People caring for people

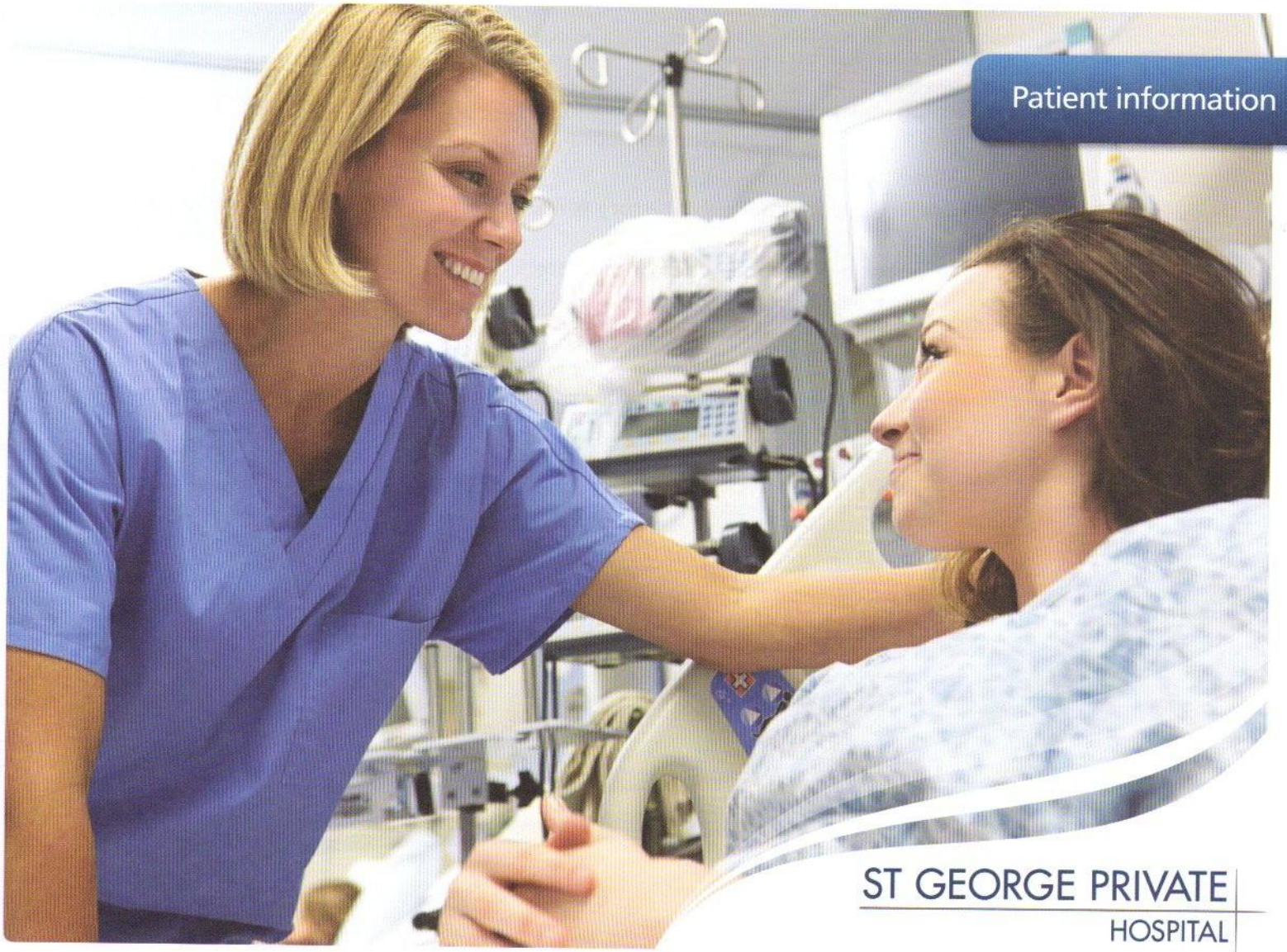
RAMSAY HEALTH CARE

Please read this booklet and return the completed forms to the Hospital as soon as possible after your appointment with your specialist.

For your convenience, you can also fill these forms in online. Visit the hospital website and click on the **online admission forms** link or visit **www.mycare.ramsayhealth.com.au**

Ramsay Health Care

Admission Information Booklet



RAMSAY
HEALTH CARE

ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR
Please PRINT clearly in block letters.

UR: .....
Surname: .....
Given Names: .....
Date of Birth: ..... Sex: .....

Please Admit

Mr, Ms, Mrs, Dr, Miss, Master: ..... (Surname) ..... (Given Names)

Address: .....

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

Date of Birth: ..... / ..... / ..... Sex: .....

Admission Details

Facility to be admitted to: .....

Proposed operation/treatment: .....

Date of Admission: ..... / ..... / ..... **Expected length of stay:** ❑ Day Only ❑ Overnight or longer ..... nights

Date of Operation: ..... / ..... / ..... ICU request: ❑ Yes ❑ No Intubated: ❑ Yes ❑ No Image intensifier: ❑ Yes ❑ No

Indication for ICU: .....

Estimated duration of operation: ..... **mins** **Type of Anaesthetic:** ❑ General ❑ Local

Clinical Details

Presenting Symptoms: .....

Provisional Diagnosis: .....

Other conditions present: .....

Infection Risk: ❑ Yes ❑ No History of MRSA ❑ VRE ❑ Other: ..... VTE Risk: ❑ High ❑ Low

CURRENT MEDICATIONS: .....

Is the patient taking any oral anticoagulants or antiplatelet medications? ❑ Yes ❑ No **If Yes, date when ceasing:** .....

History of Diabetes: ❑ Yes ❑ No If yes, what type?: ❑ Type 1 ❑ Type 2 Treated by: ❑ Insulin injection ❑ Tablet ❑ Diet

ALLERGIES: .....

Expected Item Number(s):

Equipment Details:

Implantable device: ☐ Implanting Device ☐ Removing Device

Type: Company: ☐ Contacted	Type: Company: ☐ Contacted

Will the prosthesis used attract a gap payment? ☐ No ☐ Yes If so, gap estimate $_____

Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature.....

Pre-operative instructions (including tests required):

- ❑ Pre-admission clinic attendance required.
- ❑ Pathology tests: .....
- ❑ Investigations: ❑ xray/ultrasound ❑ ECG ❑ Other .....
- ❑ Anaesthetic Consult
- ❑ Drug Orders on Admission (drug order valid 24 hours only) .....
- ❑ Special Instructions: .....

Obstetric Details:

Parity: ..... EDC: ...../ ...../ ..... Blood Group: ..... Rh: ..... Hb: .....

Anti-D & agglut screen: ..... Rubella HIA titre: ..... HBs Ag: .....

*Consent (over page) to be completed and signed

Admitting Doctor

Name: ..... Signature: ..... Date: ...../ ...../ .....

RHC100.20
Referral/Consent
DO NOT WRITE IN THIS BINDING MARGIN
Ver 1.4- 04/13
Pg 1 of 2
ADMISSION REFERRAL FORM
RHC003

RAMSAY
HEALTH CARE

CONSENT FOR TREATMENT (PRIVATE)

UR: .....

Surname: .....

Given Names: .....

Date of Birth: ..... Sex: .....

PART A - PROVISION OF INFORMATION TO THE PATIENT
To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed .....and/or
PRINT NAME OF PATIENT

..... / .....
GUARDIAN / PERSON RESPONSIBLE (IF APPLICABLE) — RELATIONSHIP (FATHER, MOTHER/WIFE ETC)

of his/her present condition, alternative treatments if available and have explained the nature, purpose, likely results and the material risks of the following recommended procedure(s).

Procedure/Treatment: .....

.....

.....

.....

INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT, DO NOT USE ABBREVIATIONS.

Side of procedure/treatment: Left ☐ Right ☐ N/A ☐

.....
SIGNATURE OF MEDICAL PRACTITIONER — DATE — TIME

Interpreter present .....
SIGNATURE OF INTERPRETER — DATE — TIME

PART B - PATIENT CONSENT
To be completed by the PATIENT / PERSON RESPONSIBLE

I acknowledge that I have consented to the procedure/treatment as detailed above.

- I understand the explanation the doctor gave me as to the need and benefits related to procedure/treatment detailed above;
- I understand the procedure/treatment carries some risk and complications may occur;
- I understand additional procedure(s) may be needed if the doctor finds something unexpected;
- I consent to anaesthetics, medicines or other treatments which could be related to this procedure(s)/treatment(s);
- I understand I am able to withdraw this consent at any time prior to the commencement of procedure/treatment;
- I understand blood products/blood transfusions carry some risk and complications may occur, which have been explained to me;
- I consent to* / do not consent* to blood products/blood transfusions, if needed;
  (* DELETE WHERE NOT APPLICABLE)

I **request and consent** to the procedure/treatment described above.

.....
PATIENT / RESPONSIBLE PERSON(S) SIGNATURE — DATE

.....
PRINT NAME OF PATIENT / PERSON RESPONSIBLE — IF PERSON RESPONSIBLE SIGNS, STATE RELATIONSHIP TO PATIENT EG; MOTHER / FATHER / HUSBAND

DO NOT WRITE IN THIS BINDING MARGIN