LONGUEVILLE PRIVATE HOSPITAL

Pre-Admission Package

PRE-ADMISSION ON-LINE
For your convenience your pre-admission can be done on-line.
Go to www.longuevilleprivate.com.au and follow the prompts.

Admission Forms

In order to confirm your admission, it is essential that the hospital receives the relevant forms/electronic data as soon as possible following your visit to the doctor. Please take the time to carefully read and complete the relevant documents.

Admission Date: _____ Admission Time: _____

Mission Statement

Macquarie Hospital Services has a philosophy which focuses on wellness and well-being for our customers and a commitment to providing a service of quality and value. Macquarie Hospital Services will provide comprehensive and profitable health care service and valued partners in an environment of growth and development

Longueville Private Hospital
PATIENT INFORMATION

Welcome and thank you for choosing a Macquarie Health Hospital. We hope that your stay with us will be as comfortable and pleasant as possible.

Pre-Admission Information

Pre-admission is an important part of your hospital care. To ensure we can confirm your admission, financial and other arrangements, **we ask that you:**

- Complete the Pre-Admission and Patient History forms (enclosed) or complete the admission on line at www.longuevilleprivate.com.au
- If you are not on line please remove the completed forms from the booklet and **forward immediately** to the hospital in one of the following ways:
  1. **In person to Reception**
     (open 8am – 5pm Monday to Friday)
  2. **In person to Bed Manager/Ward Clerk**
     (open 7am – 8pm Monday to Sunday)
  3. **Fax** (02) 9982 6843
- If you are unable to deliver, fax or post the forms, please telephone as soon as possible on (02) 9427 0844 (Bus. Hours) 8 a.m. to 4 p.m.
- Please ensure that you bring the following documentation either **when you bring your forms to the hospital or on the day of admission**.
  - Health Fund card.
  - Medicare card
  - Pharmaceutical entitlements card
  - Pension card / Health Care card
  - Repatriation / Veterans' Affairs card
  - Credit card or alternative form of payment
- If your account is subject to Workers' Compensation or a Third Party claim, forward full details of the claim, including a letter from your insurance company accepting liability for this admission, to our Admission Office.

If you have any questions about hospital procedures, completion of forms, cost or health insurance status, our staff will be happy to assist you.

The day prior to Admission

To confirm your admission, please phone the hospital between **2 p.m. and 5 p.m**., on the working day prior to your admission. At this time, please advise any special dietary requirements.

What to bring into hospital on the day of Admission

- any medications (in original packaging) you are currently taking
- if you currently use a blister pack for your medications, please contact your pharmacist and request original packaging.
- any current x-rays
- nightwear +/- day clothes
- toiletries
- reading material
- crutches / walking aids if required.

On arrival report to:-

Main Reception Desk

Valuables

Do not bring jewellery or large amounts of money to hospital, as provision for safe custody is not available. Longueville Private Hospital does not accept liability for any items brought into the hospital. We kindly request any valuables be sent home with your next of kin.

Meals

Longueville Private Hospital aims to provide a choice of meals and to supply special diets where required. Please advise admission staff of your requirements. Food or alcoholic drinks should not be brought to you by visitors, without the permission of your Nurse.

Visiting

- Visiting hours are 10 a.m. to 8 p.m.
- If you have indicated that you would like a Religious or Ex-services organisation/RSL visit, we will make every attempt to facilitate this.

Smoking

Please be aware that Longueville Private Hospital is a **NO SMOKING** Hospital

Accounts / Fees

If you are a member of a health fund, it is important prior to your admission to check with them regarding the following:

a. That your level of Health Fund Cover adequately covers the cost of accommodation.

b. If an excess is payable for this admission.

c. If you have been a member of your Health Fund for less than 12 months, your fund may not accept liability for the costs of this admission – *e.g. if your condition or any symptoms of your condition existed prior to your joining.* If there is a question regarding pre-existing symptoms your health fund has the option to obtain details in this regard from your GP or Specialist.

Pharmacy and pathology, imaging, x-ray *(and related transport),* and surgical appliances may attract an additional charge. Please note that medical and allied health practitioner's fees may be billed separately by the practitioner.

Payment Procedure

- Private patients: the portion of your estimated hospital account not covered by your health fund, *e.g. an excess*, **must** be paid on admission. Any additional costs incurred during your stay *e.g. Pharmacy Costs and some investigations,* are payable **prior** to discharge.
- Repatriation (DVA) patients: the hospital will lodge a claim on your behalf. Any personal item purchased on your behalf **must** be paid for by you.

- Workers' Compensation patients: total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.
- Third-party patients: total payment (aside from any ancillary charges) **must** be made on admission unless approval for your hospitalisation has been authorised.
- Self Insured patients: total payment (aside from any ancillary charges) must be made for a minimum of one week prior to admission.
- Payment may be made by cash, bank cheque, MasterCard, Visa/Eftpos or direct deposit.
- A credit card imprint or $200 cash **DEPOSIT** will be collected from all patients on admission
- A $35 admission fee will be charged for all patients.

Medical Records and Privacy

Records of your illness and treatment will be kept for a limited time. They are confidential. The contents will be divulged only with your consent, or where justified by law. Longueville Private Hospital complies with the Privacy Act, 2014, including the way we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our hospital *(e.g. to your health fund, DVA, the supplier / manufacturer of your prosthesis, to our insurer, or to an external company contracted by Longueville Private Hospital to evaluate customer satisfaction).*

Discharge Information

- **DISCHARGE TIME IS 10 a.m.**
- You should arrange for someone to escort you home.
- Before you leave the hospital, make sure that you or your relatives / friends know how to care for you at home.
- Check with your nurse / doctor about continuing medication, follow-up appointments, etc.
- Please do not forget to take all x-rays or medications brought with you on admission.
- **Please complete a Patient Questionnaire Form to assist us improve our service.**

Please contact your nurse, if you have any concerns, problems or suggestions during your stay.

LONGUEVILLE PRIVATE HOSPITAL

Book.No.& MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

Pre-Admission Form
Patient Details

To be completed by Patient
Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Details

Date of Admission: ..... / ..... / .....

Admission Time: .....

ADMITTING DOCTOR: .....

Admission Diagnosis / Procedure: .....

Personal Details

Title: ..... Surname: ..... Previous Surname (*if applicable*) .....

Given Names: ..... Preferred Name: .....

Address ..... Suburb.....State ..... Postcode:.....

Telephone: (Home) ..... (Business) ..... (Mobile) .....

Sex: ☐ Male ☐ Female Date of Birth: ..... / ..... / ..... Age: .....

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: .....

Are you an Australian Resident? ☐ Yes ☐ No Country of Birth: ..... If Australia, specify state .....

Are you of Aboriginal / Torres Strait Islander (TSI) descent? ☐ No, ☐ Yes, Aboriginal, ☐ Yes, TSI, ☐ Yes, both Aboriginal and TSI

Religion: ..... Do you wish to be visited by a member of your clergy? ☐ Yes ☐ No

Person to Contact (Next of Kin)

Name: ..... Relationship to patient: .....

Address: ..... State: ..... Postcode: .....

Telephone: (Home) ..... (Business) ..... (Mobile) .....

Email .....

Second Contact / Power of Attorney: ..... Telephone: .....

Section A: Private Health Insurance

Fund Name: ..... Membership Number: ..... Date Joined: ..... / ..... / .....

Has the level of cover changed in the last 12 months? ☐ No ☐ Yes

Type of cover: ☐ Single ☐ Family ☐ Other ..... ☐ Level of cover *(if known)* .....

Do you have an excess? ☐ No ☐ Yes Amount $ ..... Have you paid an excess this year? ☐ No ☐ Yes Amount $ .....

Section B: Workers' Compensation or Third Party

☐ Workers' Compensation ☐ Third Party *(Please tick one box)*

The approval letter for this admission *(from your insurance company)* must accompany this form.

Insurance Company Details: Name of Insurance Company:.....

Address: .....State: ..... Postcode: .....

Telephone: ..... Claim No: ..... Authorised by: .....

Has your insurance company accepted liability: ☐ Yes ☐ No. Please specify reason *(if no)* .....

Workers' Compensation Patients Only – Employer Details: Name of Employer: .....

Address: .....State: ..... Postcode: .....

PRE-ADMISSION FORM FADM 046 v1

Telephone: ..... Date of Accident: ..... / ..... / ..... Has your employer completed a Report of Injury Form? ☐Yes ☐No

Have you completed a Workers' Compensation Claim Form? ☐ Yes ☐ No

Entitlements

Medicare Card No: | | | | | | | | | | Medicare Reference No: ..... Medicare Exp. Date: ...../ ...../.....

Pension / Health Care Card No: | | | | | | | | | | Expiry Date: ...../ ...../.....

Safety Net No: | | | | | | | | | |

Repatriation No: | | | | | | | | | | Card colour: ☐ White ☐ Gold ☐ Other

Do you wish to be visited by a member of an Ex-Service Organisation? *Please indicate:*

☐ No ☐ Yes, I will organise it ☐ Yes, please organise it for me.

GP / Local Doctor

Full name of GP: .....

GP Address: .....

GP Telephone: ..... GP Facsimile: ..... GP e-mail: .....

Previous Hospitalisation

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year: .....

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes

Which Hospital? ..... Dates: .....

How will this Admission be claimed? (please ✓ tick)

- ☐ Private Health Insurance – please complete Sections A
- ☐ Repat / Veterans Affairs – please complete Entitlements
- ☐ Workers' Compensation / Third Party – please complete Sections B
- ☐ Self Insured

Financial Consent / Valuables

I understand the portion of my estimated hospital fees not covered by a health fund must be paid on admission and any additional fees incurred during my stay are payable on discharge.
I agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables brought to the hospital.

Signature of patient / parent / guardian: ..... Date ..... / ..... /.....

Print name of patient / parent / guardian. .....

LONGUEVILLE PRIVATE HOSPITAL

Patient History Form

MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

PATIENT HISTORY FORM FADM 047 v1

To be completed by Patient. Please **PRINT** clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Date:...../...../ .....

Please specify the reason for your admission? .....

Transfer Source: ..... Ward: .....

Contact: ..... Phone: .....

Original Date of Admission: ..... Previous Hospital if any: .....

MEDICATIONS	YES	NO	COMMENTS OR FURTHER INFORMATION
ALLERGIES **Do you have any allergies to medications, food, intravenous dyes, sticking plaster, latex / rubber (*e.g. balloons, gloves)* or other substances?**			Specify :
Have you taken any steroids or cortisone tablets/injections in the last 6 months?			Name of medication: Date last taken: / / or still taking ☐ Yes
Are you taking any other prescription or non-prescription medication? If so, list the medications you currently take. **Please bring current medications to hospital on admission, in the original packaging**. Please obtain advice from your Doctor on taking medications on the morning of your operation.			
MEDICAL HISTORY	**YES**	**NO**	**SPECIFY DETAILS**
Weight			Specify: _____ kgs
Diabetes			Managed by: ☐ Diet ☐ tablets ☐ Insulin
Cancer year diagnosed……..			Site:
Stroke date ……./……../……..			Residual problems ☐ Yes ☐ No
Infectious diseases / recent infections			
High blood pressure			
Heart attack / chest pain / angina, especially heart failure or changed chest pain. *(circle)*			Date: / /
Cardiac Surgery or Stent *(circle)*			
Prosthetic heart valve			Type:
Palpitations / irregular heart beat / heart murmur			
Pacemaker			Make ..... Model ..... last checked / /
Rheumatic Fever			
Tendency to bleed / bruise easily			
Arthritis			
Asthma / bronchitis / pneumonia / hay fever			
Liver disease / hepatitis (Specify type A,B,C)			
Kidney / bladder problems			
Hiatus hernia / gastro-intestinal ulcers / bowel disorder			
Thyroid problems			
Epilepsy / fits / febrile convulsions			*If yes, discuss medication with your Doctor while 'nil by mouth'*
Depression/ /other mental illness			

Continued over page

PATIENT HISTORY FORM FADM 047 v1

PRINT NAME:

MEDICAL HISTORY	YES	NO	SPECIFY DETAILS
Dementia/confusion			
Migraines			
Recent cold or flu			
Impairment e.g. vision, hearing, mobility			Specify:
Leg or lung clots			
Other health problems			

PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations – if so, please list the year/s and operation/s performed:

.....

.....

	YES	NO	SPECIFY DETAILS
Have you ever had a blood transfusion?			Details of any reaction
PROSTHESIS / AIDS / OTHERS			
Glasses / contact lenses / eye problems			
Hearing aid or other hearing appliance			
Dentures			
Artificial joints or limbs			
Walking aids			
Continence Aids			
LIFESTYLE			
Have you ever smoked?			Daily amount ..... or date ceased / /
Do you drink alcohol?			Daily amount .....
Do you use recreational drugs?			Type ..... Daily amount .....
Do you require a special diet?			Type of diet
Have you a fear of falling or have fallen within the last 12 months?			
SLEEP APNOEA Have you ever suffered from sleep apnoea?			
If so, do you have a CPAP machine at home?			**If yes, bring your machine with you.**

DISCHARGE PLANNING ***(this information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete)***

	YES	NO	SPECIFY DETAILS
Are you over 75 years of age?			
Do you live alone?			
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			
Do you require assistance with any aspect of day-to-day living?			
Do you have multiple health problems?			
Do you have more than 1 – 2 external or internal stairs in your home?			

DISCHARGE PLAN			
Who will care for you after discharge from hospital?			
Name of Person:	Relationship:		
Where do you plan to go after discharge?	How will you get there?		

Signature of patient / guardian: ..... Date ..... / ..... /.....

Print name of patient / guardian. .....