Mater
Women's & Children's
Hospital Hyde Park

Pre-Admission Information

This form is available for completion on-line, go to
www.matertsv.org.au

This form should be returned as soon as possible and no later than one week prior to your date of admission

If less than one week before your admission date, please deliver in person, fax or phone the hospital between the hours of 8am to 5pm

Maternity Patients:
Please return this form to the Women's Unit by 20 - 25 weeks

The Mater Health Services North Queensland is a smoke free zone

Admissions Phone: (07) 4722 8807
Facsimile: (07) 4721 3365
Email: hp.reception@matertsv.org.au

Mater
Health Services
North Queensland

Thank you for choosing Mater Health Services North Queensland for your hospital care. It is our privilege to welcome you as our patient and guest.

Staff at the hospital understand that coming to hospital can be an unsettling experience, this information has been compiled to help answer some of your questions.

PREPARING FOR YOUR ADMISSION

Prior to your hospital admission you are required to complete the Pre-Admission Form at the back of this booklet and return it to the Mater Hospital as soon as possible and no later than one week prior to your date of admission, therefore enabling us to prepare for your hospitalisation. Please complete to the best of your ability, providing as much detail as possible.

If you have any questions please contact the Mater on 4727 4444 and ask for our Patient Services Department.

Please bring a list of all medications (including natural therapies) and any medicine you will need to take during your stay (refer to the Medication Summary Form within this booklet). Report all medication you are taking. Please ensure you have your medications with you in their original containers/packaging and any current prescriptions you may have. Webster packs and dosettes that have already been prepared cannot be used by our staff.

Information for your visitors

Please refer to your hospital ward for visiting hours. We do request that you advise your loved ones that a rest period is scheduled daily as this is an important aspect of your recovery. You may also visit our website or contact us on 4727 4444 to confirm the visiting hours for your ward.

Your visitors may like to know that they are able to order meals from our Food Services Department which will be delivered along with your meal, if you wish to take advantage of this service please see your nursing staff. Meals provided by the hospital to your visitor will incur a charge that is payable on discharge.

Accommodation is also available for patients and relatives who are from out of town. Please contact us on 4727 4444 and ask for our Patient Services Department for further information.

Day procedures

Please arrange for a responsible person to transport you home following your procedure and stay with you overnight – it is unsafe and you may not be covered legally or by insurance to drive for 24 hours after your anaesthetic.

You must not sign any contracts or make important decisions for 24 hours following your procedure – these may not be legally binding.

You must follow any post-procedural instructions given to you and contact your doctor or present to an Emergency Department should you have any post-procedural complications.

Fasting

If you are having surgery you will need to "fast". This means that you will not be able to have any food or fluids (including water) for a specified period of time. You will be advised by your doctor if you are required to fast and how long you would need to fast.

You must not drink alcohol or smoke for 24 hours prior to your surgery. You must not drink alcohol for 24 hours after your anaesthetic.

Valuables

Please do not bring valuables to the hospital including large amounts of cash or jewellery. The Mater Hospital will not accept any liability from loss or damage, howsoever caused, for any items of value retained in your responsibility whilst a patient in the hospital. However, please note that the Mater will require payment of any expected out of pocket expenses prior to or on admission.

Electrical Testing

In the interests of patient safety, all electrical equipment, eg shavers, hairdryers and computers must be checked by our technical staff prior to use. Please arrange this with our Patient Services staff.

Power of Attorney and Advanced Healthcare Directions

If you have an Advanced Healthcare Directive or Power of Attorney, please ensure you discuss this with your treating specialist/doctor and bring a copy of the documents with you to hospital.

Dietary Requirements

Should you have any special requirements please contact our Food Services Manager on 4727 4535 prior to your admission.

Smoking

The Mater Hospitals are committed to good health for everyone therefore, smoking will not be permitted on hospital grounds (including car parks and outbuildings). If you are a patient coming into hospital you will not be able to smoke within the hospital premises and grounds.

PLEASE RETAIN FOR YOUR RECORDS

WHAT TO DO ON THE DAY OF ADMISSION

On the day of your admission, please present to the hospitals main reception area at the time requested by your doctor. Please note that the requested time is your admission time only, this is not your operation or procedure time. You have been asked to arrive at this time by your doctor to allow for any necessary preoperative requirements.

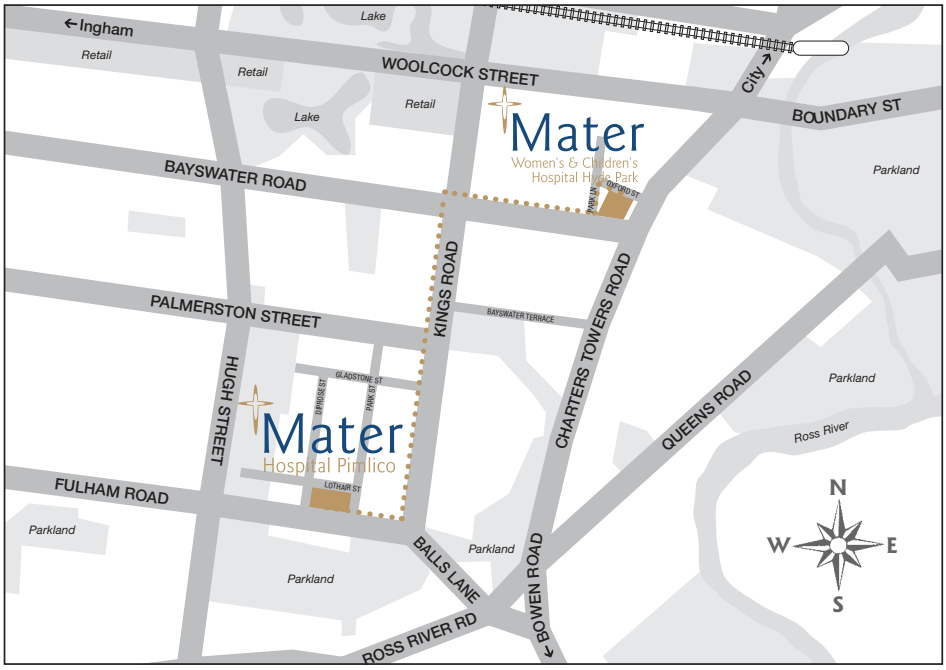
Your doctor sets the order of the operating list and makes the decision about what time you are needed in the operating theatre. As a result, you may have to wait between two and six hours before your surgery or procedure. The staff will aim to make your wait as comfortable and pleasant as possible.

Your admission checklist:

- ☐ Any letters from your doctor including your consent form
- ☐ Any appropriate x-rays, scans and medical reports
- ☐ All medication that you are currently taking (in original packaging) and all prescriptions
- ☐ A list of any known allergies
- ☐ Your EFTPOS, credit card or other means of payment for any out of pocket expenses (all charges are payable on admission)
- ☐ If you are having day surgery please shower and wear loose, comfortable and appropriate clothing
- ☐ Do not wear any chemicals for example perfume, makeup, nail polish or deodorant
- ☐ If you are staying overnight, for your comfort we suggest you bring a small bag containing slippers, dressing gown, personal toiletries, night attire and contact lenses / glasses.
- ☐ Please bring any item of a personal nature you may require (e.g. sanitary products)
- ☐ If you are an insulin dependent diabetic, please bring your pens/needles with you.
- ☐ A book or reading material.

If your relative or friend will be waiting at the hospital our friendly staff will provide directions for them to relax in the café or one of the lounges within the hospital. We will ensure our staff have a mobile number for your relative or friend to ensure they can be contacted.

Hospitals location



Distance between Hospitals 2.65kms.

PRIVACY STATEMENT

We acknowledge our obligations to you under the Privacy Amendment (Private Sector) Act 2000. Personal information collected about you will be used primarily to provide your health care and for a limited number of purposes.

PLEASE RETAIN FOR YOUR RECORDS

Mater Health Services North Queensland

YOUR SAFETY IN HOSPITAL

PLEASE RETAIN FOR YOUR RECORDS

Identification

You will wear an identification band which will state your name, date of birth and unique hospital identification number and other relevant information. At various times staff will check the details on this band and ask you to tell them information such as your name and date of birth. This is not because they don't know who you are - they are taking precautions to ensure you are the correct patient to receive the medication or treatment.

The staff are taking these steps to ensure that everything goes as planned for your procedure.

Ensuring Correct Surgery

Before you are transferred to the operating theatre your doctor may need to make a mark, with a pen on the part of your body which requires surgery.

It is important that this mark does not rub off. It is essential for the doctor and nursing staff to see the mark before your surgery commences. If for any reason the mark is removed, please advise the staff as soon as possible.

When you arrive in the operating theatre, the nurse will ask you to state your name, date of birth and the type of operation you are having. This is done to ensure that your surgery is performed correctly.

Just prior to the commencement of your surgery, the surgical team will undertake a 'Final Team Check' to verify your identification and procedure you are to undergo.

Stop the clot

As a result of your admission to hospital you may be at increased risk of developing a blood clot in your legs or lungs.

As part of your care your doctor will assess you on admission to determine your level of risk and if necessary implement treatment options to reduce the risk of developing a clot.

These treatment options may include:

- Wearing compression stockings
- Using a compression pump on your lower legs
- Taking tablets or injections to help prevent blood clots
- Gently exercising your feet or legs in bed
- Getting out of bed and walking as soon as possible.

Some of these treatments are not suitable for all patients. Your doctor will decide the correct treatment option for you.

Falls Prevention

For a number of reasons, people of all ages are at increased risk of falling whilst in hospital. These reasons include unfamiliar surroundings, poor balance, poor eyesight, unsafe footwear, their medical/surgical condition and some medications.

While only a small number of these falls cause serious injury, they often result in a loss of confidence which can interfere with independence and prolong the time spent in hospital.

Everyone has a role to play in helping reduce the risk of falls, while in hospital.

On your admission, staff will show you around the ward to ensure you are familiar with your surroundings. You may also have a Falls Risk Assessment completed which staff will discuss with you and put in place a plan that suits your needs. This may involve seeing a range of staff eg physiotherapist, dietitian to provide you with information and support.

Please ensure you have appropriate clothing and footwear when you come into hospital. Footwear should fit securely; have a flat or low heel and a non-slip grip.

Many patients are fitted with anti-embolism stockings while in hospital. These stockings increase the risk of slipping or falling when walking. It is therefore important to wear slippers or other footwear if you are using these stockings.

Preventing Pressure Ulcers

To reduce the risk of developing a pressure ulcer –

- Ensure good posture when sitting in a chair. Change your body position frequently if lying in bed for a prolonged time. At least every 1-2 hours if you are in bed, or every 15 minutes to 1 hour if you are in a chair. If you cannot move easily yourself, ask for assistance.
- Staff may use special equipment like air mattresses and heel elevators, to help relieve the pressure.
- Inspect your skin for early warnings of redness that does not go away, broken or blistered skin, or numbness. If you cannot see all your body ask a nurse, a family member or a friend to check regularly for you.
- Use moisturising lotion to prevent your skin drying out. Avoid vigorous massage or rubbing of the skin, as this can damage the underlying tissue.
- Keep your skin clean and dry at all times. If you use a continence device to control your bowel or bladder, it is important that you change it regularly to keep the skin clean and dry to reduce skin irritation from any urine or faeces.

Mater Health Services North Queensland

10 TIPS FOR SAFER HEALTH CARE (Australian Council for Safety and Quality in Health Care)

1. Be actively involved in your own health care

Take part in every decision to help prevent things from going wrong and get the best possible care for your needs.

2. Speak up if you have any questions or concerns

Ask questions.

Expect answers that you can understand.

Ask a family member, carer or interpreter to be there with you, if you want.

3. Learn more about your condition or treatments

Collect as much reliable information as you can.

Ask your health care professional:

- what should I look out for?
- please tell me more about my condition, tests and treatment.
- how will the test or treatments help me and what is involved?
- what are the risks and what is likely to happen if I don't have this treatment?

4. Keep a list of all the medicines you are taking

Include:

- prescriptions, over-the-counter and complementary medicines (eg vitamins and herbs); and
- information about drug allergies you may have.

5. Make sure you understand the medicines you are taking

Read the label, including the warnings.

Make sure it is what your doctor ordered for you.

Ask about:

- directions for use;
- possible side effects or interactions; and
- how long you'll need to take it for.

6. Get the results of any test or procedure

Call your doctor to find out your results.

Ask what they mean for your care.

7. Talk about your options if you need to go into hospital

Ask:

- how quickly does this need to happen?
- is there an option to have surgery/procedure done as a day patient.

8. Make sure you understand what will happen if you need surgery or a procedure

Ask:

- what will the surgery or procedure involve and are there any risks?
- are there other possible treatments?
- how much will it cost?

Tell your health care professionals if you have allergies or if you have ever had a bad reaction to an anaesthetic or any other drug.

9. Make sure you, your doctor and your surgeon all agree on exactly what will be done

Confirm which operation will be performed and where, as close as possible to it happening.

10. Before you leave hospital, ask your health care professional to explain the treatment plan you will use at home

Make sure you understand your continuing treatment, medicines and follow-up care.

Visit your GP as soon as possible after you are discharged.

Find out more about the Safety and Quality Council or obtain copies of 10 Tips for Safer Health Care by calling **(02) 6289 4244** *or from its website at www.safetyandquality.org*

PLEASE RETAIN FOR YOUR RECORDS

Mater Health Services North Queensland

RIGHTS AND RESPONSIBILITIES

The information provided reflects our commitment to providing you with exceptional care. It explains your rights and responsibilities relating to the care and treatment you will receive as our patient.

As a patient you have a right:

- To be treated with respect, dignity, care, consideration, courtesy and understanding of your individual, spiritual, emotional, social, physical and cultural needs.
- To be involved in the planning of your continuing health core needs, from admission through to discharge from our hospital.
- To be informed of services available at the Mater or in the community that you can access.
- To have a family member or nominated person present when you receive information about your condition. To ask for a second opinion and extra information on any diagnosis or treatment.
- To withdraw consent and refuse treatment after discussion about the outcomes of your decision with the health care professionals caring for you.
- To be informed of the names and roles of key health care providers and be able to refuse a particular health care provider at any time.
- To have access (with advanced notice) to a confidential interpreter service.
- To refuse to take part in clinical training or medical research without reason.
- To have your medical history and personal information kept confidential to the extent allowed by the law.
- To choose who is able to visit you and the right to refuse to see visitors.
- To receive an itemised final account for services within the hospital's control.
- To express an opinion or make reasonable verbal or written complaints regarding your treatment or any facilities or services which you feel are below your reasonable expectations. If you have concerns with any aspect of your care please discuss this with the staff looking after you. If you would like to voice a concern or make a complaint, you may wish to speak to the nurse in charge of that particular shift. The Executive Director of Nursing is also available on telephone 07 4727 4570.

As a patient at the Mater Hospital Pimlico you or your authorised representative have a responsibility:

- To give staff as much information as you can about your health and any ethnic, cultural or religious beliefs that may affect your care.
- To give the hospital accurate information about your personal and health details including current treatment and medications including recreational drugs and natural remedies.
- To be well informed about your condition and proposed treatment, before giving consent to any procedure. Feel free to ask for more information.
- To keep to the agreed treatment plan and discuss any desired change.
- To consider the consequences of refusing to comply with instructions and recommendations.
- To inform staff if you are having any problems or reactions to the treatment or the medicines being taken.
- To inform staff if you have any concerns about your discharge from hospital and the instructions you need to follow at home.
- To inform staff if you have an Advance Health Directive/Enduring Power of Attorney which includes health care instructions before or at the time of the admission or when consenting to treatment which might be relevant to the directives.
- To understand that there may be a reason why a service is not available at a particular time.
- To tell staff if you change your contact details.
- To be on time for appointments and let staff know in advance if you want to cancel.
- To finalise any accounts relating to your hospitalisation.
- To be considerate and respectful of the confidentiality, privacy and wellbeing of others including staff, volunteers, patients and visitors and ask your visitors to be considerate.
- To show respect for hospital property as well as the property of other persons. To take responsibility for your personal belongings.

PLEASE RETAIN FOR YOUR RECORDS

FEEDBACK

Providing Feedback or Making a Complaint

If you have any issues or problems that relate to your admission to hospital please let us know.

At the time of your discharge you may receive a patient feedback form or a phone call which we use to obtain information about our care and service delivery. We would appreciate your assistance with this survey.

The hospital has a formal compliments and complaints management process and we value feedback.

If you wish to provide us with additional feedback or make a complaint about any aspect of your hospital experience, you may either:

- Speak to the Nurse Manager of your ward. After hours, request to speak to the Hospital Co-Coordinator;
- Complete a Patient Feedback Form (located in the Patient Services Information folder in your room or in all patient care areas)
- Write to the Chief Executive Officer or Executive Director of Nursing, Mater Health Services North Queensland Limited, Locked Bag 1000, Aitkenvale BC, QLD, 4814.

Issues that are not resolved to your satisfaction can be taken to the Health Quality and Complaints Commission:
Telephone: (07) 3234 0272 Toll Free: 1800 077 308
Web Address: www.hqcc.qld.gov.au or contact the Commission directly at:
Level 18, 288 Edward Street, Brisbane
Health Insurance Complaints may be directed to your health fund or to the Private Health Insurance Ombudsman:
Telephone: 1800 640 695 Email: info@phio.org.au

HOSPITAL FEES AND CHARGES

Hospital charges can include accommodation, use of theatre, prostheses and essential pharmacy items for your care. Charges can vary depending on treatment required, length of stay, prostheses (implants) provided, accommodation category and individual private health insurance contracts.

Hospital costs do not include non-hospital or medical provider costs, such as your doctor, anaesthetist, assisting doctor, pathology, x-ray or STD, ISD and mobile phone charges from your room. Additional charges may also include allied health providers, eg physiotherapy and the hire of physical aids.

Listed below are the different forms of cover patients may use when they are admitted to hospital. *(Please read the one applicable to you.)*

If you have any questions about your hospital accounts please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Estimates Department. Payment methods available at the Mater are cash, visa/mastercard, cheque, EFTPOS or direct deposit (Amex and Dinners facilities are unavailable).

All hospital estimates and out of pocket expenses are required to be paid prior to or on admission. Any additional costs that may arise during your hospital stay (eg, co-payments, pharmacy, phone call charges, visitors meals or unforseen circumstance), are required to be paid on discharge.

After you have been discharged from the Mater, our Finance Department will finalise your hospital account, please note that this process **may take up to three weeks**. Once complete you may receive an invoice in the mail if there are any outstanding charges.

Private Health Insurance

If you have private health insurance please speak to your health fund prior to your admission into hospital, to ensure you understand your level of cover.

Important questions to ask your health fund are:

- Am I covered for the procedure at the Mater? (Do I have any exclusions or restrictions?)
- What level of cover do I have?
- Does my health fund cover all medication expenses?
- Do I have to contribute to the hospital costs? (Do I have an excess or co-payments)
- Have I served all waiting periods? (Did I join less than 12 months ago or is this a pre-existing aliment?)

The Mater will require payment of any health insurance policy excess or co-payment at the time of admission. If any additional costs arise because of your stay (eg, co-payments, pharmacy, phone call charges, visitors meals or unforseen circumstance), you are required to pay these on discharge.

The Mater has agreements with most major health funds in Australia. Under those agreements, subject to your membership, your insurer will meet the costs of your hospital fees. An account for your hospital stay will be sent directly to your Private Health Insurer for assessment in accordance with our contract. If your hospital claim requires any further documentation prior to submission or assessment by your health insurer, we ask that you comply and return to us as soon as possible.

If you have any questions about your hospital fees and charges, including medication, please contact your health fund insurer directly to discuss any out of pocket expenses prior to your admission.

PLEASE RETAIN FOR YOUR RECORDS

PLEASE RETAIN FOR YOUR RECORDS

Cosmetic Surgery

Private Health Funds do not cover cosmetic surgery and the estimate of all costs related to cosmetic surgery needs to be paid prior to or on admission. For an estimate please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Estimates Department.

Department of Veterans' Affairs (DVA)

If you have Department of Veterans' Affairs (DVA) cover

- Gold Card Holders – No approval necessary
- White Card Holders – You must provide your approval letter from DVA prior to admission

Overseas Travel Insurance

If you have travel insurance, the hospital requires you to pay for your hospital stay prior to admission unless approval has been given by a recognised insurer and proof of the approval and billing details are provided prior to admission. For an estimate please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Estimates Department.

Self Insured

If you are self insured (paying the hospital account yourself), you will need to contact the Mater to discuss hospital costs once you have discussed your hospital admission with your doctor. To assist in providing an accurate estimate you are required to provide as much information as possible about your stay. This would include, the procedure item numbers for your proposed theatre procedure/s, prostheses (implants) items to be used (such as screws or mesh) and proposed length of stay.

You will be required to pay all estimated hospital costs prior to or on admission. Estimates provided are based on the information available at the time and are subject to change. If any aspect of your stay changes due to medical necessity, for example your doctor performs a different or modified procedure, the doctor uses additional or different prostheses or the length of stay changes, this will affect the cost. Any additional costs that arise during your hospital stay are required to be paid on discharge.

Workers Compensation and Third Party

If you have Workers Compensation Cover or Third Party Compensation we will require the approval letter from your employer or related Third Party Insurer provider prior to admission.

Defence Force

If you are covered under the Defence Force we will require your defence approval and EP identification number prior to admission.

If your hospitalisation is not covered by private health insurance or if it is related to a Workcover or Third Party claim that has not been approved for payment, then you are fully responsible for the costs and an estimate of fees needs to be paid prior to or on admission, with any balance on discharge.

OFFICE USE ONLY		
Medical Consent	Date/ Time	Staff

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

PRE-ADMISSION FORM

Please print using blue or black pen

Admissions Phone: 4727 4444 Facsimile: 4727 4449 Email: customer.services@matertsv.org.au

ADMISSION DETAILS

Admission Date: ____/____/____ Time: _____ AM ☐ Date of Operation: ____/____/____

Doctor Caring for you at the Mater Hospital: Dr: _____

Your GP / Medical Centre: Dr _____ Phone: _____

Admission Type: ◯ Overnight ◯ Day

MATERNITY

Doctor: _____ Expected date of delivery: _____

PATIENT DETAILS

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Master ◯ Other (e.g. Rank) _____

Surname: _____ First Name: _____ Middle Name: _____

Previous surname (if applicable) _____

Date of Birth: ____/____/____ Sex: ◯ Male ◯ Female Country of Birth: _____

Marital Status: ◯ Married/Defacto ◯ Never Married ◯ Divorced ◯ Separated ◯ Widowed

Residential Address: _____

Suburb: _____ Postcode: _____

Postal Address: _____

Suburb: _____ Postcode: _____

Phone (Home): _____ Phone (Work): _____ Mobile: _____

Email Address: _____

Indigenous status (QLD Health requirement): Are you of Aboriginal or Torres Strait Islander Origin?

Tick all that apply: ◯ No ◯ Yes, Aboriginal ◯ Yes, Torres Strait Islander ◯ Yes, South Sea Islander

Religion: _____ Occupation: _____

MEDICARE DETAILS

Medicare Card Number: |_|_|_|_| |_|_|_|_|_| Number beside Patient on Card: ____ Valid to: ____/____

CONCESSION CARDS

Without the provision of correct and complete details the patient is advised that they will be billed the full amount and must take responsibility for later claiming from Medicare and /or the appropriate provider

Pension/Health Care: ◯ Yes ◯ No Number: |_|_|_| |_|_|_|_|_| |_|_|_|_|_| Valid to: ____/____/____

Pharmacy Safety Net: ◯ Yes ◯ No Number: |_|_|_| |_|_|_|_|_| |_|_|_|_|_| Valid to: ____/____/____

MATER WOMEN'S & CHILDREN'S HOSPITAL HYDE PARK

MATER WOMEN'S & CHILDREN'S HOSPITAL HYDE PARK

NEXT OF KIN DETAILS

Title: _____ Surname: _____ Given Names: _____

Relationship to Patient: _____

Address: _____

Suburb: _____ Postcode: _____

Phone (Home): _____ Phone (Work): _____ Mobile: _____

TOWNSVILLE BASED EMERGENCY CONTACT (IF ANY & ONLY IF DIFFERENT FROM NEXT OF KIN)

Title: _____ Surname: _____ Given Names: _____

Relationship to Patient: _____

Phone (Home): _____ Phone (Work): _____ Mobile: _____

HOSPITAL ACCOUNT (PLEASE SELECT ONE OF THE BELOW OPTIONS)

◯ **Private Health Fund**

Fund name: _____ Member no. _____

◯ **Workcover/Third Party Liability**

Have you lodged a claim yet? ◯ Yes ◯ No Claim no. _____

◯ **Defence Force** ◯ Army ◯ RAAF ◯ Navy

Rank: _____ Unit: _____ EP ID: _____ Defence Approval no. _____

◯ **DVA (Department of Veteran's Affairs)**

DVA Card Number: _____ Card Colour: ◯ Gold ◯ White

◯ **Self Insured** Please contact the Mater on (07) 4727 4444 for an estimate of hospital fees and charges

◯ **Overseas** Please contact the Mater on (07) 4727 4444 for an estimate of hospital fees and charges

DECLARATION (REQUIRED FOR ALL PATIENTS)

I certify that the above information is true to the best of my knowledge and agree to its release in support of my insurance claim.

Signature: _____ **Date:** _____

NURSING STAFF USE ONLY

Admission status: ☐ Inpatient ☐ CFAA ☐ DTW/Emergency Bed No.: _____ Admission Time: _____

Has patient presented at another hospital in the last 7 days? ☐ Yes ☐ No Transferred in? ☐ Yes ☐ No

If 'Yes", name of hospital: _____ Date of Admission from: ___/___/___ to ___/___/___

Admitting Diagnosis: _____

OFFICE USE ONLY

MRN No: _____ Pre-Adm Clerk 1: _____ Pre-Adm Clerk 2: _____ ☐ To Fund Check on: ___/___

Adm Clerk: _____ ☐ HC21 ☐ Notes Time processed: _____

VALUABLES? ☐ Yes ☐ No Receipt number for Valuables Received: _____

This needs to be completed & returned with your Pre-Admission form

Mater Health Services North Queensland

INFORMED FINANCIAL CONSENT

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

Informed Financial Consent

I acknowledge **full responsibility for all Mater Hospital accounts** including any shortfall in reimbursement by my Health Insurance Fund, including any excess or co-payments payable under my health insurance policy.

If surgery includes a prosthetic device, **my doctor has advised me** about any prostheses or medical devices planned to be used in my surgery and whether I will have to pay a gap for any prostheses; the likely amount of any gap payment; and the availability of gap free alternatives for any prosthesis that requires a gap payment. **I understand that the hospital will charge me for any prosthesis gap payment required** and acknowledge that I will be liable to pay that charge.

I understand that the hospital will charge me for STD, ISD and mobile phone calls as well as any additional costs related to single room if applicable.

I understand there may be medication not covered by my health fund as part of my admission and I acknowledge responsibility for any or all pharmaceutical accounts that may be generated by the Mater Hospitals' external pharmacy service provider.

I understand that my personal medical record may be provided to allied health providers who are providing my clinical care and that there may be separate charges incurred with the use of allied health providers (eg xray, pathology, physiotherapy).

I acknowledge that in the event that I do not pay accounts rendered by the Mater Hospital within three (3) months after they are issued I shall also be responsible for payment of a further administration fee which the Hospital is entitled to charge me to cover their costs of administering the account. I further agree that in the event that I fail to pay accounts rendered by the Mater Hospital, I will be responsible for any additional costs actually incurred by the Hospital including legal fees on an indemnity basis.

Patient Name: _____

Signature: _____ Date: _____

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

This needs to be completed & returned with your Pre-Admission form

Mater Health Services North Queensland

PERMISSION TO USE INFORMATION (PRIVACY)

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

The National Privacy Principles prohibit the use of the personal information that the Mater Hospital collects and holds about you for certain purposes in the event that you do not consent to the use of such information for those purposes.

The Mater Hospital would like you to indicate in this form whether or not you consent to the use of the personal information it holds about you for the purposes described below.

You should note that in the event that you do consent, the information will be used in an identified format. This is, your identity will be clear in any material generated for the purposes for which you provide your consent.

You are under no obligation to 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.

Please indicate if you consent to the use of your personal information for the purposes described below, by ticking the relevant boxes and signing and dating the form where indicated.

YES	NO	
☐	☐	To assist the health care provider in undertaking quality improvement activities and data collection.
☐	☐	To assist the health care provider in providing practical training and education to medical, nursing and other allied health students.
☐	☐	To allow the health care provider to supply my name to Ministers of Religion (from my denomination) and/or members of Returned Services Organisations (if applicable) to enable them to visit me whilst I am a patient in this facility.
☐	☐	The record of my operation may include photographs or video footage. These de-identified data may be used for teaching purposes.
☐	☐	To inform next of kin identified in my Pre-Admission Form of the outcome of treatment or obtain consent to necessary treatment when I am not able to provide such consent.

By signing you acknowledge that you have read and understood the following:

- The health care provider may provide my information to my health fund of which I am a member if requested by the fund.
- Medical and/or clinical staff may generate clinical photographic material or information technologies relating to my medical condition eg videos, CDs.
- My personal medical record may be provided to other healthcare facilities in case of transfer or for continuation of my care.

Patient Name: _____

Signature: _____ Date: _____

PERMISSION TO USE INFORMATION

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

This needs to be completed & returned with your Pre-Admission form

Mater Health Services North Queensland

MEDICATION SUMMARY FORM

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

Whilst you are a patient at the Mater Hospital we will endeavour to ensure all medications prescribed for you are safe and appropriate. An important part of this process is to have an accurate record of all medication you are already taking. Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products. If you have any problems completing the list please contact your GP or Community Pharmacy for assistance.

Medication	Strength	Dose	Reason for Taking	Taking for how long
eg Aspirin	100mg	1 daily	Thin Blood	2 years

Medications STOPPED in the last 2 weeks

Medication	Strength	Dose	Reason for Taking	When/Why stopped?
eg Warfarin	5mg	1 daily	Heart Valve	1 Dec - Dr told me to stop

The Mater Pharmacy may need to contact your local health care providers to obtain or provide information (eg Safety Net number or values, preadmission medication, discharge medication summary). If you consent to this, please provide contact details for the following healthcare providers.

Retail/Community Pharmacy: _____

Respite or home nursing service: _____

In order to ensure an uninterrupted supply of your regular medicines during your stay in hospital, please remember to bring in **ALL** your medications in their original labelled containers and/or repeat prescriptions with you upon admission. Please include all eye drops, patches, natural/complimentary medicines or topical products.

Charges for medication provided during your stay in hospital may be billed to your account according to the agreement between your Private Health Fund and the Mater Hospital. Not all pharmacy items may be covered by your health fund. Any amount not covered would be payable on discharge.

The information I have provided here is accurate and complete to the best of my knowledge.

Patient Name: _____

Signature: _____ Date: _____

MEDICATION SUMMARY FORM

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ADMISSION PROFILE

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

PLEASE READ QUESTIONS CAREFULLY & PLACE TICK IN THE APPROPRIATE BOX.
USE SPACE PROVIDED FOR ANY FURTHER INFORMATION.

NB SHADED AREAS FOR **STAFF ONLY**
If yes response, follow prompts

PATIENTS TO COMPLETE THE WHITE AREA ONLY

Reason for admission: _____

Next of Kin contact no: _____

Has information been provided to patient on (refer to Patient Information folder located in patient room):

- Rights and Responsibilities ☐ initial: _____
- Compliment/Complaint process ☐ initial: _____

ENDURING POWER OF ATTORNEY/ADVANCED HEALTH DIRECTIVE

Do you have an Advanced Health Directive?	◯ N ◯ Y	Please provide copy
Do you have an Enduring Power of Attorney?	◯ N ◯ Y	Please provide copy
Name of Attorney:_____	Phone No: _____	File copy in medical record
Do you have a Guardian?	◯ N ◯ Y	
If yes, Guardian must be present during pre-procedure checks.		

ALLERGIES & REACTIONS ◯ N ◯ Y

Please document any known allergies or reactions eg medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit.

Have you ever been allergic to latex? ◯ N ◯ Y	Reaction:	Refer to MHSNQ Latex Policy 227 Apply ALLERGY ID band
Food Allergy ◯ N ◯ Y	Reaction:	
Allergy/Sensitivity	**Reaction**	

PAST SURGICAL/MEDICAL HISTORY

Surgery & medical conditions to be listed below

Year	Surgery/Medical Condition	Year	Surgery/Medical Condition	Year	Surgery/Medical Condition

Previous anaesthetic problem (self/family) ◯ N ◯ Y if Yes, specify: — Advise Anaesthetist

GENERAL HEALTH & WELLBEING

How much do you weigh?	_____ kgs	If > 120kg refer to Bariatric Management Plan
What is your height?	_____ cms	
Do you smoke?	◯ N ◯ Y _____ per day	
If no, have you smoked in the past?	◯ N ◯ Y Date ceased: ____/____/____	
Do you drink alcohol?	◯ N ◯ Y _____ standard drinks/day	
Do you have pain?	◯ N ◯ Y Where: _____	
Disturbed sleep patterns/sleep apnoea?	◯ N ◯ Y ◯ Sedation ◯ CPAP	
Immunisations?	◯ N ◯ Y	Patient advised to update ☐ N ☐ Y
Female patients: Are you pregnant?	◯ N ◯ Y _____ weeks	Consider Obstetric review

Do you have, or have you in the past, had a problem with?

CANCER

Name of Specialist/s

Do you have or have you had cancer? ◯ N ◯ Y Site: _____

If yes, Year diagnosed? _____ Treatment: ◯ Surgery ◯ Last Chemo___/___/___ ◯ Radium

Do you have a family history of cancer? ◯ N ◯ Y Explain: _____

DERMATOLOGY

Name of Specialist/s

Skin condition? ◯ N ◯ Y Specify: _____

Pressure ulcer? ◯ N ◯ Y Where: _____ When: _____

ADMISSION PROFILE

3C

ADMISSION PROFILE

RESPIRATORY	Name of Specialist/s	
Bronchitis/Asthma/Emphysema/COPD/ Shortness of breath/bronchiectasis/asbestosis	◯N ◯Y	Do you use: ☐ Nebulisers ☐ Home oxygen ☐ Puffers
Breathing problems	◯N ◯Y	
Other chest problems	◯N ◯Y	Explain:

Document on Medication Chart 21H

High blood pressure	◯N ◯Y	
Chest pain, angina	◯N ◯Y	
Heart attack(s)	◯N ◯Y	Year/s:
Heart failure/congestive cardiac failure	◯N ◯Y	
Elevated cholesterol/triglycerides	◯N ◯Y	
Rheumatic fever/valve disease	◯N ◯Y	
Palpitations/heart murmur/ irregular heart beat	◯N ◯Y	
Previous blood clots	◯N ◯Y	Specify:
Family history of cardiac disease	◯N ◯Y	
Other related problems: eg arterial/venous ulcers	◯N ◯Y	Specify:

NEUROLOGY	Name of Specialist/s	
Stroke/TIA (Transient Ischaemic Attack)	◯N ◯Y	
Any Residual weakness?	◯N ◯Y	Where:
Fits/faints/'funny turns'	◯N ◯Y	When:
Limb paralysis/weakness	◯N ◯Y	Where:
Speech problems	◯N ◯Y	Specify:
Epilepsy	◯N ◯Y	Last seizure:
Parkinson's Disease	◯N ◯Y	Diagnosed:
Polio/meningitis	◯N ◯Y	When:
A fall or falls within the last 6 months	◯N ◯Y	How often:
Difficulty walking/unsteady on feet	◯N ◯Y	
Short term memory loss/dementia	◯N ◯Y	Specify:
Migraines/headaches	◯N ◯Y	

Initiate Discharge Planning

If yes, high falls risk – implement fall prevention strategies.

Initiate Discharge Planning

GASTROINTESTINAL	Name of Specialist/s	
Gastric ulcer / reflux / hiatus hernia	◯N ◯Y	
Hepatitis/Liver Disease	◯N ◯Y	type: Jaundice ◯N ◯Y
Diarrhoea	◯N ◯Y	
Constipation	◯N ◯Y	
Stoma	◯N ◯Y	
Nausea/vomiting	◯N ◯Y	

GENITOURINARY	Name of Specialist/s	
Dialysis	◯N ◯Y	
Renal impairment/'kidney trouble'	◯N ◯Y	
Bladder problems	◯N ◯Y	☐ Incontinence ☐ Frequency ☐ Urgency ☐ Pain
Stoma	◯N ◯Y	

MUSCULOSKETAL SYSTEM	Name of Specialist/s	
Arthritis	◯N ◯Y	
Back or neck injury or problems	◯N ◯Y	
Pins, plates, implants or devices	◯N ◯Y	Specify:

Note: Cytotoxic precautions may need to be implemented depending on type of medication eg methotrexate

ENDOCRINE	Name of Specialist/s	
Do you have diabetes?	◯N ◯Y	☐ Type 1 ☐ Type 2 ☐ Insulin ☐ Tablets ☐ Diet
What is your usual blood glucose reading in the morning?	_____	or ☐ Do not test
What was your last HbAlc?	_____	Date: _____ ☐ Unknown
Have you had a HYPO (very low blood sugar) in the last 3 months?	◯N ◯Y	
Thyroid problems	◯N ◯Y	

Educator to see if answer is >8

Educator to see if answer is >8

Educator to see if answer is yes

NUTRITION		SCORE		If score is >1 refer to MUS tool.
1. Have you lost weight recently without trying?	◯No ◉Unsure	0 2		
If yes, how much weight have you lost?	◯0.5 – 5.0 kg ◯5.1 – 10.0 kg ◯10.1 – 15 kg ◯Over 15 kg ◯Unsure	1 2 3 4 2		
2. Has your appetite decreased recently?	◯N ◯Y	0 1	**Total Score**	
Do you need a special or modified diet?	◯N ◯Y Specify:			If yes notify Food Services.

HAEMATOLOGY	Name of Specialist/s	
Blood disorders/bleeding problems/clotting disorders	◯N ◯Y	
Anaemia	◯N ◯Y	
Previous blood transfusions	◯N ◯Y When:	Adverse reaction: ☐ N ☐ Y document on Progress Notes
Do you take blood thinning/arthritis or aspirin based medication?	◯N ◯Y Specify:	
If yes, have you ceased this medicine?	◯N ◯Y Date last taken:	Consider notifying medical officer

INFECTION CONTROL		
Have you been a patient, in another hospital/ nursing home in the past 24 hours?	◯N ◯Y	If yes, obtain swabs from: ☐ Nose ☐ Groin ☐ Axilla ☐ Wound
Do you have a wound/infection?	◯N ◯Y	Commence Wound Assessment chart 15V
Have you ever had an infection with any multi resistant bacteria eg “golden staph”?	◯N ◯Y	☐ MRSA ☐ Nose &Groin ☐ ESBL/VRE ☐ Rectal Swab/Faecal Spec
Have you had neurosurgery prior to 1990?	◯N ◯Y	
Have you taken human pituitary hormone (growth hormone, gonadotrophin) prior to 1986?	◯N ◯Y	If yes notify infection control officer or Hospital coordinator if required
Does anyone in your family have CJD (Creutzfeldt-Jacob Disease)?	◯N ◯Y	
Has the patient been identified as potentially CJD after a surgical procedure or shown you a medical letter regarding their risk for CJD?	◯N ◯Y	

PSYCHOSOCIAL		
Depression/Anxiety	◯N ◯Y	Details
Diagnosed Mental illness	◯N ◯Y	
PTSD	◯N ◯Y	

SPECIAL NEEDS		
Primary Language_____ Interpreter Required ◯N ◯Y	Cultural considerations: _____ Specify:_____	
We encourage you to leave valuables at home. **The hospital will take no responsibility for valuables kept with patients.**		☐ Kept at own risk ☐ Taken home by_____ ☐ Placed in safe Receipt No:_____
Visual aids ◯N ◯Y	☐ Glasses ☐ Contact Lenses ☐ Eye Prosthesis	
Walking aids ◯N ◯Y	Specify:	
Hearing aids ◯N ◯Y	☐ Left ☐ Right	
Dentures ◯N ◯Y	☐ Upper: ☐ Partial ☐ Full ☐ ☐ Lower: ☐ Partial ☐ Full	
Valuables ◯N ◯Y	If yes, document in Progress Notes.	

Patient History Form reviewed/completed by: ☐ **(Preadmission Clinic Staff)** ☐ **Unit staff** ☐ **SAU**

Signature _____ Name (Print) _____ Designation _____ Date: ____/____/____

ADMISSION PROFILE

Mater Health Services North Queensland Limited

ADMISSION PROFILE

OFFICE USE ONLY

Surname: _____

First Name: _____

U.R. Number: _____

Ward: _____ Bed: _____

Please affix patient's identification label

DISCHARGE PLANNING

Do you live alone?	◯N ◯Y
Do you live in a: ◯House ◯Unit/flat ◯Retirement Village ◯Hostel ◯Nursing Home ◯Other_____ Do you have stairs?	◯N ◯Y
Do you have problems caring for yourself at home? If yes, who will care for you on discharge?	◯N ◯Y Name:_____
Is this person in good health and able to assist?	◯N ◯Y
Are you the carer for someone else?	◯N ◯Y
Do you currently use any community services? If yes, which service?	◯N ◯Y
Proposed length of stay_____days.	
Discharge time is 10am for inpatients. Can someone collect you by this time? If not, how do you plan to get home?	◯N ◯Y Name:_____ Phone:_____ ◯N ◯Y Explain:_____

Discuss possible post discharge needs with patient/carer.

Refer to Discharge Planning Guidelines.

Discuss Discharge Time of 10am with patient/carer.

Transport required – documented in notes.

Post procedure patients only

Who will care for you on discharge?	Name:_____Ph No._____ Relationship._____
Transport arrangements?	◯N ◯Y Explain:_

Patient or Carer Signature

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

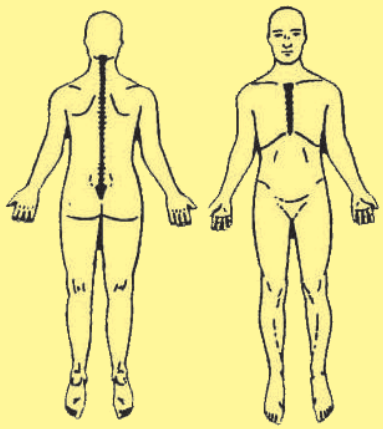
Name: (Print) _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____/_____/_____

If not completed by patient

PRESENTATION ON ADMISSION: initiate appropriate nursing intervention/s; document issue action and outcome in notes

Physical Appearance: **Assessment Attended:** ☐ Yes



Identify Observations with the use of Symbols on the above illustrations eg - P (for pain)

Symbol	*Observation*	
P	Pain ☐ Yes ☐ No	
#	Fracture	
PA	Pressure area	(Refer to 15V Wound Assessment as applicable)
U	Ulcer	
ST	Skin tears	
W	Wound	
S	Swelling/oedema	
R	Rash	
B	Bruise	
D	Drains	
IV	Intravascular device including IVT, port-a-cath, CVC etc.	
SC	Subcutaneous line	
IDC	Indwelling catheter: Type:_____ Date last changed:_____	
E	Enteral feeding eg N/G/peg feeds	
O	Ostomy – Type:_____	
LA	Limb amputation - Prosthesis ☐ Yes ☐ No	
Oth	Other:_____	

Mental Status: ☐ Orientated ☐ Vague ☐ Confused ☐ Other

Emotional Status: ☐ Calm ☐ Anxious ☐ Distressed ☐ Other

Medications: ☐ N/A ☐ Yes – Documented on 21H Medication Chart (Refer to Medication Management Policy 53q V1)