Healthscope
HOSPITALS

These forms can be completed online via our eAdmission Portal at
https://healthscope.eadmissions.com.au

Alternatively, please complete the following forms and send to the **hospital** as soon as possible.

Prompt completion of your admission forms will ensure your admission is not delayed. Please ensure it is completed as soon as possible, and no later than 72 hours prior to your admission.

Consent Form

(Specialist to complete and sign Part A)

(Patient to complete and sign Part B and Ellis Disclaimer section)

Patient Registration Form

(Patient to complete and sign)

Patient Health History

(Patient to complete and sign)

Healthscope

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

PART A: PROVISION OF INFORMATION TO PATIENT (To be completed by Medical Practitioner)

I, Doctor _____ have discussed with _____

(insert name of patient / parent / guardian)

the nature, likely results, and material risks of the recommended operation / procedure and/or treatment. I have also discussed the alternative treatments / procedures which are available.

The agreed operation / procedure / treatment is:

_____

_____

_____

(Insert name of operation / procedure / treatment)

MBS Item Number(s):

☐ Left Side

☐ Right Side

☐ Not applicable

Will this procedure have a cosmetic portion? ☐ Yes ☐ No

Interpreter required? ☐ **Yes** ☐ **No**

I, _____

(Name of interpreter)

have given a verbal translation of this form to consent to the treatment in the language that the patient understands,

which is: _____

Medical Practitioner Signature

Date / /

Admission Date / / **Time**

Operation Date / /

Interpreter's Signature

Date / /

PART B: PATIENT CONSENT (To be completed by Patient)

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

- The operation / procedure / treatment carries some risks and complications may occur.
- Anaesthetics, medicines, and/or blood transfusion may be needed and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected.
- The procedure / treatment may not give the expected results even though the procedure / treatment will be performed with due professional care.
- Which alternative treatments / procedures are available.

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 at any time prior to the procedure / treatment.

I **request, understand and consent** to the procedure / treatment as outlined in Part A. I agree to additional anaesthetics, medicines or procedures / treatments being carried out if required, provided they are related to the procedure / treatment outlined in Part A. I also consent to the taking of a blood sample for appropriate testing of communicable diseases including HIV and Hepatitis B and C, should contamination of any staff member or myself occur during my hospital stay.

▶ **Do you consent to a blood transfusion if needed?** ☐ **Yes** ☐ **No**

Signature of Patient / Parent / Guardian

Date / /

Print name of Patient / Parent / Guardian

Signature of Witness of Signatory (adult person)

Date / /

Print name of Witness of Signatory

BINDING MARGIN – DO NOT WRITE IN THIS AREA

HS000024

Print Media Group HSHGXFMR047A 11/16

Patient Name: ..... D.O.B.: ...../...../..... UR Number: .....

CERTIFICATION OF INABILITY TO GIVE CONSENT FOR EMERGENCY PROCEDURES (To be completed by Medical Practitioner)

The undersigned registered medical practitioner certifies that _____
(Name of patient)

is incapable of giving effective consent by reason of _____
(State reason for inability to give consent, for example unconscious)

their Next of Kin is unable to give consent due to _____
(State reason for inability to give consent, for example uncontactable)

for the procedure(s) stated: _____

and that immediate treatment is necessary in order to avert a serious and imminent threat to the patient's life or physical or mental health. I / We have no knowledge of any prior written refusal to consent to the procedure(s) having been communicated to any medical practitioner.

(Signature)	*(Print Surname)*	*Date*
		/ /
		/ /

(Signature) *(Print Surname)* *Date*

Second signature may not be available in extreme circumstances ie. second Medical Practitioner is not available

ADMISSION DETAILS (To be completed by Medical Practitioner)

Diagnosis _____

Proposed Admission Date: / / Time *(if known)*: : AM / PM

Proposed Procedure Date: / / Time *(if known)*: : AM / PM

Estimated Length of Stay: ☐ Day Stay ☐ Overnight

HDU required Post-Op? * ☐ Yes ☐ No

ICU required Post-Op? * ☐ Yes ☐ No

Pre Admission Clinic? * ☐ Yes ☐ No

* If the service is provided by the hospital

Referrals Required: _____

Special Instructions / Past History _____

_____ / /

Medical Practitioner's Signature *Date*

ELLIS DISCLAIMER & RELEASE OF INFORMATION (To be completed by Patient)

'I have engaged Dr _____ as my private treating doctor to
(Insert first and last name)

undertake the medical management of my medical condition and to provide medical services to me. I acknowledge that my private treating doctor is not an employee, servant or agent of the hospital and I will not hold the hospital responsible or liable for any injury to me caused by negligence or breach of duty by my private treating doctor or any other doctor or health professional engaged by me or referred to me by my private treating doctor to provide me with medical, pathological, radiological or other medical type services. I acknowledge that in each case, these services are arranged by referral from my private treating doctor to the practitioner concerned. I acknowledge that my private treating doctor may have in place arrangements for the provision of care to me at times of his/her unavailability, and that any questions regarding the referral process should be directed to my private treating doctor.

I acknowledge that the hospital will provide hospital facilities for nursing services and paramedical services to assist with my medical management and services, and is liable for any injury to me caused by any negligence or breach of duty by it in respect of these services provided to me.'

- **I acknowledge that I have read and understand the Ellis disclaimer.**

Patient or Guardian's signature ..... Date.....

Patient or Guardian's full name .....

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 / Healthscope (e.g. to your health fund, DVA, third party insurers such as Workcover, TAC, State Governments for public contract patients, the supplier / manufacturer of your prosthesis, to our insurer, to an external company contracted to evaluate customer satisfaction, your local doctor)

- **I authorise the release of information about this admission.**

Signed _____ Date / /

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Print Media Group HSHGXFMR0044 03/17

HS000012

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PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, or no later than 72 hours prior to admission.

TO BE COMPLETED BY PATIENT

Have you been to this hospital before? ☐ No ☐ Yes

Preferred accommodation ☐ Private room *(subject to availability)* ☐ Shared room

Method of payment for this admission: ☐ Private Health Insurance ☐ Self Funded ☐ Workcover ☐ TAC/MVIT(WA) ☐ DVA ☐ Other: .....

Please tick if you do not wish to receive a patient satisfaction survey: ☐

How did you find out about this hospital?

☐ Specialist ☐ G.P. ☐ Newspaper ☐ Internet

☐ Other: .....

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Have you been in ANY hospital within the past 28 days? ☐ No ☐ Yes - If yes, please state previous hospital: ..... Is this admission related? ☐ Yes ☐ No

Dates of hospitalisation: From ...../...../..... to ...../...../..... Any related admissions prior to that? ☐ No ☐ Yes - If yes, please specify: .....

National Health Identifier Record Number (NHIRN): *(if known)*

Procedure or reason for this admission: .....

Admitting Doctor: .....

Date to be admitted: ...../...../..... Operating date *(if different from admission date)*: ...../...../..... ☐ Day Stay or ☐ Overnight Stay *(please tick)*

Referring Doctor: .....

Title: ☐ Mr ☐ Master ☐ Miss ☐ Ms ☐ Mrs ☐ Dr ☐ Other:

Surname:

Previous surname:

First given name:

Second given name:

Sex: ☐ Male ☐ Female

Date of birth: Estimated D.O.B. ☐

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Widowed ☐ Divorced ☐ Separated

Religion: Religious visit? ☐ Yes ☐ No

Country of birth:

(If Australia, please specify state):

☐ Resident ☐ Non-Resident

Indigenous status: *(Required by Dept. of Health)* ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ N/A ☐ ASSI *(QLD ONLY)*

Interpreter required? ☐ Yes ☐ No

Preferred language:

Address:

Suburb: State: Postcode:

Medicare Card Number: Number before patient name:

Expiry date:

Occupation:

CONCESSION CARD DETAILS

These cards entitle patients to medicines at the concession rate and may be requested as proof of eligibility for subsidised medicine.

Safety Net Number:

DVA Card No.:

DVA Card Colour: ☐ Gold ☐ White ☐ Orange Expiry: /

Would you like a visit from a member of an Ex Service organisation / DVA Liaison Officer? ☐ Yes ☐ No

Pension No.: Expiry: /

Healthcare Card No.: Expiry: /

Senior Pharmacy Concession Card No.: Expiry: /

Home phone:

Work phone: Mobile phone:

Email:

GENERAL PRACTITIONER DETAILS

Upload admission information to My Health Record? ☐ Yes ☐ No

Can we notify your GP of your admission and discharge? ☐ Yes ☐ No

Local Doctor:

Name of Practice:

Address:

Suburb: State: Postcode:

Telephone: Fax:

PRIVATE HEALTH INSURANCE DETAILS *Please bring your card to hospital with you*

Health fund:

Level of cover / table:

Member number:

Have you confirmed your level of cover? ☐ Yes ☐ No

Patient Name: ..... D.O.B.: ...../...../..... UR Number: .....

EMERGENCY DETAILS

NEXT OF KIN

Given name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient:

☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter ☐ Other (specify):

Telephone (Home):

Telephone (Work):

Mobile:

Email:

CONTACT 1

Given name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient:

☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter ☐ Other (specify):

Telephone (Home):

Telephone (Work):

Mobile:

Email:

PERSON RESPONSIBLE FOR ACCOUNT

Given Name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient (if applicable):

☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter

☐ Other (specify):

Telephone (Home): (Work:)

Mobile:

POSTAL ADDRESS

☐ Same as residential address

Address:

Suburb: State: Postcode:

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY DETAILS *Written approval will be required prior to admission*

☐ Work Cover* ☐ Third Party* ☐ Public Liability **Work Cover & Third Party patients accommodated at patient's request in a private room will incur some out of pocket expenses*

Employer:

Address:

Suburb: State: Postcode:

Employer Phone:

Cause of injury:

Contact Name:

Date of accident: | | | | | | | | Location:

Insurance Company:

Claim Number:

Claim approved? ☐ Yes ☐ No

Person / Company Responsible for Account

Name:

Address:

Suburb: State: Postcode:

Relation:

Phone (Home): (Work)

RESPONSIBILITY

I certify that the information provided on this form is true and accurate to the best of my knowledge and I have read and understand the *Admission Information* brochure provided with these forms.

Patient or Guardian's Signature: ..... Patient or Guardian's full name: ..... Date: ...../...../.....

BINDING MARGIN – DO NOT WRITE IN THIS AREA

Healthscope

PATIENT HEALTH HISTORY

It is preferable that this form is received by the hospital as soon as possible, or no later than 48 hours prior to admission.

TO BE COMPLETED BY PATIENT

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

If you have been a patient at our hospital in the last three months, this admission is for the same reason as your previous admission and no details have changed about your medications or medical history, please tick the box to the right, and proceed to the end of this form and sign. ☐

Grey shaded areas to be completed by nursing staff and initial all actions. Document as necessary ↓

MEDICATIONS

Please tick (✓) Yes or No to all of the following questions *Please bring to the hospital all medication, including complementary therapies you are currently taking, in the original dispensed packaging and repeat / authority prescriptions. On admission, please bring with you a list of your current medications from your G.P.*	**NO**	**YES**	**Provide details if requested below**	**Nursing Staff Use ONLY** Consider commencement of Medication Management Plan. * Notify Surgeon if appropriat
Do you use any strong pain medications regularly at home? (ie. Morphine) Do you have chronic pain?	☐ ☐	☐ ☐	Name of Medication: ..... Date last taken: ...../...../..... or still taking ☐ ***If you take more than one, please list details in below chart***	*
Do you take or have you recently taken blood thinning medication ie. Aspirin, Pradaxa, Warfarin, Clopidogrel, Plavix or anti-inflammatory drugs?	☐	☐	Name of Medication: ..... Date last taken: ...../...../..... or still taking ☐	*
Have you taken any Steroids or Cortisone tablets / injections in the last 6 months?	☐	☐	Name of Medication: ..... Date last taken: ...../...../..... or still taking ☐	*
Are you taking any other medications, prescription medications or non-prescription medications or complementary medicines including vitamins / mineral / herbal remedies / fish oil / glucosamine?	☐	☐	If Yes, please list your current medications below, (please attach a separate list if insufficient space).	If patient on ≥ 4 medications notify Pharmacist
Do you use non-prescription or illicit drugs?	☐	☐	Specify:	Notify Surgeon if appropriate

Medication	**Dose**	**Frequency**
EXAMPLE: Aspirin	100mg	Once a day

ATTACH LIST IF NOT ENOUGH SPACE

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HS000013

Print Media Group HSHGXFMR0045 02/17

Patient Name: ..... D.O.B.: ...../...../..... UR Number: .....

PRE ANAESTHETIC HEALTH INFORMATION

Please tick (✓) Yes or No to all of the following questions	NO	YES	Provide details if requested below	Nursing Staff Use ONLY
Do you have any allergies or sensitivities? Have you had an allergic reaction to any drugs / tapes, lotions, foods (eg. peanuts), latex or rubber? **ATTACH LIST IF NOT ENOUGH ROOM**	☐	☐	Specify allergy and reaction:	Document on anaesthetic & Medical Record - Alert Sheet & NIMC If latex allergy, follow latex policy.
What is your : **Height:** ..... **Weight:** ..... **Body Mass Index** *(if known)*: ..... Reason for admission: .... Past / Surgical history (attach a list if insufficient space). Have you had any previous operations? Please list operations and dates performed.				Elective Admission ☐ Emergency Admission ☐ Unexpected re-admission within 28 days ☐ Transfer from: .....
Have you or any family member had any reactions / side effects to anaesthetic? (eg. malignant hyperthermia)	☐	☐	Specify:	If yes - inform Anaesthetist
Do you or have you ever smoked?	☐	☐	Current daily amount: Date ceased: ...../...../.....	
Do you suffer from blood disorders / anaemia / bleeding problems / bruise easily?	☐	☐	Details:	Advise surgeon if relevant
Have you ever had a blood clot in your legs or lungs (ie. DVT or PE)?	☐	☐	Specify:	If yes - inform treating Doctor
Have you had an organ transplant?	☐	☐	Specify:	
Have you had Laparoscopic Gastric Banding / Sleeve Gastrectomy / Gastric Bypass?	☐	☐	Date of procedure: ...../...../..... If YES, is band deflated? ☐ Yes ☐ No Does your surgeon or anaesthetist know that you have a band? Surgeon ☐ Yes ☐ No Anaesthetist ☐ Yes ☐ No	
Do you drink alcohol?	☐	☐	Daily amount:	
Have you ever had jaundice / liver problems or disease?	☐	☐	Specify:	
Have you had any blood tests / autologous blood or other pathology taken for this admission?	☐	☐	If yes specify where: ..... When? ..... Where are the results?	Results in medical record
Have ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission?	☐	☐	If yes, with you ☐ or with your Doctor ☐ **Please bring with you to hospital**	Films with patient or Doctor
Have you ever had a blood transfusion?	☐	☐	Last transfusion: ...../...../.....	If reaction - inform admitting Doctor and record reaction on Alert Sheet
Any reaction?	☐	☐		
Do you have any implants / prosthesis? (eg. hip replacement, cardiac valve or stent)	☐	☐	Specify:	Document on operation checklist
Do you have any body piercings or hair extensions?	☐	☐	Specify:	

BINDING MARGIN – DO NOT WRITE IN THIS AREA

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PATIENT HEALTH HISTORY

- CONTINUED

Attach patient identification label

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Patient Details

BINDING MARGIN – DO NOT WRITE IN THIS AREA

HEALTH HISTORY

Please tick (✓) Yes or No to all of the following questions	NO	YES	Provide details if requested below	Nursing Staff Use O
DIABETES				
Do you have Diabetes? Type 1☐ Type 2☐ Gestational Diabetes☐ Other☐	☐	☐	Managed by Diet ☐ Tablets ☐ Insulin ☐ Specialist:	Document
Do you have any side effects related to your diabetes? (eg. reduced sensation in feet)	☐	☐	Specify:	
HEART				
Have you ever suffered from chest pain / discomfort / heart attack?	☐	☐	Details:	Document
Do you have high blood pressure, high cholesterol AND/OR a family history of cardiac disease?	☐	☐	Details:	Document
Do you see a Cardiologist?	☐	☐	Name:	
Do you have a pacemaker or implantable defibrillator?	☐	☐	Date of procedure: ...../...../..... Has your Surgeon or Anaesthetist been informed? Surgeon ☐Y ☐N Anaesthetist ☐Y ☐N	Advise Surgeon / Anaesthetist if present
Have you had bypass surgery?	☐	☐	Date of procedure: ...../...../.....	Document on Alert Sheet
Do you have palpitations / irregular heartbeat / heart murmur?	☐	☐	Specify:	
Have you ever had Rheumatic Fever?	☐	☐	If yes, when?	
AIRWAYS				
Do you suffer from Asthma / Bronchitis / Emphysema / shortness of breath on exertion / Pneumonia?	☐	☐	Do you use - Nebulisers? ☐ Puffers? ☐	Suggest referral to Physi with Doctors consent
Do you have any sleep problems/ snoring?	☐	☐	Specify:	If yes - inform Anaesthet
Do you suffer from sleep apnoea?	☐	☐	Please bring CPAP machine to hospital if applicable.	
Are you receiving home oxygen therapy?	☐	☐		
NEUROLOGICAL				
Do you suffer from strokes / mini strokes / Multiple Sclerosis / Motor Neurone Disease / Parkinson's Disease?	☐	☐	Specify any residual weakness / symptoms:	If functional deficit notify Doctor
Do you suffer from migraines?	☐	☐	Frequency:	
Do you suffer from faints / blackouts / dizzy spells / TIA's?	☐	☐	Specify:	
Do you suffer from epilepsy / fits / seizures?	☐	☐	Date of last seizure: ...../...../.....	
Do you have short term memory loss / confusion / dementia?	☐	☐	Specify:	Notify Doctor if appropria

Patient Name: ..... D.O.B.: ...../...../..... UR Number: .....

PRE ANAESTHETIC HEALTH INFORMATION

Please tick (✓) Yes or No to all of the following questions	NO	YES	Provide details if requested below	Nursing Staff Use ONLY
Do you have any allergies or sensitivities? Have you had an allergic reaction to any drugs / tapes, lotions, foods (eg. peanuts), latex or rubber? **ATTACH LIST IF NOT ENOUGH ROOM**	☐	☐	Specify allergy and reaction:	Document on anaesthetic & Medical Record - Alert Sheet & NIMC If latex allergy, follow latex policy.
What is your : **Height:** ..... **Weight:** ..... **Body Mass Index** *(if known)*: ..... Reason for admission: .... Past / Surgical history (attach a list if insufficient space). Have you had any previous operations? Please list operations and dates performed.				Elective Admission ☐ Emergency Admission ☐ Unexpected re-admission within 28 days ☐ Transfer from: .....
Have you or any family member had any reactions / side effects to anaesthetic? (eg. malignant hyperthermia)	☐	☐	Specify:	If yes - inform Anaesthetist
Do you or have you ever smoked?	☐	☐	Current daily amount: Date ceased: ...../...../.....	
Do you suffer from blood disorders / anaemia / bleeding problems / bruise easily?	☐	☐	Details:	Advise surgeon if relevant
Have you ever had a blood clot in your legs or lungs (ie. DVT or PE)?	☐	☐	Specify:	If yes - inform treating Doctor
Have you had an organ transplant?	☐	☐	Specify:	
Have you had Laparoscopic Gastric Banding / Sleeve Gastrectomy / Gastric Bypass?	☐	☐	Date of procedure: ...../...../..... If YES, is band deflated? ☐ Yes ☐ No Does your surgeon or anaesthetist know that you have a band? Surgeon ☐ Yes ☐ No Anaesthetist ☐ Yes ☐ No	
Do you drink alcohol?	☐	☐	Daily amount:	
Have you ever had jaundice / liver problems or disease?	☐	☐	Specify:	
Have you had any blood tests / autologous blood or other pathology taken for this admission?	☐	☐	If yes specify where: ..... When? ..... Where are the results?	Results in medical record
Have ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission?	☐	☐	If yes, with you ☐ or with your Doctor ☐ **Please bring with you to hospital**	Films with patient or Doctor
Have you ever had a blood transfusion?	☐	☐	Last transfusion: ...../...../.....	If reaction - inform admitting Doctor and record reaction on Alert Sheet
Any reaction?	☐	☐		
Do you have any implants / prosthesis? (eg. hip replacement, cardiac valve or stent)	☐	☐	Specify:	Document on operation checklist
Do you have any body piercings or hair extensions?	☐	☐	Specify:	

BINDING MARGIN - DO NOT WRITE IN THIS AREA

Patient Name: ..... D.O.B.: ...../...../..... UR Number: .....

HEALTH HISTORY *continued*

Please tick (✓) Yes or No to all of the following questions	NO	YES	Provide details if requested below	Nursing Staff Use ONLY
GENERAL MEDICAL				
Do you have anxiety, depression or mental illness?	☐	☐	Name & contact details of specialist: ..... Current treatment ☐ Yes ☐ No	
Do you have, or have you had cancer? Site:	☐	☐	Diagnosed: ...../...../..... Surgery ☐ Chemotherapy ☐ Radiotherapy ☐ Current ☐ OR Complete ☐	
Do you have any significant neck or back injuries?	☐	☐	Specify:	
Do you suffer from any thyroid problems?	☐	☐	Specify:	
Do you suffer from bowel problems / disorders?	☐	☐	Specify:	
Do you suffer from kidney / bladder problems / incontinence?	☐	☐	Specify:	
Are you on dialysis?	☐	☐		
Do you suffer from reflux / stomach ulcer?	☐	☐	Specify:	
Do you suffer from a hiatus hernia?	☐	☐	Specify:	
Do you have speech / swallowing problems?	☐	☐	Specify:	Notify Doctor if appropriate. Consider speech therapist, dietitian and kitchen
Do you suffer from arthritis?	☐	☐	Specify:	Document
Do you have impairment of: ☐ Vision ☐ Hearing	☐	☐	Specify aids used:	Aids with patient in hospital ☐
Female patient - could you be pregnant?	☐	☐	Name & contact details of specialist: ..... Due Date: ...../...../.....	Inform anaesthetist
Do you have any other medical conditions?	☐	☐	Specify:	
DENTAL				
Have you had any recent dental treatment?	☐	☐	Specify:	
Do you have any crown, caps, dentures or braces?	☐	☐	Specify:	
NUTRITION				
Do you have any eating difficulties or special dietary needs? (eg. cultural / religious)	☐	☐	Specify:	Complete Adult Malnutrition Screening form if patient answered yes to any of these questions
Did you lose weight in the last 6 months without trying?	☐	☐		
Do you have a decreased appetite / are you eating poorly?	☐	☐		

INFECTION CONTROL ASSESSMENT	NO	YES	DETAILS	Nursing Staff Use ONLY
Do you have a fever, cold, cough or sore throat?	☐	☐		Complete admission screening questionnaires (SARs / Avian Flu and Swine Flu) if symptoms present and patient answered yes to either question.
Have you had recent contact with a person/s diagnosed with Acute Respiratory Infections or Acute Respiratory illness in the last 7 days - Seasonal or Pandemic, eg. SARS/H5N1 Avian Influenza/H1N1 Influenza 09?	☐	☐		
Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or Pandemic, eg. SARS, H5N1 (Avian) Influenza, H1N1 Influenza 09, either overseas or in Australia within 7 days of onset of symptoms?	☐	☐		

INFECTION CONTROL ASSESSMENT continued over page →