MR1

Epworth HealthCare

Please tick which Epworth site you are being admitted to:

- ☐ Richmond Acute
- ☐ Richmond Rehab
- ☐ Eastern
- ☐ Brighton
- ☐ Cliveden
- ☐ Camberwell
- ☐ Freemasons Clarendon St
- ☐ Freemasons DPC
- ☐ Freemasons 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: Preferred Name:

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

Title: (Mr/Mrs/Miss/Ms/Master)

Surname:

Given Name:

Relationship to Patient:

Address:

Suburb / Town: Postcode:

Contact No: Home: Work:

Mobile:

ADDITIONAL CONTACT PERSON

Title: (Mr/Mrs/Miss/Ms/Master)

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

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

Name of regular Dr:

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

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

Referring Specialist Address: ....

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

I understand that the hospital may contact my Health Fund and/or Medicare for verification of my eligibility for treatment.

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.

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: ______

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: ☐ Diet ☐ Tablets ☐ Insulin	Diab Educator Dietitian
Do you smoke Have you ever smoked	**No** **No**	**Yes** **Yes**	Frequency................. Date ceased...../...../.....	

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

			Comments & Further Information	**Staff Use**
Do you have any Allergies. ☐ Medication ☐ Tapes ☐ Latex/Rubber ☐ Food ☐ Other	**No**	**Yes**	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**	☐ with patient - **Please bring with you**. ☐ 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 ☐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 ☐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 ☐	**Dose / frequency**	last taken	**Medication** / brought in ☐	**Dose / frequency**	last taken
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

Staff to complete on E prescribe if available

PATIENT HEALTH HISTORY

MR 9

Jan 2010

PLEASE TURN OVER

MR9

GENERAL MEDICAL CONDITION (circle)			Comments & further Information	Consider referral to
Have you: Had an anaesthetic Any side effects / reaction A family member who had any side effects / reactions to anaesthetic	No No No	Yes Yes Yes		Anaesthetist if yes to side effects
Dental problems Do you have all your own teeth Limited jaw movement	No No No	Yes Yes Yes	☐ Denture-☐ Upper ☐ Partial ☐ Full -☐ Lower ☐ Partial ☐ Full ☐ Caps ☐ Crowns ☐ Loose teeth	Dentures with pt ☐ Yes ☐ No
Speech / swallowing problems	No	Yes	Describe:	Speech therapist
Recent cold or flu or sore throat	No	Yes		
Sleep problems / apnoea	No	Yes	☐ CPAP used	CPAP with pt ☐ Yes ☐ No
Epilepsy / fits / seizure Migraines /Motion sickness	No No	Yes Yes	Last seizure ....../....../...... Managed by	
Strokes / mini strokes Multiple Sclerosis / Motor Neurone Disease	No	Yes	Any residual weakness/symptoms?	OT or Physio
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: ☐ Nebulisers ☐ Puffers ☐ Home Oxygen	Physio
Thyroid problems	No	Yes		
Infectious diseases: HIV / sexual / hepatitis Hospital infections	No No	Yes Yes		
Blood clots / Blood disorders / tendency to bleed/ bruise easily / Anaemia Blood transfusion	No No	Yes Yes		
Elimination issues: Kidney / bowel bladder problems / incontinence	No	Yes		
Reflux / hiatus hernia / ulcers	No	Yes		
Neck and back problems Arthritis	No No	Yes 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 ☐ chemotherapy ☐ 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

PLEASE TURN OVER

MR3

Epworth HealthCare

Please tick which Epworth site you are being admitted to:

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

Unit Record Number: .... Adm. Number: ....

Surname ....

Given Name ....

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

Medical Officer ....

Affix Patient Identification Label

PART A To be completed by the TREATING MEDICAL PRACTITIONER

I have informed.., of the:

Print name of patient/ person responsible

- Reason and nature of his/her admission ....

  ....

OR

- Nature, likely results and risks of the planned procedure ....

  Planned operation/ procedure including side and site

  ....

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

☐ Interpreter used. Language ....

Treating Medical Practitioner ....

Signature *Print name* *Date*

PART B To be completed by the PATIENT / person responsible

Doctor .... and I have discussed treatment of my condition

Print name of Treating Medical Practitioner

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

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

....

I understand that:

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

I acknowledge that:

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

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

....

Signature patient *Date*

....

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

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

Epworth HealthCare is committed to training the next generation of medical specialists. Specialist trainees are fully qualified and registered medical practitioners who are undergoing advanced training in their chosen medical speciality but they do not have the same level of experience as your treating specialist.
Under the direct supervision of your treating specialist, a specialist trainee may participate in your surgery/procedure and may perform some of your operation/procedure as part of their training. Your specialist will always be present in the operating theatre during the operation or during your procedure.

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

I understand and acknowledge consent that ....
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.

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: ☐ Vision ☐ Hearing	**No** **No**	**Yes** **Yes**	Aids used:	Aids with pt ☐ Yes ☐ No
Are you a registered organ donor	**No**	**Yes**		
MALNUTRITION SCREENING				
Any appetite problems causing weight loss? Have you lost more than 5kg without trying?	**No** **No**	**Yes** **Yes**		If yes, ref Dietitian / GP

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 ☐ Alone ☐ With others ☐ 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 ☐ Walking ☐ Hygiene ☐ Meals ☐ Medications	 **No** **No** **No** **No**	 **Yes** **Yes** **Yes** **Yes**	 ☐ Stick ☐ Frame ☐ Crutches ☐ Council ☐ Other ☐ Council ☐ Other ☐ Dosette /Webster ☐ Family ☐ Other	Consider Ref. To discharge planner / CCC / UM / TL
Where do you plan to go after discharge?	-	-	☐ Home ☐ Rehab ☐ Convalescence ☐ 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:**

PATIENT HEALTH HISTORY

MR 9