MR1

Epworth HealthCare

Please tick which Epworth site you are being admitted to:

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

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

Surname:

Given Name:

Relationship to Patient:

Address:

Suburb / Town: Postcode:

Contact No: Home: Work:

Mobile:

ADDITIONAL CONTACT PERSON

Surname:

Given Name:

Relationship to Patient:

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:

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 ☐

ADMISSION DETAILS

MR1

11/10

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 MEDICAL FOUNDATION

Epworth Healthcare is a not-for-profit hospital group which relies on the generosity of its community to assist it to continue to deliver excellence in treatment and care.

From time to time the Epworth Medical Foundation contacts patients seeking their support. Please let us know if you **do not** wish to be contacted.

☐ I **do not** wish to be contacted by 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 PRINT

Patient Name: .... D.O.B. ....

Admission Date (required): ....

Operation Date (required): ....

Treating Doctor: ....

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 ....
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*

REQUEST FOR MEDICAL TREATMENT OR OPERATION/PROCEDURE

MR3

SPECIALIST TRAINEES AT EPWORTH HEALTHCARE

Epworth HealthCare has for many years undertaken a medical education role and currently there are registrars / fellows in many disciplines within the hospital, including intensive care, emergency medicine, rehabilitation, cardiology and orthopaedics. As part of Epworth HealthCare's broader commitment to ensuring that we can offer our patients the best medical care, the organisation also aims to be at the forefront of medical education and research.

Epworth HealthCare is committed to training the next generation of medical specialists. Specialist trainees are fully qualified and registered doctors who are undergoing advanced training in their chosen medical specialty. Most specialist trainees undertake at least 7 years of training after gaining their medical degree and becoming a medical practitioner in order to gain the appropriate knowledge and skills to be acknowledged as a medical specialist.

Specialist trainees do not have the same level of experience as your treating specialist and hence they work closely with your specialist, under the supervision of your specialist whenever they participate in your care.

OPERATIONS AND PROCEDURES

If you are undergoing an operation or other procedure AND your treating specialist is involved in supervising a specialist trainee, you may be asked whether you consent to a specialist trainee being involved. The specialist trainee may assist or perform some of your operation / procedure as part of their training, but this will always be under the direct supervision of your treating specialist.

GENERAL MEDICAL CARE

Specialist trainees may participate in your medical care during your admission. This may include taking your history, ordering tests and liaising with your treating specialist. Under supervision, they may participate in providing treatment.

If you do not wish specialist trainees to be involved in your medical or surgical care during your admission, or if you would like further information about specialist trainees at Epworth HealthCare, please feel free to discuss this with your treating specialist.

EMERGENCY MEDICAL CARE

Trainees play an essential role at Epworth HealthCare in providing emergency assistance when your specialist is not on site at the Hospital. In an emergency, and if your specialist is not immediately available, Epworth will ensure that necessary medical care is provided. In these circumstances, it is the role of the medical staff to ensure that you are medically stable and that your treating specialist is notified immediately of any medical concerns. Further management and treatment requirements will be determined by your treating specialist.

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

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

____

☐ Has blood tests/pathology been taken for this admission?

____

☐ Have X-rays been taken for this admission?

PAST MEDICAL HISTORY please tick

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

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

____

____

____

____

CLARENDON STREET PATIENT HEALTH HISTORY MR9

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 admininstered 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 ☐ Yes

Do you have a family history of two or more relatives with Creutzfeldt Jakob Disease or other unspecified neurological disorders? ☐ No ☐ Yes

Have you received human pituitary hormones (growth hormone or gonadotrophins) prior to 1985? ☐ No ☐ Yes

Has 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 DISCHARGE

Do 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 __/__/__