Crows Nest
Day Hospital

Patient Information & Pre-Admission Booklet

To assist us in processing your admission, please follow the instructions enclosed in this booklet, complete the attached documents and return to Crows Nest Day Hospital as soon as possible and no later than 5 days prior to your surgery. We look forward to caring for you during your short stay with us.

OPENING HOURS
Monday to Friday
8.00am till 5.00pm

Suite 101, Level 1,
22 Clarke Street,
Crows Nest, NSW 2065

Phone: (02) 9955 5677
Fax: (02) 9966 4869

Email: **info@crowsnestday.com.au**
Website: **www.crowsnestday.com.au**

2019:V1

Welcome
and thank you for choosing Crows Nest Day Hospital to meet your current healthcare needs.

Crows Nest Day Hospital (CNDH) is a purpose built, specialist day surgery facility offering world class healthcare services in a boutique environment. The well-being of our patients is paramount. We aim to provide comfortable and attractive surroundings coupled with high quality care and support from our skilled nursing and administrative staff.

Preparing for Your Admission

Admission Time, Fasting Instructions and Procedures

The date of your admission is arranged through your doctor. You will need to ring CNDH between 2pm and 4pm on the business day prior to your surgery to confirm your admission time and fasting instructions.

It is vital you have a responsible adult accompany you home and to stay with you for 24 hours following surgery. Please be advised that cancellation of your procedure may result if you do not have these arrangements in place. You must not drive a vehicle, drink alcohol, operate machinery, make important decisions or sign legal documents for 24 hours after an anaesthetic.

Accounts / Fees

If you are a member of a health fund CNDH will conduct an eligibility check for you to establish your level of cover and any excess payable. It is the patient's responsibility to disclose health fund details to CNDH. Any outstanding amounts are required to be paid prior to your admission. Our admission officer will be in contact with you to inform you of any estimated costs.

If you are having elective cosmetic surgery, your surgeon will provide information about the fees payable.

CNDH accepts cash, bank cheques, money orders, Visa, Mastercard, American Express and EFTPOS. Personal cheques are not accepted.

Please note that you will also receive a separate account from the doctors involved in your treatment (surgeon, anaesthetist, assistant).

Paediatric Patients

If it is your child who is to be admitted, we encourage parental support and understand that this can be a stressful event for the family. As we are a small unit, only one parent will be able to accompany the child in the recovery area.

Medications

Check with your specialist anaesthetist or GP whether you should take your normal prescribed medications on the morning of your procedure with a sip of water. If you are taking medication for diabetes please consult your anaesthetist.

Smoking

DO NOT smoke on the day of your procedure. Please be advised that CNDH is a smoke free environment.

On the Day of Admission

What to Bring

- Medicare card, Health Insurance membership card, Veterans' Affairs card, Pension card
- List of medications that you are currently taking
- Any recent x-rays, scans or test results
- Advanced Care Plan and /or treatment limiting orders
- If the patient is a child, feel free to bring their pyjamas and their favourite toy, story book or activity. A change of clothes is also recommended.

Wear loose comfortable clothing and leave valuables at home.

DO NOT wear make-up or nail polish.

Patient Identification

Once you arrive at CNDH, our staff will confirm your name, date of birth, admitting details and doctor. Do not be alarmed if at each stage of your care our staff members confirm these details in addition to the proposed procedure and site of the procedure. These standard identification procedures are designed for your protection. Please note that our staff are aware of who you are, but must ensure these identification procedures are carried out.

Waiting Period on Day of Surgery

Although every attempt is made to ensure the waiting period before your procedure is not unduly long, it is often not possible to schedule operations for a specific time or to follow a specific schedule. Each procedure varies from patient to patient, some may require longer periods in theatre than others. You are therefore asked to bring with you something to occupy your time whilst you are waiting.

Parking

2 hours free parking is available at the Council car park which is located across the road in Hume Street. Alternatively, there is street parking (metered) outside the hospital.

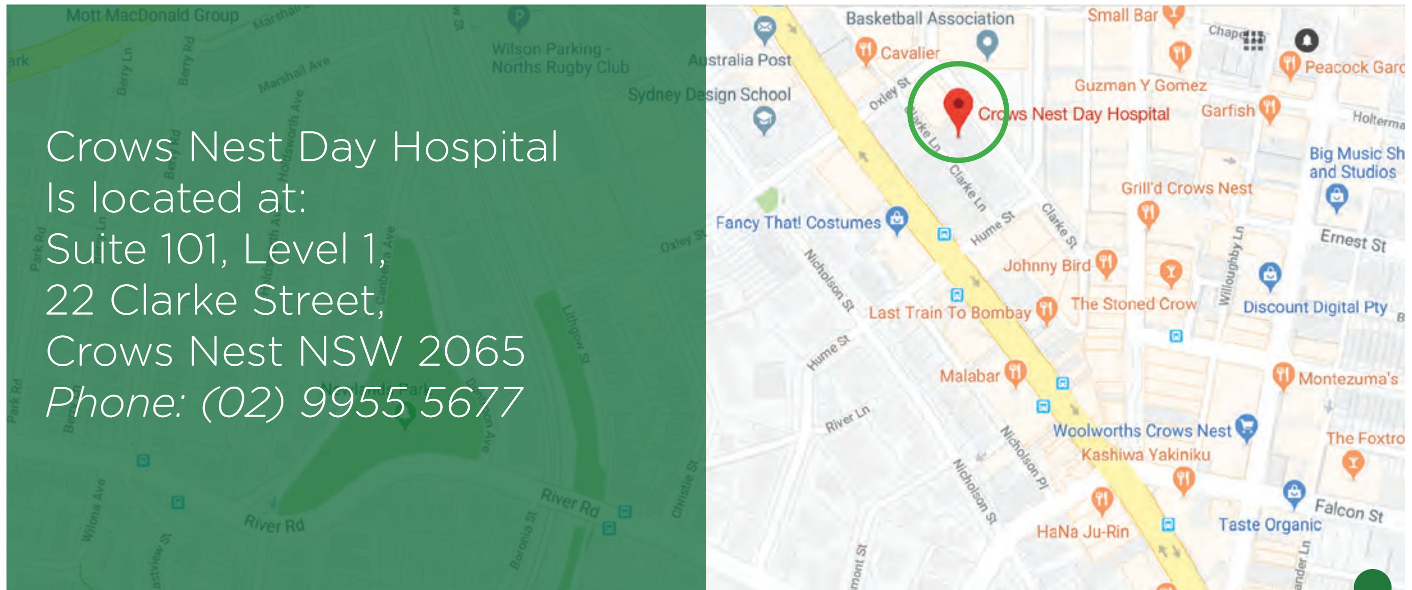
After Your Surgery

The hospital staff will assist you by estimating the time of your discharge on the day of your surgery. It is essential that you have a responsible adult to collect you from CNDH, accompany you home and stay with you for 24 hours. Your carer will receive discharge instructions, please ensure you follow these.

If a post-operative appointment has not been made for you prior to discharge, please call your surgeon's rooms to arrange one.

Most patients are given a prescription for pain relief and/or antibiotics. This will need to be filled on the way home as the drugs may be required soon after arriving home.

The nursing staff will phone you a few days after your surgery to enquire about your recovery.



Your Privacy

In selecting CNDH, we assure you that both your privacy and dignity will be maintained at all times. Medical records will be held relating to your medical treatment and the contents of those records will only be divulged with your consent or where permitted or authorised by law. We will handle your personal information in accordance with the CNDH Privacy Policy, a copy of the policy can be provided upon request or alternatively downloaded from the CNDH website.

Understanding Your Rights And Responsibilities

As a patient of CNDH you have certain responsibilities and the right to expect a certain standard of healthcare. A leaflet is provided to assist you with all the information you require regarding your rights and responsibilities. If you have not received this leaflet, please advise our reception staff.

Complaints, Concerns & Feedback

Please take the time to complete the Patient Satisfaction survey your nurse will give you following your procedure. Your honest feedback is very important to us and any suggestions for improvement you may have will be valued as well as welcomed.

If, in the event you are dissatisfied with any aspect of your care, please contact the Director of Nursing. Any complaint will be promptly acknowledged and investigated thoroughly by the relevant person in the organisation. CNDH will then communicate the outcome of the investigation and recommendations to you.

Any unresolved complaints may be referred to:

Health Care Complaints Commission
Locked Mail Bag 18
Strawberry Hills, NSW 2012
Phone: (02) 9219 7444

Declaration of Pecuniary Interest

For your information, Dr Greg Moloney has a non-controlling pecuniary interest in Crows Nest Day Hospital.

Patient Registration Form

Crows Nest Day Hospital

This form is URGENTLY required PRIOR to your date of admission. Please take the time to complete this form and all other enclosed forms and deliver either in person or by mail no later than 5 days prior to admission to:

Patient Label

Crows Nest Day Hospital
Level 1, 22 Clarke Street, Crows Nest, NSW 2065
Phone: (02) 9955 5677 Fax: (02) 9966 4869

Date of Admission ___ / ___ / ___ Time of Admission (Office Use Only) ___

Admitting Practitioner ___

Proposed Procedure ___

Have you been a patient at Crows Nest Day Hospital before? ☐ NO ☐ YES Year ___

PERSONAL / DEMOGRAPHIC DETAILS

Title ___ Given Name ___ Surname ___

Address ___

Suburb ___ State ___ Post Code ___

Telephone (h) ___ (m) ___ Email address ___

Date of Birth ___ / ___ / ___ Gender ☐ Male ☐ Female

Country of Birth ___ Are you an AUSTRALIAN Resident? ☐ YES ☐ NO

Are you of Aboriginal/Torres Strait Island (TSI) descent? ☐ NO ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, Both

Marital Status ☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

Religion ___ Occupation ___

PERSON TO CONTACT (NEXT OF KIN) This is the person we will contact during your stay

Given Name ___ Surname ___ Relationship ___

Address ___

Suburb ___ State ___ Post Code ___

Telephone (h) ___ (m) ___ Email address ___

Second Contact: Name ___ Telephone ___

ENTITLEMENTS

Medicare Card ☐☐☐☐ ☐☐☐☐☐ ☐ Valid to ___ / ___ Ref No ___

Pension Card ☐☐☐☐☐☐☐☐☐☐ Expiry Date ___ / ___ / ___

Safety Net Number ☐☐☐☐☐☐☐☐☐☐

GENERAL PRACTITIONER

Name of GP ___

Surgery Address ___

Suburb ___ State ___ Post Code ___ Telephone ___

CLAIMING FOR THIS ADMISSION

How will you claim for your admission to Crows Nest Day Hospital?

☐ **Private Health Insurance** (complete section A) ☐ **DVA** (complete section B)
☐ **WorkCover/Third Party** (complete section C) ☐ **Self Insured** (Contact Hospital for an estimate)

Only complete the section which relates to your admission.

Claiming Details

Patient Label

CLAIMING DETAILS Eligibility Check Complete ☐ Yes ☐ No (OFFICE ONLY)

SECTION A - PRIVATE HEALTH INSURANCE Excess Payable $ ____________

Fund Name ____________ Membership Number ____________

Type of cover ☐ Single ☐ Family ☐ Other Do you have any EXCESS? Amount $ ____________

Have you held this cover for greater than 12 months? ☐ YES ☐ NO

SECTION B - DVA

Repatriation Number ____________ Card colour ☐ GOLD ☐ WHITE

SECTION C - WORKCOVER/THIRD PARTY ☐ **WorkCover** ☐ **Third Party**

The approval letter (from the insurance company) for this admission MUST be received prior to surgery, otherwise alternate arrangements for payment will need to be made, which may include upfront payments based on an estimate.

Name of Insurance Company ____________

Address ____________

Suburb ____________ State ____________ Post Code ____________

Telephone ____________ Fax ____________

CLAIM NUMBER ____________ **CONTACT PERSON** ____________

Has your insurance company accepted liability? ☐ YES ☐ NO Specify reason ____________

Employer Details (WorkCover Patients ONLY to complete)

Name of Employer ____________

Address ____________

Suburb ____________ State ____________ Post Code ____________

Telephone ____________ Fax ____________

Date of Accident / / ____________

____

Has your employer completed a Report of Injury Form? ☐ YES ☐ NO Have you completed a WorkCover Claim Form? ☐ YES ☐ NO

The above information is accurate and correct and I understand and agree to disclose health fund details and to pay all fees relating to my hospital visits, including where my health fund or insurance claim is declined for any reason. I have read & understood my rights & responsibilities, the complaint process, and consent to the disclosure of my personal details for the relevant bodies as detailed on Pages 4 & 5 in this information booklet. I also understand that the hospital will not be liable for any valuable that I bring to the hospital.

Signature ____________
(PATIENT or PARENT/GUARDIAN – PLEASE INDICATE)

Date: ____________

Patient History

Patient Label

Please complete the following and ensure this form is forwarded with all other pre-admission documents immediately to Crows Nest Day Hospital

ADMISSION DETAILS	YES	NO	PLEASE PROVIDE DETAILS
Is this admission for a past or present injury?			Cause of injury: Place: Date:
Have blood tests been taken for this admission?			Pathologist: Results with:
Have x-rays been taken for this admission?			With patient (✓) please tick With Doctor
Height.............. Weight..............			Blood group (if known)..
ALLERGIES			
Have you any allergies to medication, food, sticky plaster, latex/rubber (balloon, gloves) or other substances?			Specify details and reactions
MEDICATIONS			**PLEASE PROVIDE DETAILS**
Have you recently taken blood thinning medication or Aspirin in the last 2 weeks?			Name of medication:
Have you been instructed to cease this medication?			Date last taken / / or still taking Y / N
Have you previously taken any anticoagulant therapy (Warfarin)?			Date last taken / / or still taking Y / N
Have you taken any steroids or cortisone tablets in the last 6 months?			Name of Medication Date last taken / / or still taking Y / N
Are you taking any other prescription, non-prescription or complimentary medication? List the medications you currently take (include the name of the medication).			
GENERAL MEDICAL CONDITION			**PLEASE PROVIDE DETAILS**
Asthma/bronchitis/obstructive airways/hay fever			(circle type)
Recent cold/flu/pneumonia			
Heart attack/chest pain/angina Palpitations/irregular heart beat/heart murmur			(circle type) Date / /
Pacemaker or heart valve			Make: Model: Last checked / /
High Blood Pressure			
Rheumatic fever			
Tendency to bleed, clot or bruise easily			
Diabetes			Type I Type 2 Unsure Managed by: Diet: Tablet: Insulin: (please ✓)
Thyroid problems			
Liver Disease/hepatitis (specify type A,B,C)			(circle type)
Hiatus hernia/gastrointestinal ulcers/bowel disorder			(circle type)
Stroke			Date / / Residual problems
Epilepsy/fits/febrile convulsions			(circle type)
Depression/dementia or other mental illness			(circle type)
Migraines			
Arthritis			
Broken skin or pressure areas			
Eye disease			
Impairment e.g. vision, hearing or mobility			
Have you fallen in the last 2 months?			
Exposure to other people with a communicable disease in the last 2 weeks.			
Infectious Diseases/recent infections/MRSA/VRE/HIV/CRE			
Female patients - could you be pregnant?			No. of weeks
Kidney/bladder problems			(circle type)
Cancer			Site:
Any other issue not mentioned above			
PROSTHESES/AIDS/OTHER			
Glasses/contact lenses			
Hearing aids			
Dentures/caps/crowns/loose teeth/implants			
Artificial joints or limbs/metal plates or pins			

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Previous Operations, Procedures or Anaesthetic Details

Patient Label

Please list any previous operations; include the dates and procedures performed

Date: / /	Date: / / ....
Date: / /	Date: / / ....

ADMISSION DETAILS	YES	NO	PLEASE PROVIDE DETAILS
Have you had any anaesthetics in the past?			
Have you had any problems with anaesthetics?			
Have you any blood relatives with anaesthetic problems?			
Have you ever had a problem with a blood transfusion?			

LIFESTYLE

Have you ever smoked?			Daily amount or date ceased / /
Do you drink alcohol?			Daily amount
Do you use recreational drugs?			Type daily amount
Do you have a special diet?			Type of diet
Do you require an interpreter? Indicate if you have an interpreter			Language spoken Name and contact details.

CREUTZFELDT JAKOB DISEASE (CJD) - (In the event of 'yes', please contact Infection Control Consultant)

Have you had a dura mater graft between 1972 – 1989?			
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?			
Have you received human pituitary hormones (growth hormones gonadotrophins) prior to 1985?			
Have you ever suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?			
Have you been involved in a "Look Back" study for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD?			

ACUTE RESPIRATORY INFECTIONS (Seasonal and Pandemic)
- (In the event of 'yes' to all 3 questions, please contact Infection Control Consultant)

Do you have fever and respiratory symptoms?			
Have you travelled to areas of high prevalence for acute respiratory infections (seasonal or pandemic) either overseas, or in Australia within the last 4 – 6 weeks?			
Have you had an overnight stay in an overseas residential aged care facility or hospital in the past 12 months?			

DISCHARGE PLANNING

Do you currently receive community support?			
Do you require nursing support after discharge?			
Have you organised for any necessary support aids on discharge?			

Patient Compliance Statement

1. I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify that I have not had and will not have anything to eat or drink from the time instructed.
2. I certify that I have a responsible adult to accompany me home and to stay with me overnight.
3. I understand the importance of following instructions regarding my post-operative care and agree to follow these instructions.
4. I am aware of the danger to myself/others and undertake to not drive a motor vehicle, operate machinery, drink alcohol or sign important documents for 24 hours following my anaesthetic.

Patient Please Sign Here

Name of escort/carer ______________________ Phone No ______________________

Signed: ______________________ Witness ______________________

(PATIENT or PARENT/GUARDIAN - PLEASE INDICATE)

NURSE USE ONLY – PRE ADMISSION ASSESSMENT

ADMISSION CRITERIA MET ☐ YES ☐ NO if No, what action was taken ______________________

Name of Nurse ______________ Date / / Signature ______________

Doctor Referral / Consent Form

Patient Label

To be completed by Doctor (please PRINT clearly)

Please Admit

Date of Admission: / /

Title Given Name Surname

Address:

Telephone D.O.B. / / Sex:

Home Business/Mobile

Clinical Details

Presenting Symptoms:

Principal Diagnosis:

Other conditions present:

Medications:

Allergies:

Operation

Proposed operation/treatment:

Date of operation: / / Item Numbers:

Prostheses: Yes / No If yes, please provide details:

Expected time in theatre:

Specific pre-operative instructions (including tests required):

Specific orders on admission:
Please list specific instructions required ie: Medications/pathology/E.C.G/discharge needs.

Referring Doctor's Details

Name: Signature: Date: / /

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Surgical / Patient Consent Form

Patient Label

REQUEST/CONSENT FORM FOR SURGICAL OPERATION PROCEDURE

PART A: Provision of information regarding treatment to Patient (To be completed by Medical Practitioner)

I, Doctor ____

(Insert name of medical practitioner)

have informed ____

(Insert name of patient/guardian)

of the nature and purpose, likely results, material risks and alternatives to the recommended operation/procedure and/or treatment/anaesthesia. The agreed operation/procedure that the patient is to undergo is:

____

(Insert the name of the operation/procedure and/or treatment)

Operative site: ____

Interpreter required? ☐ YES ☐ NO I,______________________, an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to

________________________	________________________
Signature of the Medical Practitioner	Signature of the interpreter
Date: / /	Date: / /

PART B: Patient Consent (To be completed by patient/parent/guardian)

The doctor whose name appears in Part A above and I have discussed my/my child's/my charge's present condition and the various alternative ways in which it might be treated.

The doctor has told me that:

- The administration of an anaesthetic, medicines, and/or a blood transfusion may be needed in association with this operation/procedure and/or treatment and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedures and/or treatment being carried out if required as long as they are related to the primary procedure set out in Part A.
- Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not give the expected result.
- The operation/procedure and/or treatment carries some risk and that complications may occur.

I have been advised of the material risks associated with this operation/procedure and/or treatment.

I understand the nature of the procedure/treatment and that undergoing the operation/procedure and/or treatment carries risk.

I consent/do not consent to a blood transfusion if needed (cross out whichever does not apply)

I consent/do not consent to the taking of a blood sample for appropriate testing of communicable diseases including A.I.D.S and hepatitis, should contamination of any staff member or doctor, or myself, occur during my hospital stay. This blood sample may be taken during the course of the procedure itself or during the preparation for or recovery from the procedure (cross out whichever does not apply)

I request, understand and consent to the operation/procedure and/or treatment as outlined above in Part A.

____

Signature of patient/parent/guardian

Date: / /

____

Print name of patient/parent/guardian

Address: ____________________

Our Quality and Safety Program

CNDH has a comprehensive Quality & Safety Program. We aim to maintain the highest level of care to our patients in a patient centred, safe and supportive environment. Our hospital adheres to all statutory, legislative, relevant body guidelines and Australian Standards.

To achieve a high standard of care we work together as a team under the management of the Board of Directors, Medical Advisory Committee (MAC) and Director of Nursing within the following functions:

Quality Management

A comprehensive program is in place to continually monitor, assess and improve the quality of patient care. Peer reviewed activities are conducted by the MAC to ensure that the safest possible care is provided to our patients. As part of this process we publish information about clinical performance, health outcomes and patient satisfaction. This information is also benchmarked against the National Standards, where applicable.

Leadership & Risk Management

CNDH uses an integrated approach to identify, assess, analyse, evaluate, treat, measure, monitor and control the complex array of risks involved in healthcare. We take a proactive approach, placing the emphasis on risk prevention to provide the safest possible environment for patients, visitors and staff.

Workforce Planning

We employ dedicated specialist clinical staff members to ensure our patients receive the highest standard of care possible in a comfortable and safe environment. Our staff are all credentialed and competency assessed to perform the roles they are engaged to undertake.

Safety Management

CNDH undertakes planned and regular biomedical testing and maintenance of its equipment and plant. Audits are conducted on a frequent basis to ensure the environment is safe for all who visit CNDH.

Clinical Handover

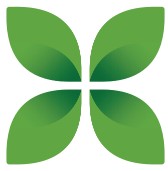
Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for patients when they are transferred from one person to another. The clinical leaders and senior managers of CNDH have implemented systems for the effective and structured clinical handover of our patients. Our patients and carers are encouraged to be involved in the clinical handover process particularly when they are discharged to go home.

Infection Control Program

CNDH has a comprehensive Infection Control program aimed at preventing and limiting the spread of infection through evidence based research to guide clinical practice. Our program consists of education for all stakeholders, including auditing of staff practices, infection prevention measures, surveillance, monitoring and investigation of health care associated infections.

Consumer Participation

As a consumer of the healthcare services provided at CNDH, we welcome your interest in reviewing our Quality & Safety report and providing feedback on how the services could be improved at CNDH. Our staff may approach you or your family to ask you for feedback through a short survey. Your feedback and advice is both welcomed and greatly appreciated.



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