Seymour Health
Bretonneux Street, Locked Bag 1,
Seymour, Vic, 3660
☎ (03) 5793 6100 Fax (03) 5792 4193

REQUEST FOR ADMISSION

UR No : | | | | | | |

Family Name: _____

Given Name: _____

Date Of Birth: | | | | | | | | |

Sex: M / F OR *Use Patient identity Label*

LMO: _____

Date:	Requesting Doctor:

Admission Type:		Surgical	☐ LA	☐ GA	☐ Sedation
		Medical			

Date of Operation: ___/___/___	☐ AM	☐ PM	Day case ☐	Yes ☐	No

Intended Stay: No. Day/s	☐ Public	☐ Private	☐ DVA	☐ Other

CLINICAL DETAILS

Proposed Operation:

Provisional Diagnosis:

Significant Past History:

Adverse G/A's past History: | | Yes | | No

COMMENTS:

Allergies/ Drug Sensitivities:

Signature

Requesting Doctor's Name: _____ Signature: _____ Date ___/___/____

REQUEST FOR ADMISSION MR/7

SEYMOUR HEALTH
Bretonneux Street Seymour Vic 3660
Postal: Locked Bag 1 Seymour Vic 3661
Phone: **5793 6100** Fax: 5792 4193
W: www.seymourhealth.org.au
E: info@seymourhealth.org.au

No out-of-pocket Private Patient Admission Information

Frequently Asked Questions (FAQ's)

Why does Seymour Health want patients to elect to be admitted as private patients?

Patients who choose to use their private health insurance are a great help to Seymour Health. This is because the private health funds will contribute significantly to the cost of their care. This helps us to:

- continue to improve and maintain the highest level of patient care and service
- upgrade and maintain our facilities and equipment
- attract and retain services and staff to benefit the Seymour and district community

Public or Private? What is the difference for Seymour Health?

- If a patient elects to be admitted as a public patient, Seymour Health pays for all services received by the patient
- Patients admitted privately have their services paid for by their health fund

Are there any exclusions from Seymour Health's no out-of-pocket policy?

Any programs which Seymour Health is not directly funded for through the Department of Health are excluded from the no out-of-pocket policy. These programs currently include:

- Dental – with the exception of DVA Gold Card holders
- Self Funded admissions – Please contact Seymour Health prior to admission to confirm if this relates to you.

Because these services are not funded, patients are required to pay their account in full on the day of admission. Patients may be able to claim a rebate from their private health insurer, please contact your insurer directly to discuss this.

What about excess or co-payments on my private health insurance policy?

Many patients are apprehensive about being admitted as a private patient because of an excess or co-payment on their health insurance policy.

Seymour Health will cover any excess or co-payment required up to the total cost invoiced to the health fund.

What if I have a $1000.00 excess?

Yes. Seymour Health will cover any excess up to the total cost invoiced to the health fund.

Will electing to be admitted as a private patient cost me anything?

No. Seymour Health will cover any excess or copayments up to the total amount invoiced to the health fund, as well as directly reimburse any out-of-pocket expenses you may incur.

For example, you may receive an invoice from providers for inpatient services such as pathology and medical imaging. If after paying these accounts and claiming a reimbursement from Medicare and your private health fund you are 'out of pocket' Seymour Health will reimburse this amount to you directly upon providing Seymour Health with a copy your remittance advice and receipt of payment. This reimbursement will be in the form of a cheque or EFT payment and will be paid to you within 14 days of providing the required documentation to Seymour Health.

Will private patients be guaranteed a private room?

Every effort will be made to accommodate private patients in private rooms, depending on availability.

What about choice of doctor?

Due to on-call rosters and arrangements with individual clinics we cannot guarantee that a patient will always see their own doctor.

Will private patients receive any other benefits?

All patients at Seymour Health receive the same exceptional level of care from clinical and administrative staff at all times.

Is the admission process any more complicated than it is now?

No. To elect to be admitted as a private patient you simply need to sign the election for admission form and the Private Health Insurance claim form as a private patient and provide the admissions officer with your current Medicare and private health insurance details.

What if a patient is admitted as a public patient but later decides that they want to use their private health insurance after having more time to consider the options?

Patients can request to see the admissions officer to discuss this and liaise with your health fund to seek acceptance as a private patient.

This situation sometimes happens with patients admitted through the Urgent Care Department. It can be a stressful time for the patient and family where concerns about medical treatment prevent full consideration of the private patient option.

Do patients have a choice in whether or not to use their Private Health Insurance?

All patients continue to have the choice of whether they are admitted as a public or private patient and all patients at Seymour Health will continue to receive the highest possible standard of care from this hospital.

Where can I get more information?

Any questions can be addressed to the admissions officer who will be available to provide you with more information.

People who elect to use their private health insurance are supporting Seymour Health to support the Seymour community

SEYMOUR HEALTH
PRE-ADMISSION CLINIC

Please complete paperwork provided as soon as you finish reading this information and return to us in the envelope provided.
Your pre admission nurse needs this information to discuss with you

PURPOSE OF THE PRE-ADMISSION CLINIC

The purpose of this clinic is to provide you with education and preparation prior to your planned surgical intervention. The clinic gives you the opportunity to discuss with the pre-admission nurse, your medical history and any questions you may have regarding your procedure, anaesthesia and your recovery process.
In addition, the clinic allows you and the health care team to identify any physical, social or psychological care needs you may have in preparing for your discharge home.

PRE ADMISSION APPOINTMENT

Your pre-admission appointment will be sent to you via mail with the date and time of your appointment prior to your procedure. If you have any questions please call us on **5793 6100**

WHAT TO BRING TO YOUR PRE-ADMISSION CLINIC APPOINTMENT

- A list of current medications (including dosage)
- Pacemaker type and manufacturer details (if you have one)

Bring any questions you have about your procedure (it's a good idea to write them down to discuss)

BEFORE SURGERY AT SEYMOUR HOSPITAL

One of the important factors for us to know before surgery is your BMI (Body Mass index).
Body mass index is determined by your weight and height. This is one method of helping to identify any increased health risks. ***Please make sure you complete these details on the Pre – Operative assessment form enclosed.***

SURGERY AT SEYMOUR HOSPITAL – WE ASK THAT YOU:

Do not wear powder, perfume, after shave, make-up, nail polish or any jewellery. Long hair must be tied back. No clips or clasps.

If you wear contact lenses: please bring your container with soaking solution and advise our nurses if you are wearing contact lenses

Leave valuables at home: rings, watches etc. You may require an amount of money for purchasing medical aids if required.

Bring your usual medications to hospital with you. Check with your doctor or pre-admission nurse if you should take any of your usual medications on the day of surgery

If you are staying overnight or longer: bring your nightwear, dressing gown, slippers, toiletries, tissues, sanitary needs and a book/magazine if desired.

BEFORE SURGERY

If there is any change in your condition, such as a cold or fever please contact the hospital on:

5793 6100

Have a shower or bath
Wear comfortable clothes on the day of surgery
Remove body piercings; for your safety, all body jewellery must be removed.

DISCHARGE

It is illegal for you to drive or operate machinery or make major/legal decisions within 24 hours after administration of an anaesthetic or sedation.
Please organise for a family member/friend to drive you home from hospital.

AFTER SURGERY

Please assist our reception and nursing staff by having only ONE person telephone to make enquiries. Allow a minimum of 4 hours after the scheduled admission time before telephoning, (this allows time for both the procedure and your recovery).
The nursing staff will provide you with patient information fact sheets relevant to the type of anaesthetic administered and the operation of procedure performed.

IMPORTANT INFORMATION - PLEASE READ

As soon as you receive your paperwork from your doctor/surgeon, please complete and return to the hospital in the envelope provided. You will be sent an appointment letter from our pre admission admin team.
If you haven't received your paperwork from your doctor/surgeon ten days prior to your procedure – please contact your Doctor/ Surgeons rooms directly.

LOCATION / HOURS

Pre-Admission clinic is held at the Ambulatory Care Centre (opposite Healthscope Pathology) on the **corner of Villers and Bretonneux** Street, Seymour (entry and parking via Villers St).
Pre-Admission clinic operates on Mondays and Fridays.

For further directions you can refer to our website www.seymourhealth.org.au
Or call us on **5793 6100.**

ADMISSION TIME

Please note that your actual admission times may not be known until after **1:00pm** on the working day prior to your scheduled procedure. Please ring us after 1pm to find out the time you need to arrive to hospital.

PUCKUPUNYAL DEFENCE PERSONNEL

Please contact the nursing staff at the Puckapunyal Health Centre 5735 7655 to discuss your Pre-Admission requirements.

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PATIENT REGISTRATION

To be completed for all admissions to Seymour Health and forwarded as soon as possible for processing to:

Admissions
Seymour Health
Locked Bag 1, Seymour VIC 3661

ADMISSION DATE

SURGEON **LOCAL GP**

Surname	Previous Surname	Title
Given Names		Sex ☐ M ☐ F
Address Postcode		Date of Birth:
Email Address:		
Home Phone Mobile Phone	*Medicare Number* Expiry date ___ ___ / ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___	
Work Phone	*Pension Number* Expiry date ___ ___ / ___ ___	
Marital Status ☐Single ☐Married ☐Widowed ☐ De Facto ☐ Separated ☐ Divorced	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___ ☐ Health ☐ Disability ☐ Aged	
Country of Birth If Australia, what State?	Language Spoken Religion	Interpreter Required ☐ Yes ☐ No Aboriginal /Torres Strait Islander ☐ Yes ☐ No

NEXT OF KIN (Contact Person 1)

Name _____
Relationship _____
Home Phone ( ) _____
Bus Mob _____

NEXT OF KIN (Contact Person 2)

Name _____
Relationship _____
Home Phone ( ) _____
Bus Mob _____

RE-ADMISSION

Have you been hospitalised in the past twenty eight (28) days? ☐ Yes ☐ No If so, where _____

Have you been hospitalised in the past seven (7) days? ☐ Yes ☐ No If so, where _____

Have you ever been a patient of Seymour Hospital? ☐ Yes ☐ No When (year) _____

ADMISSION TYPE

If your Doctor has requested you to be a private patient for this episode at Seymour Health please ensure you provide the following;

☐ Private → Health Fund _____ Member Number _____

Also complete ☐ National Private Patient Hospital Claim Form (left front side only)
☐ Patient Election Form and specify Doctor and single/non single room

☐ Public

☐ DVA → DVA Number _____ Card Colour _____

☐ TAC → Reference No _____ Date of Accident ____/____/____

☐ WorkCover → Employer's Business Name _____
Insurance Company _____ Claim No _____

PATIENT REGISTRATION

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PRE-OPERATIVE ASSESSMENT

Unit Record No: _____

Name: _____

Address: _____

Date Of Birth: _____ Sex: Male/Female

Affix Identification Label

All patients please complete this pre-operative assessment questionnaire and return to Seymour Hospital at least 10 working days prior to operation/procedure. Failure to do so may result in rescheduling or cancelling of your appointment.

Surgeon:	**Proposed procedure:**	**Date:**
List previous operations including approximate dates and places:		
How tall are you? _____cm	How much do you weigh? _____kg	BMI_____

PLEASE ANSWER ALL QUESTIONS

Do you have any ALLERGIES / SENSITIVITIES to: ☐ **No** ☐ **Yes, please add details**

Medications	☐ Latex ☐ Rubber	☐ Tapes ☐ Lotions ☐ Food
	Other	

Current Medications	**Dose**	**Freq**	**Current Medications**	**Dose**	**Freq**

A medication summary report from your Doctor can be attached

Have you recently taken the following medications? ☐ **No** ☐ **Yes** **(please circle)**

Blood thinning / Aspirin based	Cortisone / Steroids	Have you ceased this medication for the procedure? ☐ No ☐ Yes
Anti Inflammatory, Arthritis	Warfarin	

Past Anaesthetic Details	**No**	**Yes**	**Details**
Have you or a relative ever had a reaction to an anaesthetic?			
Have you ever had a blood transfusion?			

Lifestyle	**No**	**Yes**	**Details**
Do you smoke tobacco/cigarettes?			No.per day _____Ex-Smoker (Date ceased) _____
Do you consume alcohol?			☐ Daily ☐Weekly Quantity _____
Do you require a special diet?			

Do you wear: ☐ Contact lenses ☐ Glasses ☐ Hearing Aids ☐ Dentures ☐ Other _____

Creutzfeldt Jacob Disease (CJD)	**No**	**Yes**
Have you had a dura mater graft prior to 1989?		
Do you have a family history of CJD?		
Have you received human pituitary (growth) hormone prior to 1985?		
Have you suffered from a recent progressive dementia the cause undiagnosed?		

Infectious Disease (H1N1)	**No**	**Yes**
Have you travelled overseas lately and where to?		
Have you been back in Australia less than 14 days?		
Do you have signs and symptoms of a respiratory infection or fever?		

Do you currently have, or ever had, any of the following complaints (please circle condition)	No	Yes
Diabetes (please tick) ☐ NIDDM Type 2 OR ☐ IDDM Type 1 (please also tick) ☐ Insulin dependant ☐ Tablet ☐ Diet		
Angina / Coronary Disease / Heart Attack / any other heart problems		
Cardiac Surgery / Pacemaker / Heart valve replacement (please bring pacemaker details)		
Rheumatic fever / Heart Murmur / Atrial Fibrillation		
Palpitations / Irregular heart beat		
High Blood Pressure (Hypertension)		
Asthma / Chronic Bronchitis / Emphysema / Sleep Apnoea / Hay fever		
Pneumonia / TB		
Blood clot in Legs or Lungs (thrombosis or embolism)		
Blood Disease / Bleeding or Bruising problems / Haemophilia / Anaemia		
Stroke / TIA's / Blackouts / Fits / Epilepsy / Conditions of the nervous system		
Kidney / Bladder Problems (specify)		
Heartburn / Gastric Reflux / Hiatus Hernia / Peptic or Duodenal Ulcer		
Bowel problems eg. Diverticulitis, Crohns		
Jaundice / Liver Disease / Hepatitis A / B / C		
Mental Health Condition eg. Depression, Schizophrenia, Panic Attacks, Anxiety		
Could you be pregnant or are you pregnant? If yes, how may weeks?		
Cancer diagnosis (specify)		
Have you had chemotherapy / radiotherapy?		
Recent Cold / Flu / Other infections		
Do you believe you may be at increased risk of HIV / Hepatitis?		
Do you have any health problems not covered by these questions?		
Details		

Do you require assistance with any of the following daily activities?	No	Yes
☐ Walking / Moving ☐ Dressing ☐ Toileting ☐ Shower / Bathing ☐ Shopping ☐ Other _____ ☐ Cooking / Eating ☐ Stairs in home		

Do you care for another person?	No	Yes
☐ Frail Aged Person ☐ Disabled Person ☐ Baby / Child ☐ Other_____ ☐ Arrangements made are		

Do you receive community support?	No	Yes
☐ Meals on wheels ☐ Nursing care ☐ Social Worker ☐ Home help ☐ Home oxygen ☐ Other ☐ Lifeline ☐ Respite Care		

Do you require information regarding?	No	Yes
☐ Medical certificate ☐ Sickness benefits ☐ Workers compensation ☐ Carers certificate ☐ Social security ☐ Other		

Do you live?

☐ Alone ☐ With family ☐ With spouse/partner ☐ Nursing home ☐ Other _____

Who will be caring for you after discharge? Name:

How will you get home when you are discharged?

☐ Self/family ☐ Public transport ☐ Taxi ☐ Ambulance ☐ Other _____

Person completing this form: _____(print name)

Relative (specify relationship) Date:

Nurse - Print name Designation Date

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TREATMENT, ANAESTHETIC, BLOOD TRANSFUSION & DISCHARGE AT OWN RISK

Unit Record No: _____

Name: _____

Address: _____

Date Of Birth: _____ Sex: Male/Female

Affix Identification Label

CONSENT TO TREATMENT

I (Name) _____ request and consent to the carrying out upon myself/or _____ (parent/guardian) the following procedure/treatment

_____

Dr/Mr/Ms _____ and I have discussed my present condition and the various ways in which it may be appropriately treated. I have also been informed of the nature, effects and relevant foreseeable risks of the chosen procedure/treatment; and I accept those risks.

I also request and consent to the administration of anaesthetics, medicines, and other forms of treatment which are foreseeably associated with this procedure.

I understand other unexpected procedures/treatments are sometimes necessary, and I request and consent to these being carried out if required.

I also understand complications may occur or the expected result may not be achieved even though the procedure/treatment is carried out with due professional care.

I understand my tissues(s) will be used for diagnostic and treatment purposes. I understand it will be kept and be used for ethically approved research, education and laboratory quality procedures.

CONSENT TO ANAESTHETIC

In conjunction with the above stated procedures/treatments, I request and consent to the administration of anaesthetics as considered necessary by the Anaesthetist, with exception of (list procedure, drug or anaesthetic)

_____

CONSENT TO BLOOD TRANSFUSION

I request and consent to administration of blood transfusion or blood constituents as deemed necessary for the preservation of my life and health during the course of treatment (confirmation at Patient Signature below).

REFUSAL OF BLOOD TRANSFUSION: I refuse administration of blood transfusion and/or other blood constituents to me. I realize serious injury or death may result from my refusal. I exonerate and absolve absolutely this hospital, its agents and employees from any liability for any damage, whether direct or indirect, to person(s) including myself which may be said to flow from the omission to administer blood/ blood products to me.

Please sign here if you refuse blood transfusions _____

PATIENT SIGNATURE

I confirm, I consent to the treatment(s), anaesthetic and blood transfusions as above.

Signature of Patient/Guardian _____

DOCTOR SIGNATURE & CONFIRMATION

I, _____ (please print name), have properly informed this patient and obtained consent as indicated above.

Doctor Signature_____ Date: _____

DISCHARGE AT OWN RISK

I, _____(please print first and surnames), am removing myself from Seymour District Memorial Hospital at my insistence and against the advice of hospital (attending doctor and/or hospital staff).

I have been informed by them of the dangers of leaving the hospital at this time.

I hereby release the hospital, attending doctor and hospital staff from all liability for any adverse results caused by my action.

Date _____/_____/_____ Time _____ am /pm (please circle)

Signed _____ Relationship to patient _____

Signature of Witness _____

Please print name and designation of witness

PLEASE PLACE PATIENT LABEL HERE
IF DISCHARGE AT OWN RISK COMPLETED.

CONSENT NOTES FOR STAFF

Witten consent must be obtained before any invasive procedure, procedure in operating room or requires administration of an anaesthetic.

Staff are to obtain the patients consent before initiating any treatment. This can be verbal or implied for minor procedures such as injections. Staff are recommended to document verbal consent in the patients medical record.

When describing procedures to patients use terms the patient will understand and appropriate to their circumstances, personality, expectations, fears, beliefs, values and cultural background (use an interpreter if required).

Patients are to be given the opportunity to discuss the investigations, procedure, treatment options and possible adverse effects with their doctor .

IN EMERGENCIES
In an emergency case, a medical practitioner may carry out treatment on a person (adult or minor) without obtaining consent; if the medical practitioner is of the opinion it is necessary as a matter or urgency, to carry out such treatment to save the patient's life or prevent serious damage to health.

MINORS / LEGAL COMPETENCY
A child aged 14 years and above may give consent to medical or dental treatment. To be considered valid, the child must be able to adequately understand and appreciate the nature and the consequences of the procedure.

For patients aged 14 – 15, the consent of the parent or legal guardian should also be obtained unless the patient objects.

Patients aged 16 – 18 may consent to treatment without involvement of parent or guardian.

Patients under 14 years of age, parent/guardian consent should be obtained.

For patients who are not legally "competent", consent for treatment must be made by the legally recognized guardian of the patient. Please refer to the Guardianship Acts for further provisions.