REQUEST FOR

ADULT ELECTIVE ADMISSION

NSW GOVERNMENT Health
Mid North Coast
Local Health District

This booklet needs to be completed and delivered in person or mailed to the hospital to book your admission.
Please complete this questionnaire as accurately as possible

Doctors please
- **Tick the hospital the patient will be attending – Page 1**
- **Complete Pages 3-5**

Patients please
- **Complete Personal Details and Patient Health Questionnaire – Pages 6-9**

☐ COFFS HARBOUR HEALTH CAMPUS **POST TO:** Admissions / Booking Office Coffs Harbour Health Campus Locked Bag 812 COFFS HARBOUR NSW 2450	• **ONLY** urgent admissions (that are within 30 days) need to be delivered in person to the Day Surgery reception on Level 2 of the Hospital. **All other bookings may be mailed to the address as shown.**
☐ BELLINGEN HEALTH CAMPUS Post to: PO Box 137 MACKSVILLE NSW 2447	• The waiting list at Bellingen Hospital is managed centrally at Macksville Hospital.
☐ MACKSVILLE HEALTH CAMPUS Post to: PO Box 137 MACKSVILLE NSW 2447	• Admissions are located in the main entrance at reception.

This Booklet needs to be completed to book your admission.

Please complete this questionnaire as accurately as possible.

Once we have received your **completed** booklet you will be placed on the **Elective Waiting List**. You will receive a letter from the hospital confirming receipt of this booklet and advice regarding the approximate waiting time for your surgery.

The hospital will undertake to plan your operation in accordance with the **Clinical Priority** specified by your doctor.

You will be advised of your planned admission date by phone and/or letter and you will be required to confirm that the date is suitable.

Operation Delays:
Unfortunately from time to time it is necessary to **DELAY OPERATIONS DUE TO URGENT CASES AND EMERGENCIES**. We hope this will not happen in your case, but if it does we trust that you will understand.

If you need help to complete this form, please see your local Doctor

Next

When you have completed filling in this Booklet, please deliver or post to the hospital highlighted by your doctor. (see front page)

"We are committed to ensuring your privacy by complying with the Privacy and Personal Information Protection Act 1998 Health Records and Information Privacy Act 2002."

- *Information will be stored and managed in accordance with this legislation.*
- *Information (including personal details) will be provided to health care professionals involved in planning and provision of your ongoing care.*

If you have any questions relating to this statement contact the Admissions office at your hospital.

To be completed by the Admitting Medical Officer

REQUEST FOR ELECTIVE ADMISSION

MRN _____ *(Use patient ID if available)*

Surname _____ Sex _____

Other Names _____ DOB _____

Address _____

_____

Hospital Attending _____

Please Circle	ELECTION STATUS ON ADMISSION
1	Non-chargeable patients
2	Private
3	Worker's compensation
4	Motor Accident (Third party)
5	Veteran's Affairs
6	Ineligible
7	Defence forces
8	Public Liability

Please ✓ Tick	CLINICAL PRIORITY CODE	
	1 - WITHIN 30 DAYS	
	2 - WITHIN 90 DAYS	
	3 - WITHIN 365 DAYS	
	NOT READY FOR CARE (Staged Procedure)	Enter Status Review Date Here:

Presenting Problem

Planned Procedure

Estimated operating time: _____

Medicare Number

MBS No.

Open Access Endoscopy: Yes / No

National Bowel Screening: Yes / No

Significant Medical History, Medications and Findings: _____

_____

ADMISSION TYPE

☐ Day Only Surgery ☐ DOSA (Admit Day of Surgery)

☐ EDO (Extended Day Only) ☐ Other - Admit prior to the Day of Surgery

ALLERGIES: _____ **SPECIAL ALERTS:** _____

PLANNED ADMISSION DATE: _____ ESTIMATED LENGTH OF STAY _____ Days

SPECIAL EQUIPMENT REQUIRED IN OPERATING THEATRE No ☐ Yes ☐

If YES, please specify: _____

Please ✔ Tick if required

☐ ICU Post-op	☐ Bowel Prep: As per protocol	☐ Anticoagulant: Standing order
☐ HDU Post-op	☐ Interpreter	☐ Pre-operative physiotherapy

INVESTIGATIONS: ☐ NIL REQ. ☐ AS PER STANDING ORDERS ☐ PRE-ANAESTHETIC APPOINTMENT

Other requirements on admission? Please state _____

SIGNATURE OF ATTENDING MEDICAL OFFICER _____ DATE _____

PLEASE PRINT AMO NAME _____

BINDING MARGIN DO NOT WRITE

NSW GOVERNMENT Health
Mid North Coast
Local Health District

Facility: Coffs Harbour Health Campus

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adult and Mature Minors)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

For patients with capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr ..... have discussed with this patient the various ways of treating
(INSERT NAME OF MEDICAL PRACTITIONER)
the patient's present condition including the following proposed procedure/treatment:

.....
(INSERT SITE NAME AND REASONS FOR PROCEDURE OR TREATMENT; DO NOT USE ABBREVIATIONS)

.....

.....

.....

I have informed this patient of the nature, likely results and material risks of the proposed procedure / treatment and of the matters in the section below.

I have assessed this patient to be a minor with capacity to give consent (a 'mature minor') as they have demonstrated sufficient maturity and intellect to fully understand what is proposed. ☐ Yes ☐ No ☐ NA

..../...../20..... ...../.....
SIGNATURE OF MEDICAL PRACTITIONER DATE TIME

Interpreter* ..../...../20..... ...../..... .....
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

PATIENT CONSENT — To be completed by Patient

Dr ..... and I have discussed the present condition and the various ways
(INSERT NAME OF MEDICAL PRACTITIONER)
in which it might be treated, including the above procedure or treatment.

The doctor has told me that:

- the procedure / treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or **blood transfusion may be needed**, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand the nature of the procedure / treatment and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
*I have been told that another doctor may perform the procedure/treatment.**
I **consent** to the procedure/treatment described above for me.
I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure / treatment.

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor as acknowledgment of refusal*
While I consent to the above procedure/treatment, after discussing this matter with the doctor, I ***refuse consent*** *to have the following aspects of the recommended procedure or treatment:* .....
insert objection

.....

....
SIGNATURE OF MEDICAL PRACTITONER

☐ **I consent** ☐ **I do not consent to a blood transfusion if needed**

..../...../20.....
SIGNATURE OF PATIENT DATE

.... AM/PM
PRINT NAME OF PATIENT TIME

* Delete where not applicable

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adult and Mature Minors) SMR020.001

BINDING MARGIN DO NOT WRITE

NSW GOVERNMENT Health
Mid North Coast Local Health District

FAMILY NAME	MEDICAL RECORD NUMBER
GIVEN NAME	☐ MALE ☐ FEMALE
DATE OF BIRTH	SPECIALIST
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Referring Specialist/Medical Practitioner to complete

(If not completed, the RFA will be returned for completion before the patient is added to the waiting list.)

1. Anticipated anaesthetic required?
☐ General ☐ Local ☐ None
☐ Regional ☐ Local with anaesthetic standby
☐ Sedation by anaesthetist ☐ Sedation by non-anaesthetist

2. Allergies (including latex):

3. Medication alerts:

Is the patient taking		
	An anticoagulant?	☐ Yes ☐ No
	If yes, which one?	
	Do you want to cease this drug?	☐ Yes ☐ No
	If yes, last dose	_____ hours before surgery OR _____ days before surgery OR ☐ As per current guidelines
	An antiplatelet agent?	☐ Yes ☐ No
	If yes, which one?	
	Do you want to cease this drug?	☐ Yes ☐ No
	If yes, last dose	_____ days before surgery OR ☐ As per current guidelines
	Any disease-modifying anti rheumatic drugs (DMARD) or biologics/immunodulating drugs?	☐ Yes ☐ No
	If yes, which one?	
	Do you wish to cease this drug?	☐ Yes ☐ No
	If yes, last dose	_____ Days before surgery OR _____ weeks before surgery

OTHER DRUGS that need preoperative attention? For example: opoid, antiepilectic, insulin, corticosteroids.
☐ Yes ☐ No If yes, please complete below

Name of Drug	Do you wish to cease this drug?	If yes, last dose?
	☐ Yes ☐ No	_____ hours before surgery OR _____ days before surgery OR _____ weeks before surgery OR ☐ As per current guidelines
	☐ Yes ☐ No	_____ hours before surgery OR _____ days before surgery OR _____ weeks before surgery OR ☐ As per current guidelines
	☐ Yes ☐ No	_____ hours before surgery OR _____ days before surgery OR _____ weeks before surgery OR ☐ As per current guidelines

4. Other pre-procedure preparation

Preoperative clinic	☐ Yes	☐ No	
Group and screen	☐ Yes	☐ No	
Bowel preparation	☐ Yes	☐ No	
Preoperative antibiotics	☐ Yes	☐ No	Specify: _____
Preoperative venous thromboemlism (VTE) prophylaxis	☐ Yes	☐ No	Specify: _____
Allied health or stoma therapy	☐ Yes	☐ No	Specify: _____

Other instructions: _____

5. Does patient require Health Care Interpreter Services (language, hearing impaired) or other assistance (eg literacy)? ☐ Yes ☐ No Please Specify: _____

6. Specialist/Medical Practioner's signature: _____ Date: _____
Print name: _____

If this form is not completed, the RFA will be returned for completion before the patient is added to the waiting list.

PERIOPERATIVE ANTICOAGULATION INSTRUCTIONS

BINDING MARGIN DO NOT WRITE

PERSONAL DETAILS – TO BE COMPLETED BY PATIENT

TITLE	Please ✔ Tick
Mr	
Mrs	
Miss	
Ms	
Master	

SEX	Please ✔ Tick
Male	
Female	

MARITAL STATUS	Please ✔ Tick
Married/Defacto	
Never Married	
Widowed	
Divorced	
Separated	
Declined to respond	
Unknown	

Surname	All Given Names
Maiden Names	Other names previously known by
Address (Residential)	Postcode
Address (Postal)	Postcode
Email	

Home Phone	Mobile Phone	Business Phone

Date of Birth	Country of Birth

Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander
☐ Yes, both Aboriginal and Torres Strait Islander
☐ Neither ☐ Declined to respond

Preferred Language (language spoken at home)

Interpreter Required ☐ Yes ☐ No

Religion (This information is routinely released to the accredited hospital Chaplain)

Religion Consent
Do you consent to your name being released to any pastor or minister and pastoral carer from your religion when they visit the hospital?
☐ Yes ☐ No

Medicare No.	Do you have Private Health Insurance? ☐ Yes ☐ No			Is this an excess table?
Position on Card	Name of FUND	Fund NUMBER	Shared / Single	☐ Yes
Expiry Date	Do you elect to use your Private Health Insurance for this Admission? ☐ Yes ☐ No			☐ No

Is this admission for: (Please ✔ Tick if YES) ☐ Motor Vehicle Accident (Third Party)
☐ Workers Compensation ☐ Public Liability

Are you eligible for treatment as a Repatriation patient? ☐ Yes ☐ No

Veteran's Affairs Number _____ Colour of Card _____

Contact Person 1 Name: ..... Date of Birth: ../../..	Relationship	Address *(Residential)*	Telephone
Contact Person 2 Name: ..... Date of Birth: ../../..	**Relationship**	**Address** *(Residential)*	**Telephone**

Who is your local doctor? (GP) **Phone No.**

Do you have a carer? Yes ☐ No ☐ *If Yes, Carer's Name:* ..... Date of Birth: ../../..	**Relationship**	**Address** *(Residential)*	**Telephone**
Are you a carer? Yes ☐ No ☐ *If Yes, for whom:*	**Relationship**	**Address** *(Residential)*	**Telephone**

Are you available for admission at short notice? ☐ Yes ☐ No

BINDING MARGIN DO NOT WRITE

PATIENT HEALTH QUESTIONNAIRE:

TO BE COMPLETED BY PERSON REQUIRING ADMISSION.

(Parent or carer may complete if patient unable)

IF HELP IS REQUIRED PLEASE CONTACT YOUR LOCAL OR FAMILY DOCTOR.
If you require more room please attach additional sheet.

Patient Name: ..... Date of Birth .....

What is your weight: ..... Kgs Height: ..... cm/ft inches

What health problems are you coming into hospital for? .....

.....

IN THE PAST HAVE YOU HAD 1. Any **MAJOR ILLNESS**? (eg. diabetes, cancer, psychiatric treatment, kidney disease, rheumatoid arthritis or **DISABILITIES** (eg. blindness, deafness, intellectual problems)?	☐ No	☐ Yes	If Yes, Please give details
1a. If **Diabetic**, how is it managed (Please Circle)	DIET	TABLET	INSULIN
IN THE PAST HAVE YOU HAD 2. Any **PREVIOUS OPERATIONS / PROCEDURES**? (Please include Heart Stents.)	☐ No	☐ Yes	If Yes, Please give details
3. Have you, or a blood relative, ever had a problem with **ANAESTHETICS**?	☐ No	☐ Yes	
4. Are you **ALLERGIC** to any medicines, tapes, antiseptics, latex, rubber or foods? (Please outline)	☐ No	☐ Yes	
5. Do you have any **BREATHING / CHEST problems**? (shortness of breath, cough, pneumonia, TB, asthma, **sleep apnoea**)	☐ No	☐ Yes	
If Yes, has your condition become worse in the last 3 months?	☐ No	☐ Yes	
5a. Do you use **HOME OXYGEN**?	☐ No	☐ Yes	
6. Do you have, or have you ever had problems with your **HEART**? (High blood pressure, chest pain, angina, heart attack, rheumatic fever, heart murmurs)	☐ No	☐ Yes	
6a. Do you have a Pacemaker?	☐ No	☐ Yes	
7. Do you suffer from heartburn, indigestion, hiatus hernia or reflux? If yes, are you on any medication?	☐ No	☐ Yes	If yes, list medications:
8. Can you normally walk briskly without stopping : a. More than two flights of stairs? b. Two flights of stairs? c. One flight of stairs? d. Half a flight of stairs? e. Around the house? f. More than 50 metres?	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	
8a. Can you lie flat for one hour? If not, why not?	☐ No	☐ Yes	

BINDING MARGIN DO NOT WRITE

9. Do you have any **BLEEDING PROBLEMS**? (Easy bruising, excessive bleeding after dental extractions)	☐ No	☐ Yes	
10. Have you ever had **BLOOD CLOTS** in the legs or lungs?	☐ No	☐ Yes	
11. Have you ever had a **BLOOD TRANSFUSION**?	☐ No	☐ Yes	
12. Have you ever had a problem with epilepsy, stroke, leg or arm weakness, fits, faints, or "funny turns"?	☐ No	☐ Yes	
13. Have you ever had jaundice or hepatitis?	☐ No	☐ Yes	
14. Could you possibly be pregnant?	☐ No	☐ Yes	If Yes, no. of weeks .....
15. Do you have limited neck or jaw movement?	☐ No	☐ Yes	
16. SKIN INTEGRITY Do you have any broken skin areas/wounds?	☐ No	☐ Yes	Location:
17. Do you have false teeth?	☐ No	☐ Yes	If yes please circle: TOP: Full / Partial BOTTOM : Full / Partial
18. Do you have any speech, swallowing or hearing problems?	☐ No	☐ Yes	What type?
19. Do you wear a hearing aid, glasses or contact lenses?	☐ No	☐ Yes	What type?
20. Have you had any tests done for your GP or specialist in the last 6 months?	☐ No	☐ Yes	
21. Do you smoke? If Yes, how many per day? (please circle) 1-10 10-20 20-30 30+ If you have stopped, when did you stop? ...../...../.....	☐ No	☐ Yes	If you smoke would you like information on how to QUIT ☐ No ☐ Yes
22. Do you have more than 3 alcoholic drinks most days?	☐ No	☐ Yes	If yes, how many per day?
23. Have you ever injected yourself with any substance not prescribed by a doctor, or used illicit substances?	☐ No	☐ Yes	If yes, when did you last use?
24. Do you have any other medical conditions not mentioned previously?	☐ No	☐ Yes	What type?

25. **ARE YOU TAKING ANY MEDICINES, STEROIDS, INHALERS FOR ANY REASON**
(PLEASE LIST all medications including hormone therapy, contraceptives, aspirin, as well as any complementary therapies)

DRUG NAME	STRENGTH	HOW MANY?	HOW OFTEN?

Do you have your medications in a webster/ blister pack? ☐ No ☐ Yes

NAME OF YOUR LOCAL PHARMACY:

BINDING MARGIN DO NOT WRITE

26. Do you need to make any special arrangements whilst you are in hospital? Please tick (if applicable) ☐ Annual leave ☐ Respite for dependant relative ☐ Sick leave ☐ Pet care ☐ Child Care	Please comment		
27. Do you live alone and have self care problems?	☐ No	☐ Yes	Please outline
28. Do you have a responsible adult to stay with you the night after you leave hospital?	☐ No	☐ Yes	
29. Please provide name & contact number of the person who will take you home from hospital. Contact Name: ..... Phone Number:			
30. Are you the primary carer for someone?	☐ No	☐ Yes	Please outline
31. Do you have: a) Steps / Stairs Inside your home? b) Steps / Stairs Outside your home? c) Grab rails in your bathroom? d) Hand rails in your toilet? e) A shower over the bath? f) An outside toilet?	 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	 If Yes, how many ..... If Yes, how many .....
32. Do you use / require : a) Walking stick / Frame? b) Wheelchair? c) Assistance of one person?	 ☐ No ☐ No ☐ No	 ☐ Yes ☐ Yes ☐ Yes	
33. Do you require a special diet? (eg. diabetic, vegetarian, kosher, etc.)	☐ No	☐ Yes	Please specify
34. Do you receive any help at home from: a) Home Help b) Meals on Wheels c) Community Nurse d) Other (Please outline)	 ☐ No ☐ No ☐ No ☐ No	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes	
35. Do you live in a residential Aged Care facility?	☐ No	☐ Yes	
36. Do you think you will require further assistance when discharged from hospital?	☐ No	☐ Yes	Please specify

Please sign this part of the form before returning it to the hospital indicated by your Doctor

I have given complete and accurate answers to the best of my knowledge.

SIGNED: _____ DATE: ___/___/ 20___

Please print name _____

If completing form on behalf of patient:

SIGNED: _____ DATE: ___/___/ 20___

Please print name: _____

Reason for completing form: _____

THANK YOU FOR YOUR TIME IN COMPLETING THIS FORM

BINDING MARGIN DO NOT WRITE

FOR COMPLETION BY HOSPITAL STAFF

REFERRALS	
☐ Discharge Planner	Date:
☐ Physiotherapy	Date:
☐ Occupational Therapy	Date:
☐ Stomal Therapy	Date:
☐ Cancer Support	Date:

MRN:
Surname:
Other Names:
Date of Birth:
Sex: ☐ Male ☐ Female
Ward / Doctor:

CLINIC OBSERVATIONS at clinic		
BP	HR:	BSL:
Temp	Resp	
Weight.....kg	Height:.....cm	
BMI.....	Girth.....cm	

TESTS	Ordered	Received	Date	Checked By (Initial)
FBC				
U,E Cr				
Iron Studies				
CRP				
LFT's				
Coags				
Other				
G&S				
MSU				
CXR				
ECG				
Consult				
Other				

NOTES

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Nursing Staff Documentation

DATE / TIME	COMMENTS	SIGNATURE / NAME

BINDING MARGIN DO NOT WRITE

This section is to be utilised BY STAFF to document all correspondence relating to this booking after it has been entered into the PAS system, for example: delays, cancellations, and patient deferral requests are to be registered on this form.

DATE / TIME	COMMENTS / NAME OF PERSON SUPPLYING INFORMATION	SIGNATURE / NAME

BINDING MARGIN DO NOT WRITE

WAITING LIST HISTORY FORM	MRN _____ Surname _____ Other Names _____

- ☐ Operation date: .....
- ☐ PAC date: .....
- ☐ Patient advised to bring medications to PAC
- ☐ Patient advised of $10.00 bowel prep.
- ☐ Bloods & X-Rays .....

This section is to be utilised BY STAFF to document all correspondence relating to this booking after it has been entered into the PAS system, for example: delays, cancellations, and patient deferral requests are to be registered on this form.

DATE / TIME	COMMENTS / NAME OF PERSON SUPPLYING INFORMATION	SIGNATURE / NAME

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