Pre Admission Form

Tel: (02) 4943 1003
Fax: (02) 4943 1004
Email: admin@charlestownprivate.com.au

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PLEASE COMPLETE AND RETURN ADMISSION FORMS AS SOON AS POSSIBLE PRIOR TO YOUR DATE OF ADMISSION.

Patient Label

Surgery Booking

Date of admission:	Surgeon:

Personal details
Have you ever been admitted to CPH before ☐Yes ☐ No

Title:	Surname:	Given names:
Preferred name:		Marital status:
Date of birth:		Gender:
Street address:		
Phone home:	Mobile:	Work:
Email address:		
Postal address same as above ☐Yes ☐ No if no, postal address:		
Occupation:		
Country of Birth:		Language spoken at home:
Indigenous status:		Religion:

Next of Kin

Name:		Relationship:
Address:		
Phone home:	Mobile:	Work:

Emergency Contact

Name:		Relationship:
Address:		
Phone home:	Mobile:	Work:

Medicare

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
Your name position number is: ___	Expiry Date: ___ ___ / ___ ___ ___ ___

Department of Veteran Affairs

Card: ☐Gold ☐ White	Card number:

Work Cover ☐ TAC ☐

Insurance Company:	Claim number:

Private Health Insurance
Please check with your health fund that you are covered for your admission to CPH

Name of Health Fund:	Membership number:
Policy name:	Joining date:
Name of contributor:	Relationship:
Do you have an excess ☐Yes ☐ No $_____	Do you have a co-payment ☐Yes ☐ No $_____

Please turn over

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Please read the below carefully, complete and sign

Financial Consent

An estimate of my hospital fees has been explained to me.

Privately insured patients

I understand that the hospital will forward my account directly to my health fund on my behalf. I further understand I will be responsible for and agree to pay the balance of any monies outstanding to Charlestown Private Hospital should there be a shortfall, account denied or reduce payment by my health fund.

I understand that if I have an excess or co-payment attached to my policy that it will have to be paid before or on admission and prior to surgery.

Self funded patients

I understand that I will be required to pay the estimated cost of hospitalisation before or on admission and prior to surgery. Any variance from the estimated cost will either be invoiced for payment or refunded within 7 days.

Consent to use personal information

I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the booklet and the section related to Privacy and I understand my rights to privacy and how my personal information will be used at the hospital. I give my consent to the use of my personal information as described in the booklet. I understand that I may withdraw my consent at any time.

Discharge arrangements

We take your safety seriously and it is our duty of care and a requirement of the hospital that you have a responsible adult take you home from Charlestown Private Hospital, care for you immediately after your surgery/ procedure and at least overnight.

Please complete the details below:

Name and contact details of person driving you home

Name:..... Phone number:.....

Name address and contact details of the person caring for you overnight

Name:..... Phone number:.....

Address:.....

I have carefully read all of the above. I have been informed of the estimate of hospital fees and duly note my obligation in regard these. I consent for the use of my personal information as outlined in the booklet. I have arranged for someone to care for me after my surgery/ procedure and overnight as per the policy of the hospital. I also understand that the hospital will not be held liable for any valuable that I bring to the hospital.

Signature:..... Print name:..... Date:.....

(Patient or Parent/ Guardian – Please indicate)

Health Assessment Form

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Patient Label

PLEASE COMPLETE IN FULL

Patient Medical History: to be completed by Patient, Carer or GP prior to admission

Do you consent to the hospital communicating with your General Practitioner: ○ Yes ○ No			
GP Name:		GP Practice:	
GP Suburb:		GP Telephone:	
Allergies: including drugs, latex (rubber), food, tapes, lotions etc: Have you had a severe life threatening reaction to any of the above ○ Yes ○ No If yes which one:			
Medications: please include dose and amount taken daily (attach list if needed) including non-prescribed drugs, substances and supplements e.g. fish oil, vitamins, powders, herbs:			
Previous surgery: (attach list if needed)			
Height:		Weight:	
Diabetes: ○ Yes ○ No ○ Type 1 ○ Type 2		○ Insulin Dependent ○ Tablet ○ Diet	
Do you take Warfarin, Aspirin or other blood thinning drugs? ○ Yes ○ No		Have you been instructed to stop? ○Yes ○ No If yes when:	
Previous anaesthetic problems/ reactions: Details:	○ Yes ○ No	Family history of anaesthetic problems / reactions Details:	○ Yes ○ No
Blood Pressure: ○ High ○ Low	○ Yes ○ No	Lung disease	○ Yes ○ No
Heart attack: If yes, date:	○ Yes ○ No	○ Asthma / ○ Bronchitis / ○ Shortness of breath	○ Yes ○ No
Chest pain / Angina	○ Yes ○ No	○ Sleep Apnoea / ○ Sleep Disorders	○ Yes ○ No
Heart stents:	○ Yes ○ No	○ Emphysema / ○ Pneumonia	○ Yes ○ No
○ Heart valve replacement / ○ Repair / ○ Bypass	○ Yes ○ No	○ Recent cough / ○ Cold / ○ Sore Throat	○ Yes ○ No
Anaemia/ bleed or bruise easily	○ Yes ○ No	Do you live alone?	○ Yes ○ No
○ Pacemaker ○ Defibrillator	○ Yes ○ No	Depression or other Mental Health issues? Please specify:	○ Yes ○ No
Joint or other implants/ replacements: If yes please specify where:	○ Yes ○ No	○ Dementia / ○ Memory Loss / ○ Confusion	○ Yes ○ No
History of blood clots: If yes where:	○ Yes ○ No	High Cholesterol	○ Yes ○ No
History of blood transfusion/s:	○ Yes ○ No	History of Rheumatic Fever	○ Yes ○ No
Indigestion or reflux	○ Yes ○ No	○ Liver disease / ○ Hepatitis / ○ Jaundice Year:	○ Yes ○ No
Have you had or have a multi resistant organism infection? ○ MRSA / ○ VRE Hospital: Year: Have you received clearance? ○ Yes ○ No			○ Yes ○ No

Please turn over

Cortisone/ steroid therapy	○ Yes ○ No	Do you have a neurological condition? Please specify: ○ Stroke / ○ MS / ○ Motor Neurone / ○ Parkinson's disease	○ Yes ○ No
Peripheral Vascular Disease	○ Yes ○ No	○ Fainting / ○ Dizziness / ○ TIA's	○ Yes ○ No
Do you have Dentures, caps, crowns, bridge or plate?	○ Yes ○ No	Stress related conditions	○ Yes ○ No
Back or neck problems	○ Yes ○ No	○ Seizures / ○ Epilepsy ○ Fits	○ Yes ○ No
Body Piercings? Where:	○ Yes ○ No	Kidney disease	○ Yes ○ No
Skin condition specify:	○ Yes ○ No	Does your skin tear easily?	○ Yes ○ No
Pressure ulcer/ area Where:	○ Yes ○ No	Existing wounds specify:	○ Yes ○ No
Arthritis: Where:	○ Yes ○ No	Have you or do you have a blood borne infection e.g. HIV/ Hepatitis B and C? Which one:	○ Yes ○ No
Do you have any other infection/s? Specify:	○ Yes ○ No	Tuberculosis (TB)	○ Yes ○ No
Have you travelled from overseas in the last 10 days? Where:	○ Yes ○ No	Have you been in contact with a person known to have influenza or acute respiratory illness/ infection in the last 10 days?	○ Yes ○ No
Do you have a family history of Creutzfeldt-Jakob Disease (CJD)?	○ Yes ○ No	Do you have a "Medical in Confidence" letter or have been involved in a "Look Back" study in regards to CJD risk?	○ Yes ○ No
Did you receive human pituitary hormones prior to 1986 (growth/ infertility)?	○ Yes ○ No	Organ Transplant: Please provide details:	○ Yes ○ No
Did you undergo surgery on the brain (neurosurgery) before 1990?	○ Yes ○ No	What type of operation was it?	
Do you drink alcohol? If yes, how much?	○ Yes ○ No	Do you use or have used recreational drugs in the last 12 months? Details:	○ Yes ○ No
Do you smoke? Number per day:	○ Yes ○ No	Are you or could you be pregnant?	○ Yes ○ No
Do you have special dietary requirements: Details:	○ Yes ○ No	Are you receiving home assistance?	○ Yes ○ No
Are you the sole carer of someone at home?	○ Yes ○ No	Will you require extra assistance when you go home following your procedure? Specify:	○ Yes ○ No
Do you have a ○ hearing or ○ vision impairment? Detail:	○ Yes ○ No	Do require a walking aid? Detail:	○ Yes ○ No
Have you had a fall or tripped over in the last 6 months?	○ Yes ○ No	If yes, how many times and how:	
Do you have or had any other significant disease, illness or infection?	○ Yes ○ No	Detail	
Do you have an Advanced Care Directive?	○ Yes ○ No	If yes, please bring a copy	
Do you require an interpreter?		If yes, which language:	

I have carefully read the above and I certify that the information I have given is correct and true to the best of my ability.

Signature:..... Date:.....

Print name:.....