St Vincent's Private Hospital
PRE-ADMISSION INFORMATION

406 Victoria Street, Darlinghurst NSW 2010
Telephone (02) 8382 7111 Fax 8382 7220

PLEASE COMPLETE THE PREADMISSION INFORMATION AND RETURN TO THE HOSPITAL IN THE REPLY-PAID ENVELOPE NO LATER THAN 72 HOURS PRIOR TO ADMISSION.
WITHOUT THIS INFORMATION THE HOSPITAL CANNOT CONFIRM YOUR BOOKING

Have you been a patient at St Vincent's Private Hospital, Day Surgery or Cardiac Catheter Centre?

No ☐ **If yes, do you know the year of your previous admission** _____

Your Accommodation Preference : ☐ **Single** ☐ **Shared** (2 bed) (preference cannot always be guaranteed)

ADMISSION DETAILS

Date you are being admitted _____ **Name of Admitting Doctor** _____

Your title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms Other _____

Surname _____ **Given Name** _____

Surname last admission ☐ Unchanged **Previous Name** _____

Date of Birth _____ **Religion** _____ **Sex** ☐ Male ☐ Female

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Defacto

Address _____

_____ **Post Code** _____

Contact Numbers
H
W
M

Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Country of Birth _____ Year of arrival in Australia [ ] ☐ N/A

Do you require an interpreter? ☐ No ☐ Yes **Language spoken at home**

PERSON TO NOTIFY / NEXT OF KIN ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

Person for notification _____ **Relationship** _____

Address _____ **Post Code** _____

Contact numbers
H
W
M

Is the next of kin the same person? ☐ Yes ☐ No - if no please complete

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

Next of Kin _____ **Relationship** _____

Address **Post Code**

Contact numbers
H
W
M

Please tick ☐ if you **DO NOT** want your GP contacted

Family Doctor (GP) **Suburb**

Contact Number

Are you entitled to Government Pharmaceutical Benefits ☐ **No** ☐ **Yes**

Type of Card **Pension Number** **Expiry Date**

HEALTH FUND DETAILS

Health Fund: _____ **Membership Number** _____

Medicare Number	First number					space						space		**Expiry Date**

MR56

Signed _____ **Date** _____

*** ALL PATIENTS - Please turn the page, read & complete the sections overleaf *** PTO

DAY SURGERY PATIENTS PLEASE NOTE:

All patients who have an anaesthetic (general or sedation) MUST have a responsible adult to accompany them home.

As a guide, most patients are discharged 4 hours after their admission. Either you or the staff in DSU can contact your escort when you are ready to go home or they may like to wait for you in the waiting area.

YOUR SURGERY MAY BE CANCELLED IF YOU FAIL TO COMPLY WITH THESE SAFETY REQUIREMENTS

Is there a responsible adult to accompany you home? ☐ Yes ☐ No

Name _____ Phone _____

Coming from outside Sydney: Please make sure that we know where you are going to stay and that we have all of your contact details including telephone and facsimile numbers.

Name _____ Phone(s) _____

Signed Please print name Date

ST.VINCENT'S PRIVATE HOSPITAL - CONSENT TO USE INFORMATION

St Vincent's Private Hospital is a values based organisation and is committed to ensuring that it complies with the Health Records and Information Privacy Act 2002 (NSW) (HRIP Act) which protects the privacy of health information in New South Wales. We also respect and will uphold your right to privacy protection under the National Privacy Principles contained in the Privacy Act 1988. The National Privacy Principles prohibit the use of personal information in the event that you do not consent to the use of such information for those purposes. You are under no obligation to provide consent to the use of your personal information for any of the purposes described below. In the event that you do not consent, we will respect your wishes and will not use the information for that purpose in any identified format.

If you **DO NOT** consent to the use of your information for any of the following purposes, please indicate by initialing the relevant box and signing the form. Any initialed box indicates that consent is not given.

I DO NOT CONSENT :

☐ 1. To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to treat the particular condition I have consulted the medical practitioner or institution about. This may include forwarding relevant prior information e.g. anaesthesia records.

☐ 2. To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.

☐ 3. To assist in the development of service delivery and planning in facilities owned and operated by St Vincent's Private Hospital.

☐ 4. For research and development projects undertaken by St Vincent's Private Hospital in its own right or in conjunction with other organisations.

☐ 5. To assist the Health Care Provider in providing practical training and education to medical, nursing and other allied health students. To assist the Health Care Provider in undertaking quality improvement activities.

☐ 6. To enable the Health Care Provider to provide members of Returned Service Organisations and Ministers of Religion with sufficient details to enable them to visit me whilst I am a patient in this facility.

☐ 7. To enable the Health Care Provider to provide access to my information to the Health Fund of which I am a member if requested by the Health Fund to do so.

☐ 8. To receive educational materials on the condition I am being treated for at St Vincent's Private Hospital.

☐ 9. To communicate promotional offers, special events or marketing initiatives to me.

☐ 10. To contact me and invite me to make a contribution to or assist in fundraising activities.

☐ 11. **To clinical photographs and other images being taken for the purpose of clinical assessment and treatment of me/the patient. I also understand and agree that, unless I have indicated otherwise, the images may be used for teaching, training and research in a form that cannot identify me/the patient**

12. Irrespective of any request received, I direct you **NOT to provide my personal information to**: specify name/details below

Name .....

Signed (patient) _____ Print name in full _____

Dated this Day of 20..... MR56-2

St Vincent's Private Hospital

DAY SURGERY UNIT

PREADMISSION HEALTH QUESTIONNAIRE

Surname _____

Given name _____

DOB _____ Doctor _____

Date of Procedure _____

Please complete this form & mail it in the reply-paid envelope to the Hospital 72 hours prior to your admission or fax all pages to: 02 8382 6330

MEDICAL HISTORY (please answer all questions by ticking yes or no in the appropriate box)

Have you ever had or now have:	Yes	No	*Have you ever had or now have:*	Yes	No
Heart trouble			Blood clots in: ☐ legs or ☐ lungs		
Heart attack			Anaemia or other blood disorders		
Chest pain or angina			Bruising or bleeding problems		
High blood pressure			Indigestion or heartburn		
Rheumatic fever			Reflux or hiatus hernia		
Palpitations			Stomach or duodenal ulcer		
Heart murmur or artificial valve			Gall bladder trouble		
Shortness of breath			A stroke		
Asthma			Fits or epilepsy		
Collapsed lung			Funny turns or fainting		
Have you had a cold or flu recently			Muscle weakness		
Do you have a cough or bronchitis			Sleep apnoea		
Arthritis: ☐ rheumatoid ☐ osteo ☐ gout ☐ neck or ☐ back problems			Are you or could you be HIV positive		
			Ladies, are you or could you be pregnant		
Kidney trouble: ☐ failure ☐ stones ☐ dialysis ☐ infection			Have you ever had a blood transfusion. If yes, year:		
Diabetes, if yes, how is it controlled ☐ diet ☐ tablets ☐ insulin Year diagnosed:			Liver problems: ☐ cirrhosis ☐ jaundice Hepatitis: ☐ A ☐ B ☐ C ☐ D ☐ E Year diagnosed:		
Cancer: type _____ Year diagnosed:			Organ transplant: Type: Year:		
Do you have any implanted medical devices e.g. ☐ pacemaker ☐ joint replacement Other please specify:			Any history of multi-resistant organism (e.g. MRSA Golden Staph Year:		

Is there any other relevant medical history	**Do any serious medical problems run in your family (e.g. blood clots)**

SURGICAL HISTORY

Please list any previous operations and the year - start with the latest first	Year		Year

Please turn the page and complete the questionnaire

ANAESTHETIC HISTORY	Yes	No
Have you or a member of your family had any problems with anaesthetics e.g. difficult intubation or malignant hyperpyrexia		
Have you had problems with nausea or vomiting after anaesthetics		
Do you suffer from travel sickness or motion sickness		

DRUGS & MEDICATIONS

Have you ever taken	Yes	No	*Have you ever taken*	Yes	No
Drugs for diabetes			Drugs for asthma		
Drugs for heart trouble			Drugs for arthritis / anti-inflammatories		
Drugs for high blood pressure			Drugs for nerves or sleeplessness		
Drugs to stop blood clotting			Drugs for depression		
Any cortisone in the last 6 months			Drugs for any psychological condition		

PLEASE LIST ALL THE MEDICATIONS, TABLETS, EYE DROPS OR INJECTIONS THAT YOU NORMALLY TAKE. Include aspirin, oral contraceptives, naturopathic remedies, vitamins, products from the health food store or any "recreational drugs"

Name of medication & its strength	Dose taken & times taken	If stopped, give date
eg Panadol 500mg	2 at 6am; 2 at 2pm; 2 at 10pm	

ALLERGIES & ADVERSE REACTIONS

Are you allergic to or have you had any reaction to any medications, food, tapes, lotions or other substances such as LATEX or RUBBER. Please give details *(attach list if necessary)*

Please tick if you have no known allergies → ☐ I have no known allergies

Allergy	**Type of reaction**

SMOKING / ALCOHOL HISTORY

	Yes	No	
Do you smoke			If yes, how many cigarettes a day do you smoke:
Have you ever smoked			If yes when did you give up:
Do you drink alcohol			If yes, how much & how often:

DIET, WEIGHT & HEIGHT

Are you on a special diet			If yes, what type of diet		
What do you weigh		kg	*(or*	*stones*	*pounds)*
How tall are you		cm	*(or*	*feet*	*inches)*

Signature _____ Please print name _____ Date _____

History reviewed and entered by: Date