



Corymbia House

92-94 David Street, Dandenong 3175
Tel. (03) 9791 3533 Fax (03) 9706 8044

ATTACH PATIENT LABEL AS REQUIRED

FORM MUST BE RETURNED AT LEAST 5 DAYS PRIOR TO ADMISSION TO CONFIRM BOOKING

Admitting Doctor

General Practitioner
(Name & Address)

Date of Admission

Time

Date of Operation

Operation/Procedure

Have you been hospitalised anywhere in the last seven days?

Yes

No

If Yes, Hospital

Have you sighted a copy of the Rights and Responsibilities brochure

Yes

No

Have read the Privacy Policy

Yes

No

PATIENT DETAILS – please print

Title

Surname

Previous Surname

Given Names

Address

Postcode

Phone (H)

Phone (B)

Phone (Mobile)

Sex

Male Female

Date of Birth

Marital Status

Country of Birth (If Australia, which State)

Are you an Australian Resident?

Yes

No

Religion

Are you of Aboriginal/Torres Straight Island descent

Yes

No

Medicare Number

Patient's Reference No.

Expiry Date

Veteran's Affairs No.

Pension No./ Health Care Card

Full Part

Expiry Date

Safety Net Number

HEALTH FUND INSURER

Fund

Membership Number

Level of Cover

Date Joined

Previous Fund

Confirmed By

Confirmed With

Date Time

WORKCOVER/TRANSPORT ACCIDENT COMMISSION DETAILS

Employer Name

Employer Address

Contact

Phone

Date of Accident

Claim Number

Claims Agent

CONTACT PERSON / NEXT OF KIN

Surname

Given Name

Relationship

Address

Postcode

Phone (H)

Phone (B)

Phone (Mobile)

2ND CONTACT PERSON

Surname

Given Name

Relationship

Address

Postcode

Phone (H)

Phone (B)

Phone (Mobile)



MR001

TO BE COMPLETED BY PATIENT

PRE-ADMISSION SUMMARY

MR/001

NAME: _____

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PATIENT PRE-ADMISSION HISTORY

ADMISSION DIAGNOSIS What condition are you being admitted to hospital for?

Weight Height

Expected Length of Stay Day Case

Do you have x-rays relevant to your admission? Yes, please bring on admission
 No

MEDICAL HISTORY Have you ever had any of the following

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clot in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Coronary (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
C.V.A. (stroke)	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Pneumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Fits	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	AIDS Risks	<input type="checkbox"/>	<input type="checkbox"/>	Are you/could you be pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>						

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you had a dura mater graft? (between 1972 and 1989) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you suffered from a recent progressive dementia, the cause of which has not been diagnosed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985? | <input type="checkbox"/> | <input type="checkbox"/> |

Please give details

SURGICAL HISTORY Have you had any previous surgery? Yes No

Please give details (state year)

ANAESTHETIC HISTORY

	YES	NO
Have you ever had any previous anaesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or a member of your family ever had special problems with anaesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke <input style="width: 50px;" type="text"/> per day	<input type="checkbox"/>	<input type="checkbox"/>
Do you consume alcohol? <input style="width: 50px;" type="text"/> per week	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION

	YES	NO
Are you taking any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>
Please give details (including contraceptive pill, herbal remedies, blood thinning eg. Aspirin, Warfarin, Plavix)		

Medication	Dose	Frequency

TO BE COMPLETED BY PATIENT

NAME: _____

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CONSENT FOR SURGICAL OPERATION/PROCEDURE/TREATMENT

Part A: To be completed by Patient

The doctor whose name appears in Part B 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:

1. The administration of an anaesthetic, medicines may be needed in association with this operation/procedure and these carry some risks.
2. 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.
3. Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not achieve the expected result.
4. The operation/procedure and/or treatment carries certain risks, and the nature of those risks, and, that complications may occur.

I agree that I have been given the opportunity to ask questions of the doctor whose name appears below, and understand the nature of the procedure/treatment and that undergoing the operation/procedure carries risks. I am satisfied with the answers and information I have received.

I have been advised of the material risks associated with this operation/procedure/treatments.

I understand that whilst I am in hospital, I will receive care, medications, tests and examinations as necessitated by the operations/procedure I am undertaking.

I understand that I may withdraw my consent at any time prior to the operation/procedure and/or treatment.

I **consent / do not consent** to blood transfusion/blood products to be administered if needed.

I do not consent to the following whilst receiving care _____

Dated this _____ day of _____ 20_____

Signed _____ Relationship to Patient _____

Witness Signature _____ Print Name _____

*Witness is verifying that they have witnessed the patient/guardian signing the form only.

PART B. TO BE COMPLETED BY DOCTOR

I, Doctor _____ have informed _____ of the nature, likely results, and material risks of the recommended operation/procedure and/or treatment. The agreed operation/procedure and treatment that the patient is to undergo is _____

Surgeon's Signature _____ Date _____

Anaesthetist's Signature _____ Date _____

PART C: IS AN INTERPRETER REQUIRED? Yes No

I, _____ an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to _____

Signed _____ Date _____

PATIENTS RIGHTS AND RESPONSIBILITIES

Patient Rights

- To receive quality health care from appropriately qualified and experienced staff and to receive continuity of care when attending Corymbia House.
- To receive health care that does not discriminate, particularly on the basis of race, religion, gender, health insurance status, mental status, socioeconomic background or age.
- To obtain complete and current information on your care and treatment in a language that you understand.
- To receive information about choices and options for your care and treatment including advantages, disadvantages, risks, benefits and alternatives to these treatments.
- To be given adequate opportunity to have any information clarified or any questions answered
- To be treated with courtesy and respect and have your privacy and cultural background respected by staff as well as having access to an interpreter if required.
- To expect that a safe and secure environment is maintained whilst receiving the services, including physical and emotional support.
- To be secure in the knowledge that information concerning your condition and care is treated as confidential and only used by staff who is involved in your care, unless you direct us otherwise.
- To have your health care discussed where others could not overhear it.
- To be given the opportunity to participate in decisions affecting your health care, where relevant.
- To know the identity and professional status of all attending Corymbia House and to refuse the presence of other people during the delivery of the treatment / surgery.
- To expect staff to routinely introduce themselves to you.
- To seek a second opinion on your condition or treatment / care plan.
- Where applicable, to know in advance the charges for the services provided to you.
- To give your informed consent before the services are provided; to refuse the care or treatment options provided to you by the staff, after being fully informed of the consequences of that decision.
- To discuss any concerns, questions, provide feedback or make complaints about issues related to the services provided to you, the processes involved with the service provision and any treatment undergone at Corymbia House.
- To continue to receive appropriate alternative care if any decision to refuse treatment is made.
- To expect that expert/professional decisions to be made on your behalf and in your best interest after discussion with next of kin, partner, carer, guardian or medical agent, should you be unable to speak.

Patients Responsibilities

- To participate and cooperate with an agreed treatment and care program or inform staff of your intention not to comply.
- To be considerate of staff and other patients, treating them with courtesy and respect.
- To provide the relevant information about your health including the possibility of infectious diseases, to assist the staff involved in your care,
- To inform staff if you are covered by any special benefits/ schemes.
- To contribute to a safe and comfortable environment in relation to noise, alcohol, smoking and illicit drugs.
- Consider your ability to meet your financial obligations to pay any accounts and fees for which you are responsible.
- To advise Corymbia House if you are unable to keep an appointment within at least 24 hours notice.

PATIENT PRIVACY

Corymbia House Services takes patients privacy very seriously. It is the policy of Corymbia House that all efforts will be made to maintain patient privacy while attending the centre and all records are kept securely in accordance with privacy principles.

Privacy Compliance

Corymbia House is bound by the National Privacy Principles (Privacy Act 1998, as amended). Corymbia House deals with personal information in accordance with such principles.

The National Privacy Principles can be obtained through the website of the office of the Federal Privacy Commissioner (<http://www.privacy.gov.au>).

Information Collected by Corymbia House, 92 David Street Dandenong 3175

Part A – Patient Information

Corymbia House holds the following information with respect to its patients.

- Name
- Personal address
- Postal address
- Telephone numbers
- Fax number
- Date of birth
- E-mail address
- Clinical photographs

The purpose of the above information is to assist the Staff – both Medical and Administrative to carry out the operation of the centre. The purpose of the above information is to enable the centre to effectively treat patients

How does Corymbia House use information?

Information is collected from patients through the provision of that information on their behalf by their treating practitioner or directly from the patient.

Information concerning patients is stored electronically on our computer system which is maintained in a secure environment. All personnel have signed Privacy and Confidentiality Agreements binding them to comply with the National Privacy Principles.

Access to records

Patients of the centre may request access to personal information by writing to the Privacy Officer. Persons entitled to access do not have to provide a reason for requesting access. The patient will be notified when their record will be available for personal viewing at the centre.

Applications should be made in writing. Verification will be made prior to response.

Applications should be forwarded to: Privacy Officer
Corymbia House
92 David Street Dandenong 3175

If a person believes that information held by the centre is incorrect, incomplete or inaccurate they may request amendment of that personal information. The centre will consider if the information requires amendment. If the centre does not agree that there is any ground for amendment it will, if the person seeking the amendment requires, place with that person's personal information, a statement from that person as to why the information is not accurate or up to date.

If patients wish to obtain access to or wish to notify any changes to their details kept at the centre, they should contact the Privacy Officer for a copy of the protocol and the forms for carrying out these functions.