MR001

Corymbia House

92-94 David Street, Dandenong 3175
Tel. (03) 9791 3533 Fax (03) 8762 3154

ATTACH PATIENT LABEL AS REQUIRED

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

TO BE COMPLETED BY PATIENT

Admitting Doctor		
General Practitioner (Name & Address)		
Date of Admission	Time	Date of Operation
Operation/Procedure		

Have you been hospitalised anywhere in the last seven days? ☐ Yes ☐ No If Yes, Hospital

Have you read a copy of the Rights and Responsibilities attached ☐ Yes ☐ No

Have you read the Privacy Policy attached ☐ Yes ☐ No

PATIENT DETAILS – please print

Title / Surname		Previous Surname
Given Names		Religion
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)
Sex ☐ Male ☐ Female	Date of Birth	Marital Status
Country of Birth (If Australia, which State)	Are you an Australian Resident? ☐ Yes ☐ No	
Language Spoken at Home (Other than English)	Are you of Aboriginal/Torres Straight Island descent ☐ Yes ☐ No	

Medicare Number	Patient's Reference No.	Expiry Date	Veteran's Affairs No.
Pension No./ Health Care Card ☐ Full ☐ Part		Expiry Date	Safety Net Number

HEALTH FUND INSURER

Fund		Membership Number	
Level of Cover		Date Joined	
Previous Fund	Confirmed By	Confirmed With	Date Time

OFFICE USE ONLY

WORKCOVER/TRANSPORT ACCIDENT COMMISSION DETAILS

Employer Name		Employer Address
Contact		Phone
Date of Accident	Claim Number	Claims Agent

CONTACT PERSON / NEXT OF KIN

Surname	Given Name	Relationship
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)

2ND CONTACT PERSON

Surname	Given Name	Relationship
Address		Postcode
Phone (H)	Phone (B)	Phone (Mobile)

PRE-ADMISSION SUMMARY

MR/001

NAME:_____

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PATIENT PRE-ADMISSION HISTORY

TO BE COMPLETED BY PATIENT

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

ALLERGIES (Food, Medications, Latex.)

Weight ☐ Height ☐

Do you have x-rays relevant to your admission? ☐ Yes, please bring on admission

MRI relevant to your admission? ☐ No

MEDICAL HISTORY Have you ever had any of the following

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Blood Clot in Legs/Lungs	☐	☐	Pneumonia/Bronchitis	☐	☐
Coronary (Heart Attack)	☐	☐	Anaemia	☐	☐	Asthma	☐	☐
Angina	☐	☐	Bleeding Disorder	☐	☐	Tuberculosis	☐	☐
C.V.A. (stroke)	☐	☐	Stomach Ulcer	☐	☐	Rheumatic Fever	☐	☐
Diabetes	☐	☐	Jaundice/Hepatitis	☐	☐	Epilepsy or Fits	☐	☐
Kidney Disease	☐	☐	AIDS Risks	☐	☐	Psychiatric Treatment	☐	☐
Blood Transfusion	☐	☐	Sleep Apnoea	☐	☐	**Are you/could you be pregnant**	☐	☐
Pacemaker	☐	☐						

	YES	NO
1. Have you had a dura mater graft? (between 1972 and 1989)	☐	☐
2. Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD)?	☐	☐
3. Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?	☐	☐

SURGICAL HISTORY Have you had any previous surgery? ☐ Yes ☐ No

Details (type/year)

OTHER RELEVANT INFORMATION:

ANAESTHETIC HISTORY

	YES	NO
Have you ever had any previous anaesthetics?	☐	☐
Have you or a member of your family ever had special problems with anaesthetics?	☐	☐
Do you smoke ☐ per day	☐	☐
Do you consume alcohol? ☐ per week	☐	☐

MEDICATION

	YES	NO
Are you taking any medication at present?	☐	☐

Please give details (including contraceptive pill, herbal remedies, blood thinning eg. Aspirin, Warfarin, Plavix)

Medication	Dose	Frequency

NAME:_____

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CONSENT FOR SURGICAL OPERATION/PROCEDURE/TREATMENT

Part A: To be completed by Patient

The doctor whose name appears in Part B and I have discussed my/my child's/my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

1. The administration of an anaesthetic, medicines may be needed in association with this operation/procedure and these carry some risks.
2. Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations/procedures and/or treatment being carried out if required.
3. Even though the operation/procedure and/or treatment is carried out with all due professional care, the operation/procedure and/or treatment may not achieve the expected result.
4. The operation/procedure and/or treatment carries certain risks, and the nature of those risks, and, that complications may occur.

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

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

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

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

Dated this_____ **day of**_____ **20**_____

Signed_____ **Relationship to Patient**_____

Witness Signature_____ **Print Name**_____

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

PART B: TO BE COMPLETED BY SURGEON

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

_____

_____

Surgeon's Signature _____ **Date**_____

PRINT NAME

PART C: TO BE COMPLETED BY ANAESTHETIST

I have discussed with the patient the relevant aspects and risks of the anaesthetic and he/she has given consent to proceed.

Anaesthetist's Signature _____ **Date**_____

PRINT NAME

PATIENTS RIGHTS AND RESPONSIBILITIES

Patient Rights

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

Patients Responsibilities

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

PATIENT PRIVACY

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

Privacy Compliance

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

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

Information Collected by Corymbia House, 92 David Street Dandenong 3175

Part A – Patient Information

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

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

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

How does Corymbia House use information?

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

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

Access to records

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

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

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

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

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