



**Epworth
HealthCare**



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

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.

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

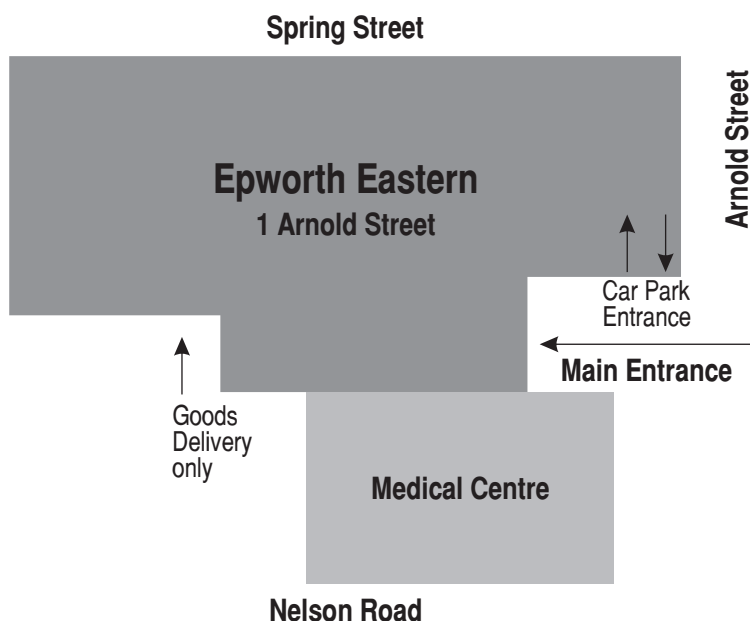
Payment Procedure

- 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 complete form in black/blue pen using **BLOCK LETTERS** and forward to Epworth **IMMEDIATELY**. This form must reach Epworth at least 7 days prior to admission.
- Please contact your health fund prior to your admission to confirm your level of cover, as co - payments or an excess may apply.

Unit Record Number:.....

Surname

Given Name.....

D.O.B. Age Sex

Medical Officer.....

Affix Patient Identification Label

ADMISSION DETAILS

Admission Date:..... Admission Time:.....

Admitting Doctor:..... Phone No:

Procedure:..... Item Number(s):

Please ask Doctor's secretary for the following information: Estimated Length of Stay:..... days Day Case Overnight Case

PATIENT DETAILS

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

Have you stayed in any hospital within the last 7 days? Yes No If yes, Hospital name:

Title: Mr Mrs Miss Ms Dr Other

Surname:..... Previous Surname:.....

Given Names:.....

Address:.....

Suburb:..... State:..... Postcode:.....

Phone No. (home):..... (work):..... (mob):.....

Date of Birth:..... Sex: Male Female Marital Status:.....

Country of Birth:..... Aboriginal & Torres Strait Islander: Yes No Religion:.....

Medicare Number: - - - - ← family reference number (left of name) Expiry Date - / /

Pension / Concession No:..... Expiry Date - / / Veteran Affairs File No:..... Gold Card White Card

PBS Safety Net Card: SN..... or CN..... Healthcare Card No:.....

NEXT OF KIN / CONTACT PERSON

ADDITIONAL CONTACT PERSON

Surname:..... Surname:.....

Given Name:..... Given Name:.....

Relationship to Patient:..... Relationship to Patient:.....

Address:..... Address:.....

..... Postcode:..... Postcode:.....

Home phone No.:..... Home phone No.:.....

Work No:..... Mobile No:..... Work No:..... Mobile No:.....

DO YOU HAVE MEDICAL POWER OF ATTORNEY? NO YES - Please bring a copy of documents to hospital

Surname:..... Given Name:..... Relationship to patient:.....

Address:..... Postcode:.....

Home phone No.:..... Work No:..... Mobile No:.....

GP DETAILS

Name of regular GP:.....

GP Address:.....

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

..... Postcode:.....

GP Phone:..... GP Fax:..... GP Email:.....

Referring Specialist:.....

Referring Specialist Address:.....

Referring Specialist Phone:..... Fax:.....

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

INSURANCE / CLAIM DETAILS

Claim Type: Nil Insured Private Workcover Veterans' Affairs TAC

Fund:..... Level of Cover:.....

Membership No:.....

OFFICE USE ONLY
EMU Yes No

It is a requirement to contact your healthfund to confirm your level of cover prior to this admission. Please be advised that Workcover, Veteran Affairs and Transport Accident Commission patients are accommodated in shared rooms only. Veteran Affairs Patients will be charged an additional fee if a private room has been provided at patient request.

OFFICE USE ONLY:

Discharge Date:

P L E A S E A L S O C O M P L E T E R E V E R S E S I D E O F F O R M



MR1

REMOVE FORM AND SEND TO HOSPITAL ASAP



ADMISSION DETAILS

MR1

WORKCOVER PATIENTS - please complete the following

Approval of your application is necessary prior to admission. WorkCover 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

Name of employer:.....
Address of employer:..... Postcode:.....
Phone No. of employer:..... Fax No. of employer..... Date of accident:.....
Has employer accepted liability: Yes No If Yes - please attach acceptance letter.
Has insurance company accepted liability for this admission: Yes No
Name of insurance company:.....
Phone No. of insurance company:..... Fax No. of Insurance Company:..... Claim No.:.....
Case Manager:..... Phone No.

Please attach acceptance letter.

TRANSPORT ACCIDENT COMMISSION (TAC) PATIENTS - Please complete the following

Approval of your application is necessary prior to admission. The 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

Date of Accident:..... Date TAC Accepted Claim:..... Claim No:.....
Location of Accident:.....
Support Co - ordinator / Rehabilitation Officer:.....
Please attach acceptance letter

PERSON RESPONSIBLE FOR ACCOUNT

Surname:..... Given Name:.....
Home Address:..... Postcode:.....
Home phone No:..... Business phone No:..... Mobile No:.....
Is this person aware that they are responsible for paying this account: Yes No

EPWORTH ENTITLEMENT

Please indicate if you are a holder of any of the following Epworth cards: Network Epworth Club Heartbeat

EPWORTH FREEMASONS ONLY

Are you entitled to a Masonic Rebate? Yes No If yes, please inform the Admission staff on arrival

Patient Signature:..... **Date**.....

REHABILITATION PATIENTS

REHABILITATION DIAGNOSIS:.....

MEDICAL DIAGNOSIS:..... **SUBGROUP No.:**.....

- NEUROLOGICAL days ORTHOPAEDIC days CARDIAC days
- PAIN MANAGEMENT days RECONDITIONING days MEDICAL days
- ABI days RESPIRATORY days

SIGNATURE OF BOOKING OFFICER:..... **DATE**.....

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 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 NURSE or 'designated other' checks that parts A and B are complete.

.....
Signature *Print name and designation* *Date*

MR3

REMOVE FORM AND SEND TO HOSPITAL ASAP

REQUEST FOR MEDICAL TREATMENT OR OPERATION/PROCEDURE

MR3

DOCTOR BOOKING FORM



To be completed by Admitting Medical Practitioner
 Forward completed form to Booking Office at the relevant campus of Epworth Hospital at least **72 hours prior** to admission

Patient Name: _____
 Date of Birth: _____
 Home Phone No.: _____
 Mobile No: _____ Work No: _____
 Address: _____
 Admitting Doctor: _____
 Health Fund & No.: _____

Procedure Date: ____/____/____ Admission Date: ____/____/____ Admission Time: _____

Admission Diagnosis: _____

Accommodation Request: Day Patient Only Overnight ICU Bed CCU Bed

Expected Length of Stay: _____ Days

Expected Discharge Outcome: Home / Rehabilitation

Procedures: _____

MBS Number/s: _____

Requirements Instruments: _____

Prosthesis Required		Prosthesis Description	Billing Code	Supplier	Is this a Gap Prosthesis?		Informed Financial Consent Given to Patient?		*Gap Amount
Yes	No				Yes	No	Yes	No	\$

* to be paid by patient

Past History, Examination, Clinical Information:

Investigations / Special Requirements on Admission:

Pathology ordered Yes No Specify: _____

Physician Review / Involved Yes No Specify: _____

Adverse Reaction / Allergies / NKA: Specify: _____

Admission Drug Orders (Maximum Duration 24 Hours):

DATE	DRUG	DOSE	ROUTE	FREQ.	DOCTOR'S SIGNATURE	TIME	TIME	TIME	TIME
						GIVEN BY	GIVEN BY	GIVEN BY	GIVEN BY

DOCTOR'S SIGNATURE: _____

DATE: ____/____/____

PLEASE PRINT



**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.**

Do you require an interpreter? No Yes What language.....

Please specify reason for admission and history of presenting illness:

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

MR9

REMOVE FORM AND SEND TO HOSPITAL ASAP

PATIENT HEALTH HISTORY

MR 9

	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?			Which company..... When..... What tests..... Where are results.....	Results in Hx
Have X-rays been taken for this admission?			<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

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

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"/>		
<input type="checkbox"/>			<input type="checkbox"/>		

Staff to complete on E prescribe if available

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		
High / low blood pressure	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
Diabetes: Type 1 / Type 2	No	Yes	Managed by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin	Diab Educator Dietitian
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				



**Epworth
HealthCare**

Unit Record Number:.....

Surname

Given Name.....

D.O.B. Age Sex

Medical Officer

Affix Patient Identification Label

LIFESTYLE

Do you smoke	No	Yes	Frequency.....	
Have you ever smoked	No	Yes	Date ceased...../...../.....	
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:	
Any unplanned weight loss + poor appetite	No	Yes		If yes, ref Dietitian / GP
Any unplanned weight loss > 5kg	No	Yes		
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		

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

