Health
South Eastern Sydney
Local Health District

THE ST GEORGE HOSPITAL
& Community Health Service

And

THE SUTHERLAND HOSPITAL
& Community Health Service

Recommendation for Admission Form

Perioperative Health Questionnaire and Discharge Planning Questionnaire

S0119 290715

NSW GOVERNMENT Health
South Eastern Sydney Local Health District
Illawarra Shoalhaven Local Health District
Sydney Children's Hospital Randwick

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

Facility:

RECOMMENDATION FOR ADMISSION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SEI030005

Information on this page To Be Completed By Doctor.

Name: .....

D.O.B.: ..... Sex: ☐ Male ☐ Female Telephone: ( ) .....

Interpreter Required: ☐ Yes ☐ No Prefered language: .....

☐ Medicare ☐ Privately insured ☐ Self funded ☐ Other .....

(Please note: Patient must complete page 7-12 before submitting)

Please indicate the preferred hospital for the patient to be admitted:

Presenting Problem

Planned Procedure *(if applicable)*

Estimated OT time _____

Significant Medical History / Co-morbidities

Anticoagulant therapy. If yes, please state:

Known Infectious Risk ☐ YES ☐ NO **Known Allergies** If yes, please state:
☐ Airborne Pathogen ☐ Blood Borne Pathogen ☐ History of Multi Resistant Organism
☐ Other, please state: _____

Clinical Priority admission within: ☐ 30 days ☐ 90 days ☐ 12 months ☐ *Can attend at short notice*
☐ - Staged Procedure - Not ready for care at this time **PLANNED ADMISSION DATE:** / /
If not recommended priority provide clinical reason. **Estimated LOS:** _____

Admission Plan ☐ Admit day stay ☐ Admit for no more than 23hrs ☐ Admit day of Procedure ☐ Other
Instruction on admission: _____
_____

Special Requirements. ☐ Nil ☐ ICU Bed ☐ HDU Bed ☐ Autologous Blood
☐ Other e.g. equipment / Prosthesis, please specify: _____

Pre-Admission Review Recommended ☐ Pre-Anaesthetic Review Recommended ☐
Diagnostic Tests Required ☐ If yes, please state:

Admitting AMO: _____ **Signature:** _____
Name If not admitting AMO: _____ Date: _____

270514

BINDING MARGIN - NO WRITING

RECOMMENDATION FOR ADMISSION SEI030.005

NO WRITING

NSW GOVERNMENT Health

Facility:

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

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

(For patients 14 years and above – not for Guardianship Act purposes.)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr ..... (insert name of medical practitioner) have discussed with this patient the various ways of treating 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 matters detailed below including the nature, likely results, and material risks of the proposed procedure of treatment.

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

Interpreter present* ..... (SIGNATURE OF INTERPRETER) ...../...../20..... (DATE) ..... (TIME)

PATIENT CONSENT

To be completed by Patient

Dr ..... (insert name of medical practitioner) and I have discussed the present condition and the various ways 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 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 **request and consent** to the procedure/treatment described above for me.

DELETE IF NOT REQUIRED — *This part must be countersigned by your doctor*

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)

.....

.... (medical practitioner's acknowledgement)

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/do not consent*** to a blood transfusion if needed.

..... (SIGNATURE OF PATIENT) ...../...../20..... (DATE)

..... (PRINT NAME OF PATIENT) ..... (TIME)

..... (ADDRESS)

.....

*delete where not applicable

SMR020001

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REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

SMR020.001

NO WRITING

Continue overleaf...