STIRLING
HOSPITAL

PART B

PATIENT DETAILS AND HEALTH ASSESSMENT

Please complete and return by email at least ten (10) days prior to your admission

Email to: reception@stirlinghospital.org.au

If you wish to provide additional information please include in the body of your email

Delivering the Stirling Experience ...

PLEASE COMPLETE AND RETURN PART B TEN (10) DAYS PRIOR TO ADMISSION

Hospital use only:

Insert Patient Label

MRN:

PATIENT DETAILS

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Dr ☐ Other **Gender:** ☐ Male ☐ Female Other

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

Surname:______________________ Given Names:______________________

Date of Birth:____/____/______ Age:__________ Previous Surname (If applicable):______________________

Address:______________________________________ Postcode:__________

Postal Address (If Different From Above):______________________________

Phone Mobile:________________ Home:________________ Work:________________

Occupation (optional): ______________________________

Country of Birth:____________________ Religion:____________________

Race: ☐ Caucasian ☐ Aboriginal ☐ Asian ☐ TSI ☐ Other: __________ (Required by Department of Human Services)

Email:

MEDICARE AND CONCESSION DETAILS

Medicare No. ☐☐☐☐ ☐☐☐☐☐ ☐ No. before name ☐ Expiry ☐☐ / ☐☐☐☐

Pension Number:____________________ Type:__________ Expiry Date:__________

PBS Safety Net Card No:____________________ Expiry Date:__________

SA Ambulance Card No:____________________ Expiry Date:__________

Dept. of Veterans Affairs File No:____________________ Expiry Date:__________

DVA Card: ☐ Gold ☐ White (White card holders need written approval from DVA prior to admission)

All cards are to be sighted by Admission Staff on arrival

ADMISSION DETAILS

Reason for Admission:______________________________

Admission Date:_____/_____/______ **Time:** __________

Hospital Stay: ☐ Inpatient ☐ Day Patient ☐ Boarding Parent (of child aged 12 years and under)

Admitting Doctor:____________________ **Referring Doctor / GP:**____________________

Your General Practitioners Name: ____________________ Address:____________________

Have you ever been a patient at Stirling Hospital? ☐ Yes ☐ No If Yes, in approx. year:__________

Have you been a patient at **ANY** hospital within the past 7 days? ☐ Yes ☐ No

If Yes, please state which Hospital:____________________ ☐ Public ☐ Private Patient

Date of Hospitalisation From: ____________________ To ____________________

Have you opted out of having a My Health Record? Yes No

STIRLING HOSPITAL

Insert Patient Label

PATIENT ADMISSION INFORMATION

PART B

NEXT OF KIN OR SUPPORT PERSON DETAILS

FIRST SUPPORT PERSON:

Title:__________ Surname:__________________ Given Name:__________________________ Relationship:______________

Address:____ Postcode:______________

Phone Home:__________________________ Work:__________________________ Mobile:______________

The above support person CAN be involved in: communications about my care: YES NO, and decision making about my care: YES NO

SECOND SUPPORT PERSON:

Title:__________ Surname:__________________ Given Name:__________________________ Relationship:______________

Phone Home:__________________________ Work:__________________________ Mobile:______________

The above support person CAN be involved in: communications about my care: YES NO, and decision making about my care: YES NO

HEALTH INSURANCE DETAILS

INSURED PATIENTS: It is important that you contact your Health Fund prior to completing this form to check your level of cover. Please be aware of the PRE-EXISTING CONDITION Rule. It is important that you are aware of all financial costs relating to your stay in hospital.

Health Fund:__________________________ Membership No:__________________________________

Current Table Membership: ☐ Over 12 Months ☐ Less Than 12 Months ☐ Exclusions?__________________

Transferred Health Fund Cover: ☐ Yes ☐ No Previously held cover with:__________________________

Do You Have An Excess +/- Co-Payment To Pay? ☐ Yes ☐ No Excess amount currently due: $__________ ☐ Paid

Person Responsible for Payment of Account (If not yourself):

Name:____ Phone:__________________________

Address:____ Postcode:______________

Relationship:____

TO STREAMLINE YOUR ADMISSION ANY EXCESS OR PAYMENT CAN BE MADE BEFORE ADMISSION, REFER PAYMENT AUTHORISATION DETAILS – PAGE 9
PAYMENT CAN ALSO BE MADE ON ADMISSION.

COMPLETE ONLY FOR WORKCOVER OR INSURANCE RELATED ADMISSIONS

Please Tick Appropriate Box: ☐ Workcover ☐ Third Party ☐ Public Liability

Date of Accident:__________________________ Claim Number:__________________________

Employer's Company Name:__________________ Contact Person:__________________________

Address:__________________________________ Phone:________________ Fax:______________

Insurer's Name:____________________________ Contact Person:__________________________

Phone:____________________________________ Fax:____________________________________

WORKCOVER OR INSURANCE COMPANY APPROVAL MUST BE OBTAINED BEFORE ADMISSION

PLEASE COMPLETE AND RETURN PART B TEN (10) DAYS PRIOR TO ADMISSION

Insert Patient Label

Patient Name:		**Date of Birth:** / /
Planned Admission Date: / /	**Planned Surgery Date:** / /	**Planned length of stay:**
In your own words please tell us why you are being admitted to hospital:		
Do you require an Interpreter? ☐ **No** ☐ **Yes**		**If Yes Specify Language:**
WHAT IS YOUR WEIGHT? ☐ **KG**	**WHAT IS YOUR HEIGHT?** ☐ **CM/FT**	**BMI** ☐

DO YOU HAVE / HAD ANY OF THE FOLLOWING:				**Staff Use Only Initial actions**
Sensitivity or allergy to medicines, foods, tapes, metals, latex / rubber, antiseptics, other?	☐ No	☐ Yes	Specific allergy and reaction :	Record on alert sheet. Notify OT of latex allergy
Side effects / reactions to an anaesthetic (nausea, confusion or aggression)	☐ No	☐ Yes	Specify:	If yes notify anaesthetist
An immediate blood relative who has had side effects/reactions to anaesthetic?	☐ No	☐ Yes	Specify:	If yes notify anaesthetist
Have x-rays / CT scan / MRI / Ultrasound been taken for this admission?	☐ No	☐ Yes	Please bring your x-rays / scans to hospital with you	Films present
Blood/Pathology Tests for this admission?	☐ No	☐ Yes	Date: / / Path Group:	Copy in Notes
Treatment from other specialists / doctors?	☐ No	☐ Yes	Name(s):	
Female patients – could you be pregnant?	☐ No	☐ Yes	If yes, date of last period: / /	
MEDICATION				
Do you take/ recently taken, blood-thinning medicines, i.e. Aspirin, Warfarin, Clopidogrel (Iscover, Plavix)?	☐ No	☐ Yes	Name of medication: Date last taken: / / Or still taking ☐ Yes	Notify surgeon if applicable Record pre-op checklist
Have you taken any steroids, anti-inflammatory or cortisone injections in the last 6 months?	☐ No	☐ Yes	Name of medication: Date last taken: / / Or still taking ☐ Yes	Notify surgeon if applicable
Are you taking any non-prescription or complementary medications (e.g. vitamins, minerals, herbal remedies)?	☐ No	☐ Yes	Name of medication: Date last taken: / / Or still taking ☐ Yes	Notify surgeon if applicable
Do you or have you ever smoked?	☐ No	☐ Yes	Number/day: Date Stopped: / /	
Do you drink alcohol?	☐ No	☐ Yes	Amount/day;	
Do you use recreational drugs (other than alcohol or tobacco)?	☐ No	☐ Yes	Type: Amount/day:	

CURRENT MEDICATIONS	DOSE / FREQUENCY	CURRENT MEDICATIONS	DOSE / FREQUENCY

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PATIENT HEALTH INFORMATION

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SURGICAL HISTORY (attach list if not enough room)			
Type of Surgery	**Date**	**Type of Surgery**	**Date**
1.	/ /	2.	/ /
3.	/ /	4.	/ /
5.	/ /	6.	/ /

MEDICAL HISTORY

DO YOU HAVE / HAD ANY OF THE FOLLOWING:				Staff Use Only Initial actions
Asthma / cough / wheeze / emphysema / shortness of breath on exertion / hay fever / pneumonia / tuberculosis	☐ No	☐ Yes	Specify: Do you use: ☐ Nebulisers ☐ Puffers ☐ Home Oxygen	☐ Nebuliser brought into hospital
Sleep problems -snoring, insomnia, dozing off during day	☐ No	☐ Yes	Specify:	If yes attend Epworth scale
Do you use a CPAP machine?	☐ No	☐ Yes	If yes, please bring CPAP machine to hospital with you	☐ CPAP with pt
Hypertension / high blood pressure?	☐ No	☐ Yes		
Heart problems: heart attack / angina / chest pain / replacement heart valve / pacemaker / bypass surgery / stent / palpitations / irregular heart beat / heart murmur / rheumatic fever	☐ No	☐ Yes	Specify:	
High cholesterol?	☐ No	☐ Yes		
Family history of heart disease?	☐ No	☐ Yes	Specify:	
Diabetes?	☐ No	☐ Yes	Managed by: ☐ Diet ☐ Tablets ☐ Insulin *If you use a glucometer please bring it to hospital with you*	☐ Glucometer brought in
Thyroid problems?	☐ No	☐ Yes	Specify:	
Strokes / mini-strokes / Multiple Sclerosis / Motor Neurone Disease?	☐ No	☐ Yes	Do you have any residual weakness / symptoms? Specify:	
Epilepsy / fits / seizures?	☐ No	☐ Yes	Last seizure: / /	
Faints / black-outs / dizzy spells?	☐ No	☐ Yes	Specify:	
Migraines?	☐ No	☐ Yes	How often?	
Mental Health Condition: anxiety / depression / PTSD / Bipolar Disorder (circle) Other:	☐ No	☐ Yes	List treating Psychologist or Psychiatrist:	Attend 1A form
Cognitive impairment / dementia / short term memory loss / confusion / delirium	☐ No	☐ Yes	Specify:	
Speech / swallowing problems	☐ No	☐ Yes	Specify:	
Reflux / indigestion / stomach ulcer	☐ No	☐ Yes	Specify:	
Nausea / vomiting / appetite loss?	☐ No	☐ Yes	Specify:	
Gastric band / surgical weight loss aid?	☐ No	☐ Yes	Has the band been deflated? ☐ No ☐ Yes	
Recent weight loss without trying?	☐ No	☐ Yes	If yes, state how much:	
Do you have any challenging conditions such as autism, OCD, claustrophobia, or other behaviours that we can assist you with?	No	Yes	Specify:	

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PATIENT HEALTH INFORMATION

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DO YOU HAVE / HAD ANY OF THE FOLLOWING:				Staff Use Only Initial actions
Liver disease / Hepatitis / Jaundice?	☐ No	☐ Yes	Specify:	
Blood/ Blood Product Transfusion?	☐ No	☐ Yes	Reason: Last given: / / Any reactions to Blood Products? ☐ No ☐ Yes	
Blood disorders / bleeding problems / bruise easily?	☐ No	☐ Yes	Specify:	
Blood clot in legs or lungs?	☐ No	☐ Yes	Specify:	
Kidney problems?	☐ No	☐ Yes	Specify:	
Bladder problems: flow/ night frequency/ incontinence/stoma?	☐ No	☐ Yes	Specify:	
Bowel problems: incontinence / constipation / diarrhoea /stoma?	☐ No	☐ Yes	Specify:	
Special diet: diabetic/ gluten free/ lactose free/ vegetarian/ Kosher/Halal	☐ No	☐ Yes	Specify:	
Dental alterations: Caps/crowns/implants/ dentures/loose teeth	☐ No	☐ Yes	Specify:	Record pre-op checklist
Problems with your eyesight or your hearing?	☐ No	☐ Yes	Specify:	Glasses or hearing aids brought into hospital
Any cultural or other specific needs?	☐ No	☐ Yes	If yes, on admission a nurse will develop a plan with you to meet your needs	
Arthritis/Osteoporosis	☐ No	☐ Yes	Specify:	
A fall in the last 12 months?	☐ No	☐ Yes	Specify:	
Mobility problems?	☐ No	☐ Yes	Specify:	
Cancer?	☐ No	☐ Yes	Site: Date diagnosed: / / ☐ Chemotherapy ☐ Radiotherapy	
Lymphoedema?	☐ No	☐ Yes	Specify:	
Skin: existing wound/pressure area / ulcer / broken skin / reddened skin	☐ No	☐ Yes	Specify:	
Do you have pain?	☐ No	☐ Yes	Specify:	
Any other conditions?	☐ No	☐ Yes	Specify:	
Any infection currently or in the past 2 weeks?	☐ No	☐ Yes	Where: When: Any treatment:	If Yes, complete 1C form and contact ICC
History of a multi-resistant organism (MRSA) / Clostridium difficile / VRE / other?	☐ No	☐ Yes	Where: When:	Record pre-op checklist. If yes fill in 1C
Have you travelled overseas in the past 4 weeks?	☐ No	☐ Yes	If Yes – which countries did you visit? Were you unwell overseas or on return? ☐ No ☐ Yes	If Yes, complete IC form and contact ICC

Creutzfeldt-Jakob Disease (CJD)			Staff Use Only Initial actions
Have you had a Dura mater graft prior to 1990?	No	Yes	If yes to any of these questions notify Infection Control immediately
Do you have a family history of two or more first degree relatives with classical Creutzfeldt-Jakob Disease (CJD) or other unspecified progressive neurological disorder?	No	Yes	
Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?	No	Yes	
Have you received human pituitary hormones prior to 1986?	No	Yes	
Have you been involved in 'look back' for CJD or do you have a 'medical confidence letter' regarding your risk of CJD?	No	Yes	

DISCHARGE PLANNING			Staff Use Only Initial actions
Are you expecting to return to your current residential address directly from hospital?	No	Yes	If No, specify plans:
Do you live alone?	No	Yes	
Do you have any home help?	No	Yes	Specify:
Do you have family support on discharge?	No	Yes	
Do you care for others at home?	No	Yes	Specify:
Have you been assessed by the Aged Care Assessment Team (ACAT)?	No	Yes	Date of assessment: Level of care approved:
Any special needs/concerns regarding discharge?	No	Yes	Specify:
Have you completed any of the following:			
Enduring Power of Attorney (Financial Decisions)	No	Yes	Obtain Copy
Enduring Power of Guardianship (Personal Decisions)	No	Yes	Obtain Copy
Medical Power of Attorney (Medical Decisions) *	No	Yes	Obtain Copy
Anticipatory Directive or Not for Resuscitation Order *	No	Yes	Obtain Copy

If yes to any of the above marked with a star (*), please provide a copy to the Hospital

TO THE BEST OF MY KNOWLEDGE, THE ABOVE DETAILS ARE TRUE AND CORRECT

Patient / relative / guardian signature: **Please print name**:

STAFF USE ONLY

Checked by Pre Admission Nurse or on admission

Nurses signature: **RN / EN** **Date:** / / **Time:** :

THE PATIENT HEALTH ASSESSMENT IS TO BE COMPLETED BY THE ADMISSION NURSE ON ADMISSION WITHIN 24 HOURS

List of prosthesis and equipment brought in:

If valuables brought into Hospital have they been taken home: ☐ Y ☐ N ☐ N/A OR

Locked away securely: ☐ Y ☐ N ☐ N/A If yes, where? Cupboard in Room Number: Safe:

Nurses signature: **RN / EN** **Date:** / / **Time:** :

SELF FUNDED PATIENTS

Patients are personally liable for their own hospital account. An estimate only can be provided prior to admission as the procedure item number may change. Payment of the anticipated fee is due before or on admission and any shortfall in the estimate, is payable on discharge. Your doctor's rooms will liaise with Stirling Hospital in providing an estimate of the expected costs. **Credit card pre-authorisation will be required for self insured patients.**

All Hospital costs for uninsured patients are payable before or on admission and are not covered by Medicare

PAYMENT AUTHORISATION DETAILS

Credit Card: **Please note we do not accept Diners and American Express**

Please tick: ☐ Mastercard ☐ Visa

Please charge this amount to my credit card in Australian $____________________

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date on Card: ☐☐ / ☐☐ (you must fill this in) **Card Security Code:** ☐☐☐

(Your credit card security number is the last 3 digits of the number in the signature strip on the back of the card).

Name on Card:____________________________ **Signature of Card Holder:**_____________________________________

Direct Debit to Stirling Hospital:

BSB: 105 079 (Bank SA, Stirling)

Account Number: 3051 329 40

Reference: Please add Admission Day, Month and Surname. *Example* ***29.5 Smith***

Cheque:

Please make the cheque payable to 'Stirling Hospital'. If you are paying by cheque, please enter the amount being paid in Australian $______________

Post cheque to: Stirling Hospital, 20 Milan Tce, Stirling, South Australia 5152

FINANCIAL INFORMATION AND CONSENT / PRIVACY CONSENT

1. I accept full responsibility for accounts rendered by Stirling Hospital, including any shortfall in reimbursement by my health fund / or workers compensation gap following settlement by a health fund and / or insurance company
2. I have had the financial costs of my hospitalisation clearly explained to me and understand that:
   - total costs cannot be quoted, but only estimated in advance
   - my obligation to pay for my hospitalisation is independent of any benefits I may be able to claim for my private health insurance and that I will be liable for any debt collection and / or solicitor's fees incurred in the collection of these accounts
3. I understand that any excess payable under my private health insurance fund will be paid on admission
4. I understand that I may be required to pay for some items used in theatre that may not be covered by my health insurance. (More information may be available from your doctor).
5. I understand that medications required and not related to my primary reason for admission will be payable by myself on discharge.
6. I also acknowledge that I have been provided with the 'Private Patients' Hospital Charter'.
7. I acknowledge that I am providing personal information to Stirling Hospital. I understand that this personal information is used by Stirling Hospital in providing health care services to me and in performing administrative tasks such as managing my hospital account. A copy of Stirling Hospital's Privacy Policy is available on request.

Name: ____

Signature: ____

(Patient / Relative / Guardian – please circle relationship if patient is unable to sign)

Date: _______ / ______ / _________

OTHER SERVICE PROVIDER ACCOUNTS

You are responsible for payment of other accounts you may receive, which may include:

- The Surgeon or admitting doctor
- The Anaesthetist
- Other specialists including Surgical Assistants and Physicians
- Pathology services
- Radiology services
- Non admission related medications

If you are unsure what services you may receive during your stay and wish to know what accounts you may receive, please contact your admitting doctor to discuss.

Has your Admitting Specialist / Anaesthetist explained to you his / her account details in relation to your admission?

☐ Yes ☐ No

If you answered NO it is recommended you talk to your Admitting Specialist / Anaesthetist PRIOR to your Admission to obtain information on any out-of-pocket expenses that may apply.