharge or alternatively, an account will be sent to your home which will require payment within 14 days.

Please note that all Doctor, Medical, Anaesthetic and Allied Health practitioners fees may be billed separately.

Pharmacy, diagnostic imaging (X-rays) and pathology services may attract an additional charge.

Please contact the relevant service for additional information:

Pharmacy - (03) 9890 9666

Diagnostic Imaging - (03) 9236 1300

Pathology Services - (03) 9895 7544

Plan for discharge

Day Stay Patients:

Please ensure you have someone to collect and accompany you home after the procedure. You will not be permitted to leave the hospital alone including using public transport or taxi.

Nursing staff will advise you of the discharge time.

Discharge instructions will be provided to you and your carer.

You should also arrange to have a responsible adult stay with you, the day and night following surgery.

The Day Surgery Unit is not a suitable environment for children, they are not able to be cared for in this environment & for the privacy and comfort of other patients, please make alternative arrangements.

Overnight Stay Patients:

Discharge time is **9.30 am**.

Discharge planning is an important part of your care. Planning for your discharge commences on admission and continues throughout your stay. This ensures that any services which you may require at or after discharge can be arranged in a timely manner (pharmacy, transport).

On the day of your admission please bring with you to hospital:

- Health fund card
- Medicare card
- Pharmaceutical entitlements card
- Pension card / Health Care card
- Current X-rays / scans
- Medication: Bring in all your medication in their original packaging including insulin repeat and authority scripts. Your G.P. or local pharmacist provides a list of current medication. You will incur a cost for any medication you are already taking if you have not brought it with you, as these will need to be purchased from pharmacy
- Personal items: Overnight patients to bring toiletries, sleep wear, dressing gown, slippers and physical aids (hearing aids, spectacles, walking stick or frame, crutches etc Please label items)

Day patients only require physical aids.

Paediatric Patients bring specific needs i.e. bottle, any special fluids/formula, favorite toy and wear loose comfortable clothing such as a track suit.

When coming into hospital

Fasting instructions (unless your doctor gives you special instruction):

- Morning Surgery: Fast (nothing to eat, drink, smoke or chew) after 12 midnight the night before
- Afternoon surgery: Fast after a light breakfast (e.g. tea and toast or fruit) before 7am. Do not eat, drink, smoke or chew after this time

Paediatric Patients confirm fasting instructions with your Doctor.

N.B. if you are attending for a Colonoscopy you **MUST** fast (nothing to eat, drink, smoke or chew) according to your doctors separate instructions.

- Medication: If you are taking medication routinely, consult your doctor about whether you are to continue, cease, or alter regimes. If you are to continue, take all medication (regardless of fasting instructions) with a small amount of water at the usual times.
- Medications that may need be ceased include
 - Anti-clotting agents eg. Aspirin, Warfarin
 - Anti-inflammatories eg. Brufen, Ibuprofen, Diclofenac
 - Cortisone eg. Prednisolone
 - Diuretic (fluids tablets) eg. Lasix
 - Complimentary therapies eg. St Johns Wart, Garlic, Echinaecia

If you are diabetic do not take insulin or diabetic medication unless instructed by your doctor to do so.

- Cease smoking. Doctors recommend you stop smoking 8 weeks prior to surgery Do not smoke for at least 24 hours before your procedure
- Do not wear make up, nail polish, jewellery or body piercing of any kind
- Do not bring valuables or large sums of money into the hospital. Epworth does not accept liability for any items brought into hospital
- Wear loose comfortable clothing and sensible shoes

Inform your doctor if

- You have a known allergy or latex allergy
- You or your family have been treated for CJD (Creutzfeldt-Jakob disease)
- There is an untoward change in your health leading up to the procedure (e.g. cold or fever)
- You use any recreational drugs

Medical Records and Privacy

Epworth HealthCare complies with legislation guiding the way your health information is collected, stored, used and disclosed. A "Patient Privacy" brochure will be provided to you upon admission which outlines patients rights and responsibilities and how to voice your concerns.

Cardiac Procedures

If you are having a cardiac procedure, the following applies to you. Identified information about you and your care will be provided to external national databases that monitor the results of cardiac procedures. This helps identify patient outcomes, greatly benefiting patients of the future. Information about this is available with your admission pack and from your cardiac doctor.

We understand that not everyone is comfortable about having details related to their cardiac condition documented in a database. If you feel this way, and do not want this information added to the database, please discuss this with your doctor and contact the Database Project Manager on 1800 998 722.

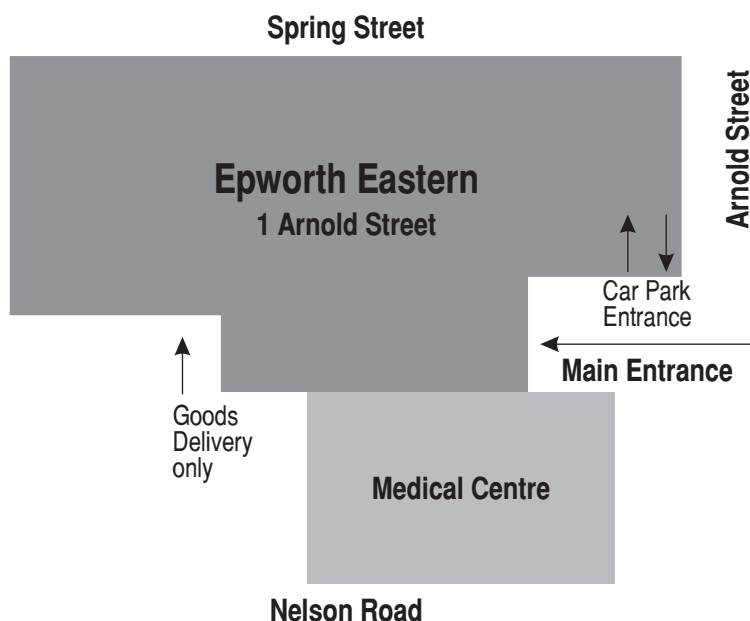
Payment Procedure

- Privately insured patients need to pay the portion of your estimated hospital account not covered by your health fund i.e. excess must be paid on admission.
Payment can be made over the phone prior to admission
- Patients funded by Repatriation (DVA), we will claim on your behalf. Work Cover, TAC & third party must have prior approval or total payment will be required on admission.
- Other costs which may be incurred during your stay are payable on discharge

**When you arrive at Epworth, please present at Main reception
Level 1, 1 Arnold Street, Box Hill.**

Epworth Location Map

Melways Ref. 47, C8



Epworth's Patients' Rights and Responsibilities Statement

Epworth respects each patient's right to participate in his or her health care.

If you are unable to make your own decisions, your treating team at Epworth aims to ensure that your interests are the focus of any decision affecting you.

You may expect from Epworth:

- Honest and adequate information about hospital services
- Free and informed choice regarding Epworth services
- Quality care in terms of delivery and cost
- Respect for your cultural and religious beliefs
- Respect for your confidentiality in the way we manage information relating to you
- Access to your medical record in accordance with the Health Records Act 2001
- Freedom from any form of discrimination
- Awareness of the professional status of those involved in your treatment
- A safe and comfortable environment
- Advice on care services for your after discharge care
- Advice on any out of pocket expenses related to your hospital stay

You may expect from your doctor:

- To be informed of and to give consent to any medical procedure
- Freedom to seek a second medical opinion
- Freedom to refuse treatment after hearing the medical implications of this refusal
- Advice on any likely out of pocket costs related to your medical treatment

In return Epworth expect that patients:

- Consider the needs and entitlements of other patients and staff at Epworth
- Provide open and accurate information to those caring for you
- Let those caring for you know if you experience any unexpected changes in your condition
- Ask questions and seek clarification
- Adhere to treatment plans you have agreed to
- Let those caring for you know if your treatment plan proves to be too difficult to follow
- Hear the implications of, and accept responsibility for, any refusal of treatment

We trust that, in the spirit of partnership, these expectations will be met. However if at any time you feel we let you down:

- Talk to your nurse about any concerns you have, or if you remain dissatisfied
- Ring **333** on your bedside phone and a member of our Senior Management Team will respond to your concern, or
- Post a letter to the Director of Clinical Services, Epworth Eastern, 1 Arnold Street, Box Hill, VIC 3128

Patient concerns are investigated in accordance with procedural fairness and respect and will in no way adversely affect the care and treatment provided.

Help us to improve by:

- Participating in Epworth's quality improvement activities by responding to patient surveys we may send you
- Giving feedback and making suggestions to staff

Copies are available from Unit Reception in Italian, Greek, Chinese, Vietnamese and Indonesian.



Epworth HealthCare

Please tick which Epworth site you are being admitted to:

- Richmond Acute
- Eastern
- Cliveden Hill
- Freemasons Clarendon St
- Freemasons DPC
- Freemason Maternity
- Richmond Rehab
- Brighton
- 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:

ADMISSION DETAILS

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"/> | Do you have a nominated Medical Power of Attorney? |
| Mobile: <input type="text"/> | <input type="checkbox"/> No <input type="checkbox"/> 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: **OFFICE USE ONLY**
 Is this the Admitting Medical Officer? Yes No
 Dr Address: State: Postcode:
 Dr Phone: Fax: Email:

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

MR1

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:



Epworth HealthCare

Please tick which Epworth site you are being admitted to:

- Richmond
- Brighton
- Freemasons Clarendon Street
- Freemasons DPC
- Freemason Maternity
- Cliveden Hill
- Eastern
- Camberwell

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*

MR3

REQUEST FOR MEDICAL TREATMENT OR OPERATION/PROCEDURE



**Epworth
HealthCare**

Unit Record Number:.....

Surname

Given Name.....

D.O.B. Age Sex

Medical Officer.....

Affix Patient Identification Label

**Please complete form & forward to Epworth as soon as possible.
Nursing staff to check / complete form & referrals on admission to ward.**

HEALTH INFORMATION Please Circle Consider referral to

What is your: Height.....cm Weight.....kg Waist Circumference.....cm Blood group.....(if known, Please bring document)

| | | | | |
|--------------------------------------|----|-----|--|----------------------------|
| High / low blood pressure | No | Yes | | |
| Diabetes: Type 1 / Type 2 | No | Yes | Managed by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin | Diab Educator Dietitian |
| Do you smoke Have you ever smoked | No | Yes | Frequency..... Date ceased...../...../..... | |

Do you require an interpreter? No Yes What language.....
Please specify reason for admission and history of presenting illness:

.....
.....
.....

| | No | Yes | Comments & Further Information | Staff Use |
|--|----------|------------|---|---|
| Do you have any Allergies. <input type="checkbox"/> Medication <input type="checkbox"/> Tapes <input type="checkbox"/> Latex/Rubber <input type="checkbox"/> Food <input type="checkbox"/> Other | | | Specify allergy and reaction: | Alert stickers Pt ID band Comply with Latex Policy |
| Has blood tests / pathology been taken for this admission? | No | Yes | Which company..... When..... What tests..... Where are results..... | Results in Hx |
| Have X-rays been taken for this admission? | No | Yes | <input type="checkbox"/> with patient - Please bring with you. <input type="checkbox"/> with Doctor | Films present. |
| Females: Are you pregnant? Are you breast feeding? | No No | Yes Yes | Due date: | If yes, urgent group & hold if pt for surgery |

MEDICATIONS

| | | | | |
|---|----------|------------|---|-----------------------------|
| Do you take or have you recently taken blood thinning medication? Have you been told to cease this? | No No | Yes Yes | Specify: Date to cease/...../..... Date last taken/...../..... or still taking <input type="checkbox"/> Yes | Notify Doctor if applicable |
| Have you taken any steroids or cortisone tablets/injections in the last 6 months? | No | Yes | Name of medication: Date last taken/...../..... or still taking <input type="checkbox"/> Yes | Notify Doctor if applicable |
| Are you taking any other prescription, non-prescription or complementary medications? (vitamins/minerals/herbal remedies) | No | Yes | If yes, list below with your current medications | |

Please bring to hospital any medication/vitamin/mineral supplements/inhalers you are currently taking in their labeled packaging, and repeat / authority prescriptions, safety net & concession cards

| Medication / brought in <input type="checkbox"/> | Dose / frequency | last taken | Medication / brought in <input type="checkbox"/> | Dose / frequency | last taken |
|--|------------------|------------|--|------------------|------------|
| <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| <input type="checkbox"/> | | | <input type="checkbox"/> | | |

Staff to complete on E prescribe if available

MR9

REMOVE FORM AND SEND TO HOSPITAL ASAP

Jan
2010

PATIENT HEALTH HISTORY

MR 9

| GENERAL MEDICAL CONDITION (circle) | | Comments & further Information | | Consider referral to |
|---|----|--------------------------------|--|--|
| Have you: Had an anaesthetic | No | Yes | | Anaesthetist if yes to side effects |
| Any side effects / reaction | No | Yes | | |
| A family member who had any side effects / reactions to anaesthetic | No | Yes | | |
| Dental problems | No | Yes | <input type="checkbox"/> Denture- <input type="checkbox"/> Upper <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/> Lower <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Loose teeth | Dentures with pt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have all your own teeth | No | Yes | | |
| Limited jaw movement | No | Yes | | |
| Speech / swallowing problems | No | Yes | Describe: | Speech therapist |
| Recent cold or flu or sore throat | No | Yes | | |
| Sleep problems / apnoea | No | Yes | <input type="checkbox"/> CPAP used | CPAP with pt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy / fits / seizure | No | Yes | Last seizure/...../..... | |
| Migraines /Motion sickness | No | Yes | Managed by | |
| Strokes / mini strokes | No | Yes | Any residual weakness/symptoms? | OT or Physio |
| Multiple Sclerosis / Motor Neurone Disease | | | | |
| Heart attack / chest pain / angina | No | Yes | | |
| Palpitations / irregularity/ Rheumatic fever | No | Yes | | |
| Prosthesis: Pacemaker / metal pins & plates / artificial joint / access devices / stents | No | Yes | | |
| Respiratory issues: Asthma / Bronchitis / Emphysema / shortness of breath on exertion / Hayfever / Pneumonia / Tuberculosis | No | Yes | Specify: Do you use: <input type="checkbox"/> Nebulisers <input type="checkbox"/> Puffers <input type="checkbox"/> Home Oxygen | Physio |
| Thyroid problems | No | Yes | | |
| Infectious diseases: HIV / sexual / hepatitis | No | Yes | | |
| Hospital infections | No | Yes | | |
| Blood clots / Blood disorders / tendency to bleed/ bruise easily / Anaemia | No | Yes | | |
| Blood transfusion | No | Yes | | |
| Elimination issues: Kidney / bowel bladder problems / incontinence | No | Yes | | |
| Reflux / hiatus hernia / ulcers | No | Yes | | |
| Neck and back problems | No | Yes | | |
| Arthritis | No | Yes | | |
| Fallen more than once in the last 6 months | No | Yes | | Falls risk assess |
| Skin issues: sores / rash / ulcers / wounds | No | Yes | | Skin risk assess |
| Short term memory loss / Confusion / Dementia / Delirium | No | Yes | | |
| Mental illness: anxiety attacks / depression | No | Yes | Specify: Psychiatrist's/Specialist's name & Contact number: | |
| Cancer | No | Yes | Location: Date diagnosed <input type="checkbox"/> chemotherapy <input type="checkbox"/> radiotherapy | |
| Creutzfeldt-Jakob disease - CJD | | | | If yes, & for surgery, notify Doctor, O.R. Manager, Infection Control & ADON |
| Have you received human pituitary derived hormones before 1985? | No | Yes | | |
| Have you received a dura mater graft prior to 1990? | No | Yes | | |
| Is this admission due to a progressive neurological disorder / dementia? | No | Yes | | |
| Do you have a family history of CJD or progressive neurological disorder? | No | Yes | | |
| Please list any operations, disabilities, other illness or health problems that you have had | | | | |
| | | | | |
| | | | | |
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| | | | | |



**Epworth
HealthCare**

Unit Record Number:.....

Surname

Given Name.....

D.O.B. Age Sex

Medical Officer

Affix Patient Identification Label

LIFESTYLE

| | | | | |
|---|----|-----|------------|--|
| Do you drink alcohol | No | Yes | Frequency: | |
| Do you use recreational drugs | No | Yes | Frequency: | Check when last taken..... |
| Do you require a special diet | No | Yes | Specify: | |
| Impairment: <input type="checkbox"/> Vision <input type="checkbox"/> Hearing | No | Yes | Aids used: | Aids with pt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you a registered organ donor | No | Yes | | |

MALNUTRITION SCREENING

| | | | | |
|---|----|-----|--|----------------------------|
| Any appetite problems causing weight loss? | No | Yes | | If yes, ref Dietitian / GP |
| Have you lost more than 5kg without trying? | No | Yes | | |

DAY SURGERY PATIENTS DISCHARGE PLAN

How are you getting home?
Who is accompanying you?
Name Contact no.

OVERNIGHT PATIENTS DISCHARGE PLAN Discharge time is 9.30 am

| | | | | |
|---|----|-----|---|--|
| Do you live <input type="checkbox"/> Alone <input type="checkbox"/> With others <input type="checkbox"/> Residential care (e.g. Nursing Home / Hostel) | No | Yes | If with others or residential care: Specify: Name..... Contact no..... | |
| Do you care for others at home? | No | Yes | Specify: | Consider Ref. To discharge planner / CCC / UM / TL |
| Are you receiving home nursing services? | No | Yes | Specify: | Consider Ref. To discharge planner / CCC / UM / TL |
| Do you currently need assistance with <input type="checkbox"/> Walking <input type="checkbox"/> Hygiene <input type="checkbox"/> Meals <input type="checkbox"/> Medications | No | Yes | <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Crutches <input type="checkbox"/> Council <input type="checkbox"/> Other <input type="checkbox"/> Council <input type="checkbox"/> Other <input type="checkbox"/> Dosette /Webster <input type="checkbox"/> Family <input type="checkbox"/> Other | Consider Ref. To discharge planner / CCC / UM / TL |
| Where do you plan to go after discharge? | - | - | <input type="checkbox"/> Home <input type="checkbox"/> Rehab <input type="checkbox"/> Convalescence <input type="checkbox"/> Other | Consider Ref. To discharge planner / CCC / UM / TL |

If you normally use a mobility aid (walking stick / frame, artificial limb) please bring this to hospital with your name clearly marked

Additional information:

Nursing staff to check, complete form and initiate referrals once considered appropriate.

Planned admission date...../...../..... Time: Transfer from

Information obtained from patient Relative Other Name:

Pre-admission nurse:
Sign Print Desig. Date...../...../..... Time:

Valuables: Stored according to local policy Date...../...../..... Sent Home with relatives

Admission nurse: DOSA/DS - Ward (circle)
Sign Print Desig. Date...../...../..... Time:

REMOVE FORM AND SEND TO HOSPITAL ASAP

PATIENT HEALTH HISTORY

MR 9

