Benalla HEALTH

Pre Admission Form

PART A

Unit Record No: _____

Name: _____

Address: _____

Date of Birth: _____ Sex: Male/Female

Place Identification Label here

At least 2 weeks before your admission to hospital please complete this form and return to PO Box 406 Benalla 3672. Alternatively, you are welcome to bring the completed form to the hospital, (45-53 Coster Street Benalla) and Talk to our Ward Administration Clerk– Monday to Friday between 8am and 8pm.

Proposed Surgery Date: _____ / _____ / _____ Day Case ☐ Overnight: ☐

Personal Details (Patient) SECTION 1

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: _____ Date of Birth: _____ / _____ / _____

Surname: _____ Given Name(s) in full: _____

Previous Surname(s): _____ Sex: Male ☐ Female ☐

Residential Address: _____ Postcode: _____

(Do not use PO Box)

Telephone Number (Home) _____ (Business) _____ (Mobile) _____

Marital Status: Married Single Widowed Separated De Facto Divorced

Country of Birth: _____ Religion: _____

Medicare No: _____ Ref No: _____ Expiry Date: ____ / _____ Pension No: _____

Are you Aboriginal or Torres Straight Islander? Yes / No. If yes please specify .....

Person to contact (Next of Kin) (Please list two) SECTION 2

First Contact:

Name: _____ Relationship to patient: _____

Residential Address: _____ Postcode: _____

Telephone Number: (Home) _____ (Business) _____ (Mobile) _____

Second Contact:

Name: _____ Relationship to patient: _____

Residential Address: _____ Postcode: _____

Telephone Number: (Home) _____ (Business) _____ (Mobile) _____

Other Details SECTION 3

Operating Surgeon: _____ Local referring Doctor (GP): _____

Local GP Phone No.: _____ Local GP Fax No.: _____

Have you been a patient in this Hospital before? Yes No Unsure

Request to be admitted as: ***Please tick***

☐ Veterans affairs, complete section 4

☐ Workcover or TAC, complete section 5

☐ Health Insurance, complete section 6

☐ Self funding private patient

☐ Public Patient

PRE-ADMISSION FORM

MR 005

REF: Version 2
April 2018

Patient name: _____ DOB: _____ UR number: _____

Veterans Affairs Information SECTION 4

Please complete the following if you are a DVA Pensioner or Dependent.

DVA No.: Colour of Card:

WorkCover/TAC SECTION 5

Approval must be obtained prior to an elective admission to hospital. **Correspondence verifying liability must be presented on admission.**

Date of Injury / Accident: _____ / _____ / _____ Claim Number:

TAC Case Manager (if known) Phone No:

If WorkCover, please also complete

Employer:

Address: _____ Postcode: _____

Insurance Company: _____ Phone No: _____

Health Insurance Details SECTION 6

Name of Fund: _____

Membership No: _____Table: _____

Level of Insurance: Top ☐ Intermediate ☐ Basic ☐ Extras Only ☐ Does an Excess Apply? Yes ☐ No ☐

Private Patients
Single rooms are not available in Victorian public hospitals. Where present, these are allocated first to patients with specific medical or clinical need for single room accommodation. Private patients desiring a single room will only be allocated this accommodation, if available, and if these rooms are not medically required for other patients.

Private Insurance
If you elect to be a private patient, the Hospital will claim bed fees on your behalf. Please contact your health fund to confirm your insurance level and possible excess or co-payment responsibilities prior to admission. If you have any further questions please contact Medical Accounts on 5721 4222 between 9:00am and 4:30pm Monday to Friday.

Election Status

The information you provide on this form does not oblige you to elect whether you are treated as a public or private patient until you are admitted (unless prior arrangement with your doctor. If unsure of your arrangement, please contact your doctor).

Your Healthcare Rights

You have a right to access, safety, respect, communication, participation, privacy and comment. These rights explained further in brochures available on request and in this online document Australian Charter of Healthcare Rights at this address
https://www.safetybeyondquality.gov.au/national-priorities/charter-of-healthcare-rights/

Patient name: _____ DOB: _____ UR number: _____

HEALTH INFORMATION

Height: _____ **cm** **Weight:** _____ **kg** **BMI:**

Please note Height & Weight is compulsory information required for your admission

Please circle correct answer			Comments and further information	
ALLERGIES Any allergies: Medication Tapes Latex / Rubber Food Other (specify):_____	 Yes Yes Yes Yes	 No No No No	Specify allergy and reaction	Alert chart and Alert stickers in history and kitchen notified Latex Policy
Have blood tests been taken for this admission?	Yes	No	Which company? When were they taken?	Ensure results are in history
Did you have an x-ray for this admission?	Yes	No	If you have these, please bring on day of procedure.	Ensure results are in history
Female: Are you Pregnant/ Breastfeeding?	Yes Yes	No No	Due Date:	
RESPIRATORY DISORDERS eg. Asthma / Bronchitis Emphysema / Shortness of breath on exertion / Hayfever?	Yes	No	Specify: **Do you use:** **Nebuliser Home Oxygen Puffer**	Physio Referral
Sleep Problem / Apnoea / Loud Snoring?	Yes	No	Do you use CPAP? If yes, please bring it with you for overnight admission	
HEART CONDITIONS Heart Attack / Chest pain / Angina?	Yes	No		
Palpitations / Irregular Beats / Murmur / Rheumatic Fever?	Yes	No		
BLOOD PRESSURE High / Low *(circle)*	Yes	No		
DIABETES TYPE 1? Type 2?	 Yes Yes	 No No	Managed by: Diet / Tablets / Insulin	
STROKE Mini Stroke, Multiple Sclerosis?	Yes	No	Any residual weakness / symptoms?	
EPILEPSY / Fits / Seizures	Yes	No	Last seizure:	OT and Physio
INFECTIOUS DISEASES Flu Vaccination/Immunisation HIV / Hepatitis / Hospital Infections?	 Yes Yes	 No No	 Specify Specify	
KIDNEY DISORDERS	Yes	No	List:	
THYROID DISORDERS	Yes	No		
BLOOD CLOTS Blood Disorders / Tendency to bleed or bruise easily / Anaemia?	Yes	No	Location of blood clots:	
REFLUX Hiatus Hernia / Ulcers?	Yes	No		

Patient name: _____ DOB: _____ UR number: _____

Neck / Back problems?	Yes	No		
Arthritis?	Yes	No		
Elimination Issues: Kidney / Bowel / Bladder problems Incontinence? (circle)	Yes	No	Please bring incontinence aids with you	
Short Term Memory Loss / Dementia / Confusion / Delirium?	Yes Yes	No No		
Mental Illness: Anxiety Attacks/ Depression etc.?	Yes	No	Specify Do you see a psychiatrist / psychologist	
Cancer?	Yes	No	Location Year Diagnosed:	

CREUTZFELDT-JAKOB DISEASE – CJD			Notify **OR** and Infection Control
Have you received human pituitary derived hormones before 1985?	Yes	No	
Have you received a dura mater graft prior to 1990?	Yes	No	
Is this admission due to a progressive neurological disorder / dementia?	Yes	No	
Do you have a family history of CJD or progressive neurological disorder?	Yes	No	

Any other current medical condition?	Yes	No	Specify:	
GENERAL HEALTH CONDITIONS				
Impairment: Vision: Hearing:	Yes Yes	No No	Aids used:	Aids with patient
Prosthesis: Pacemaker / Metal Pins and Plates / Artificial Joints / Access Devices / Stents?	Yes	No	Specify Location:	
Do you have your own teeth? Limited Jaw Movement?	Yes Yes	No No	Dentures: Upper / Lower / Partial Cap / Bridges / Crowns / Loose Teeth	
Speech problems?	Yes	No	Describe:	Speech Therapist
Recent Cold / Flu / Sore Throat?	Yes	No		
Skin Problems: Sores / Rash / Ulcer / Wounds?	Yes	No	Location:	High Pressure Ulcer Risk
Fallen more than once in the last six (6) months	Yes	No		High Falls Risk Physio Referral
SURGERY / ANAESTHETIC HISTORY				
Have you had an anaesthetic previously?	Yes	No	General Spinal / Epidural Local	

Please list all the operations you have had previously:	List any anaesthetic complications (Patient or Family)

Patient name: _____ DOB: _____ UR number: _____

MEDICATIONS

ANTI-COAGULANT THERAPY				
Do you take / recently taken Blood thinning medications e.g. Asprin / Plavix / Warfarin?	Yes	No	Specify Ceased / Still Taking **** If you take Warfarin please organise to have an INR test 1 or 2 days before your procedure. A reading below 3.0 is required.**	
Have you taken any steroids / cortisone in the last six (6) months?	Yes	No	Name	

Please list below (or attach another piece of paper) listing **all** prescriptions / over the counter medications / inhalers / vitamins / herbal remedies / mineral supplements you take.

LIFESTYLE				
ALCOHOL: Do you drink alcohol?	Yes	No	Specify	
SMOKING: Do you currently smoke?	Yes	No	How many per day?	Anti-Smoking Policy
Have you smoked in the past If yes, how long ago?	Yes	No		Anti-Smoking Policy
MOBILITY: Do you use a mobility aid? eg. Walking Stick / Frame / Crutches / Wheelchair	Yes	No	Specify Please bring your mobility aid with you	Physio
Are you a registered organ: donor?	Yes	No		
Do you use recreational drugs?	Yes	No		
MALNUTRITION SCREENING				
Do you have any appetite problems causing weight loss?	Yes	No		Dietitian Referral
Have you recently lost more than 5kg without trying?	Yes	No		Dietitian Referral
Do you require a special diet? Lactose / Gluten Free etc.	Yes	No	Specify	Notify Kitchen

Patient name: _____ DOB: _____ UR number: _____

DISCHARGE PLANNING
TIME IS 10am FOR OVERNIGHT PATIENTS

Do you live: Alone With Others Residential care eg Hostel / Nursing Home	 Yes Yes Yes	 No No No	 Which residential care centre?	
Are you the sole carer for others at home?	Yes	No	Specify:	Refer to Discharge Planner
Are you currently receiving Community Services? eg. District Nursing / Meals on Wheels etc	Yes	No	Specify:	Refer to Discharge
Where do you plan to go after discharge?			Home / Other (specify):	
Do you believe you will need Community Services organised for you after the procedure?	Yes	No	Specify:	Commence SCOT Tool
Do you require Medical /Carers leave certificate?	Yes	No		

DAY SURGERY PATIENTS ONLY

How are you getting home? _____

Who will be driving you home? Name: _____ Phone No: _____

Who will be staying with you 24 hours after discharge? Name: _____ Phone:_____

STAFF USE ONLY

Need for follow up phone call? Yes ☐ No ☐

Date and Time Call made: _____ Duration of Call _____ mins Who did you speak to? Patient / _____

What did you discuss / advice given:

Referrals Written: Yes ☐ No ☐ NA ☐

Form Reviewed by: _____Designation: _____ Date: _____

PART B – Tear at Perforation – PATIENT TO RETAIN

PRIOR TO YOUR SURGERY

- Please complete the front half of this booklet (all sections) and return to the hospital at least 7 days prior to your procedure together with a health summary from your local GP.

Via post addressed to

Ward Clerk, Surgical Ward

Benalla Health

PO Box 406, Benalla 3671 or,

In person

- To The Day Procedure Unit (refer map) Between 7am – 3pm Mon – Thurs.
- **You must have another responsible adult to stay with you for 24 hours after your procedure (unless local anaesthesia)**
- You may be required to have a pre-anaesthetic check by your anaesthetist in the days prior to your surgery – your surgeons rooms will advise.
- If you take Warfarin (Coumadin/Marevan) please ensure you have an INR blood test 1-3 days before your procedure. Please ask pathology to fax the result to Benalla Theatre on 5761 4784. Your INR needs to be below 3.
- Make-up, nail polish and all jewellery should be removed before coming to hospital.
- Confirm Admission Time and fasting instructions by phoning Ward Clerk on 5761 4363 between 4-6pm the last working day prior to surgery. Please do not eat or drink for the recommended time prior surgery.
- Any concerns or queries about medication can be discussed with your anaesthetist or surgeon.
- You should not smoke or consume alcohol prior to your surgery.
- If you are unwell leading up to the surgery please discuss concerns with your surgeon, anaesthetist or Day Procedure Nursing Staff on 5761 4268 between7am - 3.00pm Mon-Thurs.

ON THE DAY OF YOUR SURGERY

- Report to Day Procedure at the appointed time at which time the ward clerk will complete your admission paperwork.
- If sedation is part of your procedure, you will be required to sign a document confirming that you understand you cannot drive, operate machinery, or make legal decisions and that you must be in the care of a responsible adult for 24 hours after your procedure.
- The nursing staff will take you further through the admission process. This involves vital signs, general assessment, sharing information about and preparing you for your procedure.
- After your procedure you will be monitored in recovery and then DPU for a period of time during which you will have vital signs checked, be given a light meal and any appointments made before you can be safely discharged into the care of your appointed driver/carer.

SUGGESTED ITEMS TO BRING WITH YOU

For all Admissions:

- Current Medications x-ray and test results.
- Medicare and Pension cards and Health Insurance & Veterans Affairs card if applicable.
- Children are encouraged to bring favourite toy and own pyjamas.

For Overnight Stays in Acute Ward:

- Dressing gown, nightwear and slippers
- Soap, toothbrush, toothpaste, brush, comb, tissues and shaving equipment
- Small change for phone calls and papers

PLEASE DO NOT BRING VALUABLES SUCH AS JEWELLERY OR LARGE AMOUNTS OF MONEY WITH YOU. THE HOSPITAL DOES NOT ACCEPT RESPONSIBILITY FOR ANY ITEMS LOST DURING YOUR STAY.

ACUTE PATIENTS

There are numerous services available in the community that may assist you on discharge which will be discussed with you by your nurse. You are encouraged to contact the hospital with any concerns after discharge.

PART B – Tear at Perforation – PATIENT TO RETAIN

SUGGESTED ITEMS TO BRING MIDWIFERY WARD

Mother

- Nighties, dressing gown, slippers
- Toiletries, Sanitary Napkins
- Underwear, Casual Clothes
- Maternity Bras

Baby

- Nightgown, Singlet, nappies, pilchers and bunny rug are supplied by the hospital. You may wish to use your own baby clothes
- Baby soap or wash (optional)
- Cotton Balls & cotton buds
- Baby wipes
- If formula feeding – you will need to supply bottles, teats, formula of your choice and sterilizing unit

MIDWIFERY PATIENTS DISCHARGE

The following services are available to assist you:

Breast Feeding Support Service

This Service is held every second Friday between 9am and 5.30pm. There is no charge and appointments can be made by contacting midwifery ward on 5761 4749.

Maternal & Child Health Nurse and Victorian Infant Hearing Screening Program will be informed of your baby's birth and will contact you to arrange an appointment either whilst you are in hospital or shortly after your discharge.

PLEASE DO NOT BRING VALUABLES SUCH AS JEWELLERY OR LARGE AMOUNTS OF MONEY WITH YOU. THE HOSPITAL DOES NOT ACCEPT RESPONSIBILITY FOR ANY ITEMS LOST DURING YOUR STAY.

FACILITIES FOR YOUR USE IF STAYING OVERNIGHT

- Vending machines available in Dining Room
- A canteen trolley visits each morning (Mon-Fri) with newspapers, magazines and sweets
- Televisions are provided free of charge
- Telephones are on each bedside table. Charges apply for outgoing calls – phone cards are available. There is also a public phone.

MOBILES ARE NOT TO BE TURNED ON WHILE IN THE BUILDING, THEY MAY INTERFERE WITH SOME MEDICAL EQUIPMENT

VISITING HOURS

VISITING HOURS ARE FROM
10AM UNTIL 8PM EACH DAY
Rest periods are:
Acute ward 1-2pm
Midwifery ward 1-3pm
During this time we request no visitors or phone calls.

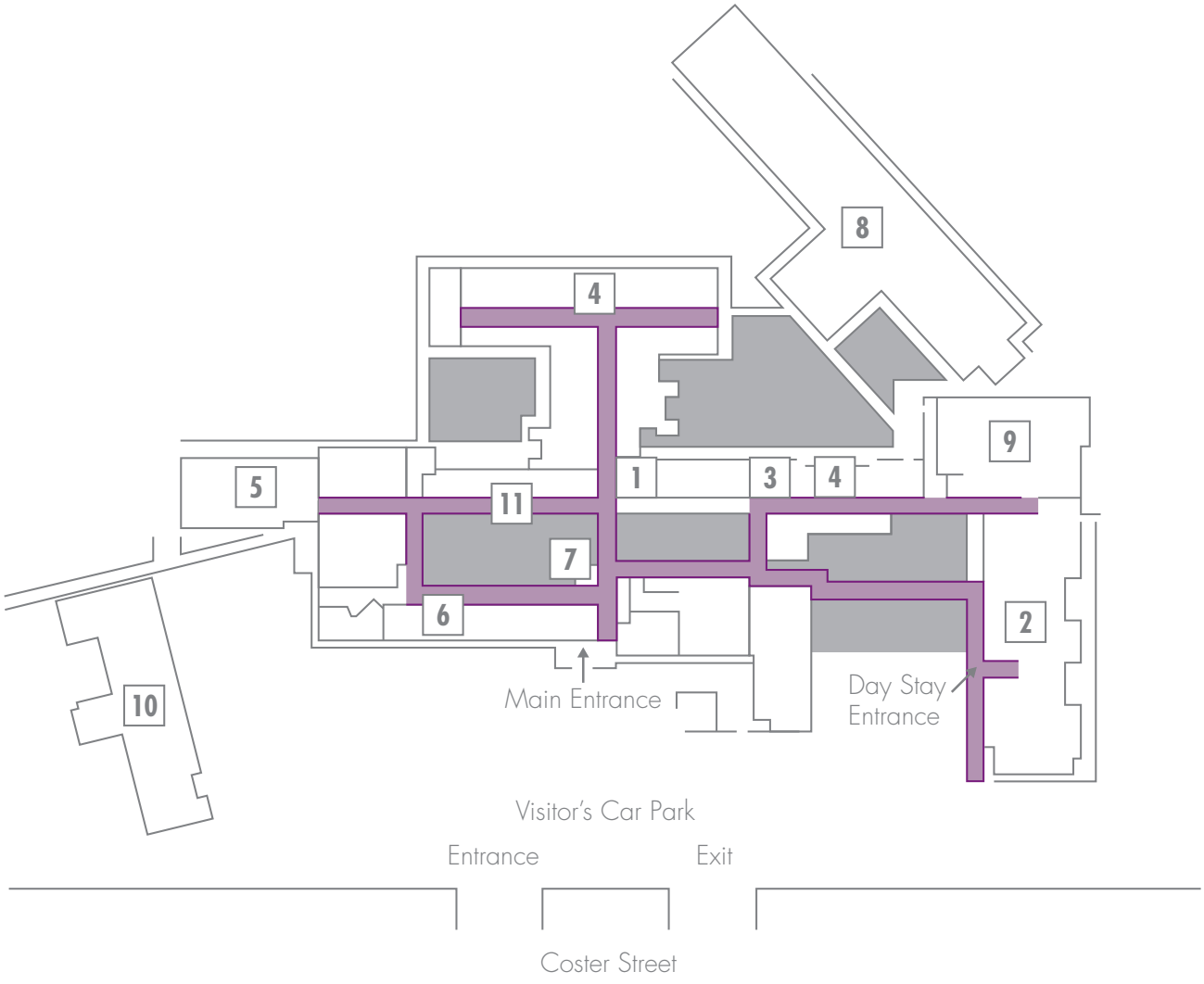
VOLUNTEERS

At Benalla Health we have active volunteers providing additional comfort for patients, this involves talking socially, taking patients for walks outside, writing letters, making phone calls on their behalf, running errands, reading, playing games and providing hand/foot massages. The volunteer service is available each weekday. Please talk to your nurse if you would like to access the service.

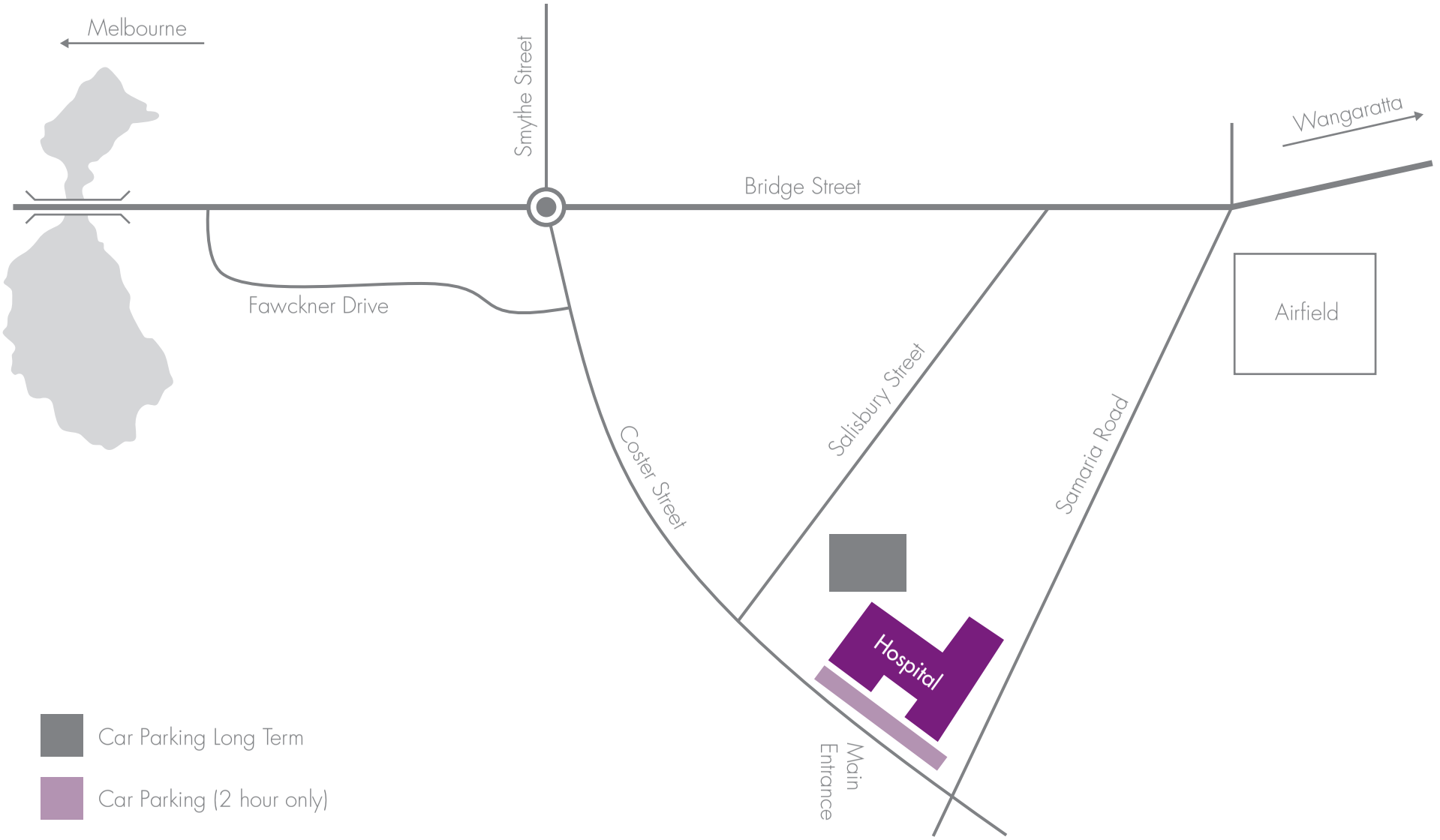
(If you or any of your family are interested in becoming a volunteer please call).

Hospital Services Map

1. Afterhours Admissions Office
2. John Lindell Day Procedure Unit
3. Midwifery Ward / Breast Feeding Support Service / Ante Natal Classes
4. Acute Ward
5. Urgent Care Centre
6. X-Ray / Broken River Imaging
7. Reception
8. Morrie Evans Wing Nursing Home
9. Theatre
10. Pathology / Consulting Rooms
11. Pay Phone



Benalla Health Location Map



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