



**Epworth  
HealthCare**

# Richmond

Welcome, and thank you for choosing Epworth Richmond 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,

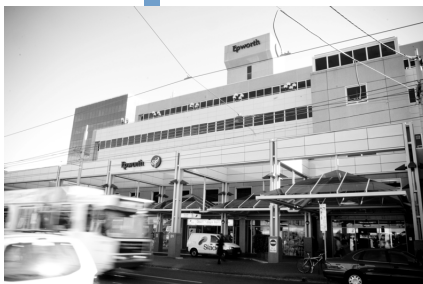
**Booking Office**  
Epworth Richmond Hospital,  
89 Bridge Road,  
Richmond, 3121

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) 9426 6155.

Admission Date: \_\_\_\_\_

Admission Time: \_\_\_\_\_



Epworth Richmond Hospital

89 Bridge Road

Richmond 3121

Tel: 03 9426 6666

Fax: 03 9428 7692

Melway Ref: Map 2G/J5

[www.epworth.org.au](http://www.epworth.org.au)

## 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 2, Bridge Road building
- **By fax 9428 7692** 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) 9429 6322 Diagnostic Imaging - (03) 9242 4888

Pathology Services - (03) 9287 7888

## 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.

Following your discharge if you have any concerns please contact the hospital or present at the Emergency Department 34 Erin Street, Richmond.

### 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).

### Discharge Lounge

If there is a delay in transport to take patients home by 9.30am there is a Discharge Lounge available. The Discharge Lounge is located near the Erin Street Entrance and is staffed by a Registered Nurse. Utilising the Discharge Lounge to await your transport home allows us to prepare your vacated hospital bed unit for the next person who may be having morning surgery.

## 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.

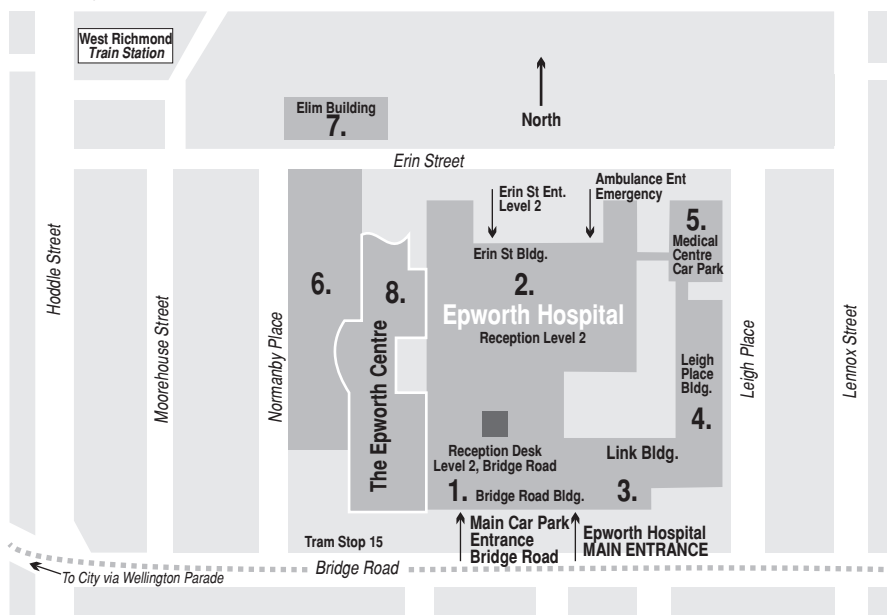
### Payment Procedure

- 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 2 Bridge Road entrance.

### Epworth Location Map

Melways Ref. 2G, J5



1. Bridge Road Building
  2. Erin Street Building
  3. Link Building
  4. Leigh Place Building
  5. Erin Street Medical Centre
  6. Normanby Place Building
  7. Elim Building
  8. The Epworth Centre
- Entrance to Car Park from Bridge Road*

## 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 Operations, Epworth Hospital, 89 Bridge Road, Richmond, VIC 3121

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.



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:  Surname:

Given Name:  Given Name:

Relationship to Patient:  Relationship to Patient:

Address:  Contact No: Home:  Work:

Suburb / Town:  Postcode:  Mobile:

Contact No: Home:  Work:  Mobile:

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:

Dr Address:  State:  Postcode:

Dr Phone:  Fax:  Email:

**OFFICE USE ONLY**  
Is this the Admitting Medical Officer?  Yes  No

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*

MR3

**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 .....  
may be performing part of my surgery or procedure. *Print name of Speciality Trainee*

.....  
*Signature patient Date*

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

June  
2010

REQUEST FOR MEDICAL TREATMENT OR OPERATION/PROCEDURE

MR3





**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 - <b>Please bring with you.</b> <input type="checkbox"/> with Doctor	Films present.
Females: Are you pregnant? Are you breast feeding?	No	Yes	Due date:	If yes, <b>urgent</b> group & hold if pt for surgery

<b>MEDICATIONS</b>				
Do you take or have you recently taken blood thinning medication? Have you been told to cease this?	No	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 Do you have all your own teeth Limited jaw movement	No No No	Yes Yes 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
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	
<b>Creutzfeldt-Jakob disease - CJD</b>				
Have you received human pituitary derived hormones before 1985?	No	Yes		If yes, & for surgery, notify Doctor, O.R. Manager, Infection Control & ADON
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		
<b>Please list any operations, disabilities, other illness or health problems that you have had</b>				



**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 <input type="checkbox"/> from
Information obtained from patient <input type="checkbox"/> Relative <input type="checkbox"/> Other <input type="checkbox"/> Name:	
<b>Pre-admission nurse:</b> Sign Print Desig. Date...../...../..... Time:	
Valuables: <input type="checkbox"/> Stored according to local policy Date...../...../.....	<input type="checkbox"/> Sent Home with relatives
<b>Admission nurse: DOSA/DS - Ward (circle)</b> Sign Print Desig. Date...../...../..... Time:	

REMOVE FORM AND SEND TO HOSPITAL ASAP

PATIENT HEALTH HISTORY

MR 9

