

Pre-Admission Form

1. Instructions for Doctors and Patients.

Preadmission form is to be completed by the treating Doctor or Patient preferably in the Doctor's consulting rooms.

Please return the form at least **TWO WEEKS BEFORE ADMISSION** to allow us time to process and streamline your / your patient's admission either by:

- Mail to Mercy Hospital Mount Lawley, Thirlmere Road, Mount Lawley, WA 6050 or
- Fax with "Attention Admissions Office" (08) 9370 9488 and (if patient) bring the original to the Admissions Office on admission.

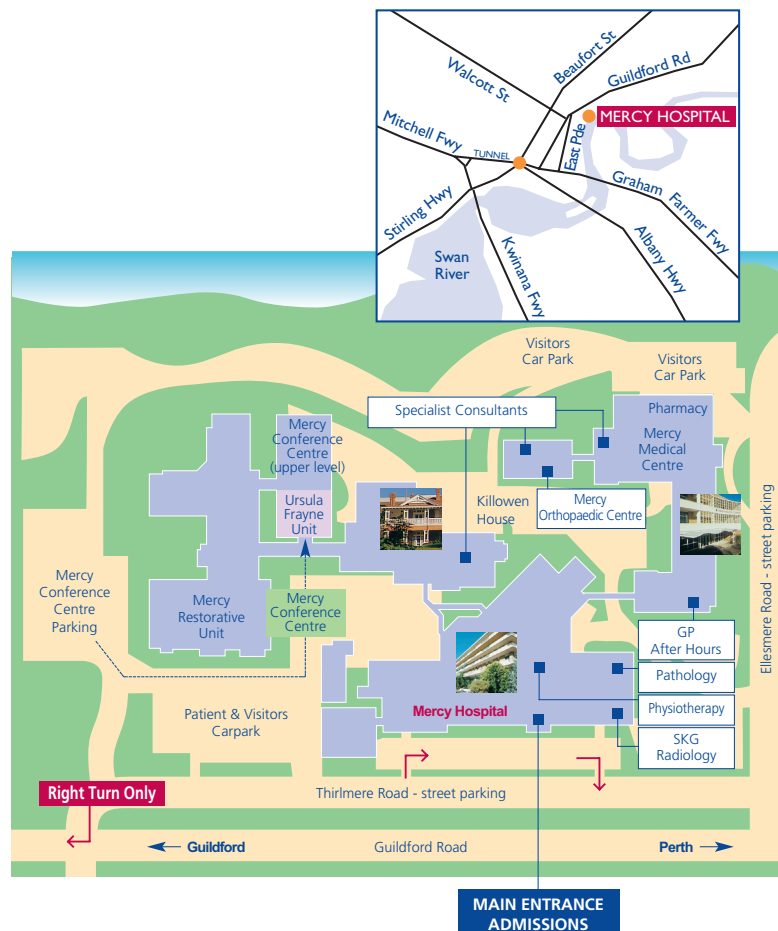
Admission to Hospital may be delayed if the paper work arrives late.

ADMISSION TO FAMILY BIRTHING UNIT PLEASE RETURN YOUR COMPLETED FORM TO THE HOSPITAL AS SOON AS POSSIBLE

2. Instructions for Patients

It is the patient's responsibility to arrange:

- Transport to the Hospital on the day of admission
- An adult to collect them on the day of discharge.
- Day surgery patients need to organise to be collected approx 2 hours following the surgery and have an adult stay with them overnight at home for the first night.
- Endoscopy Unit Patients will be in Hospital 3-5 hours. A nurse will contact your nominated driver once you are ready to be discharged.



All enquiries
Mercy Hospital Mount Lawley
 Thirlmere Road
 Mount Lawley WA 6050
 Telephone: (08) 9370 9222
 Facsimile: (08) 9370 9488

Pre Admission Clinic
Appointments only
 Telephone: (08) 9370 9523/9737

Endoscopy Unit
 Telephone: 9370 9388

Family Birthing Unit
 Telephone: (08) 9370 9420
 Facsimile: (08) 9370 9660
Day Surgery Unit
 Telephone: 9370 9360

IMPORTANT INFORMATION FOR PATIENTS

PLEASE READ THE FOLLOWING PRIOR TO YOUR ADMISSION

Fee Information and Payment of Accounts

Hospital and Theatre Fees

If you are insured you will be required to pay any excess or co-payments prior to admission. The amount will depend on the level of cover by your health insurance fund. Please verify with your health fund.

If you are uninsured you will be required to pay the estimated costs of your Hospital and theatre fees prior to admission. You may obtain an estimate of payment by contacting the Insurance Liaison Coordinator on 9370 9280.

The Hospital has EFTPOS facilities, accepts major credit cards and has ATM machine access.

On admission we will request your authorisation so we can arrange payment of your account directly with your health fund to the Hospital.

Payment for other Services

You will receive separate accounts, which will be sent to you following discharge, for the following services:

Medical Services (Surgeon, Obstetrician, Anaesthetist, Physician and General Practitioner)

These are covered under the Medicare Scheme, however it is likely there will be a charge above the Medicare rebate, which you will be required to pay.

Physiotherapy, Occupational Therapy & Dietary Services

Your health fund may provide a rebate depending on your cover. Please check with your health fund.

Radiology (X-ray) and Pathology Services

These services are partly covered by Medicare.

Pharmacy Services

All pharmaceuticals are supplied by a private pharmacy. You may need to hire equipment (e.g. crutches). Payment of these accounts can be made by cash, credit card or cheque at the Admissions Department on discharge.

Ambulance Services

There may be a charge for interhospital/home transfers. Please check with your health fund or St John's Ambulance.

Parking

Free street parking is available on Ellesmere and Thirlmere Road and in Visitors Parking Areas indicated on parking guide(see map on page 1). Disabled Access is available via the wheelchair ramp at the ambulance entrance, to the left of the main Hospital entrance on Thirlmere Road. **A pick up and setdown** parking bay is also available.

Motel Facility

Self-contained accommodation units are available for patient's relatives. Contact Admissions Office for bookings on (08) 9370 9222.

Hospital Information

What to Bring to Hospital

Health fund information/cards, Medicare/Concession cards. Relevant Doctors letters, X-rays, scans and test results, all current medications. Loose comfortable night wear, clothes, flat shoes or slippers, toiletries and reading material, etc.

The Hospital is unable to ensure security of personal items therefore you are advised not to bring valuables with you to Hospital. If you do choose to do so, this is at your risk as the Hospital does not accept any responsibility for any loss.

Smoking

Smoking is not permitted in the Hospital. Patients who smoke are advised to reduce two weeks prior to surgery and refrain from smoking on the day of surgery.

Room Allocations

Private rooms are subject to availability and every effort is made to accommodate your request as soon as possible. However, there may be times you will need to be transferred to another room or floor.

Visiting Hours

8.00 am to 1.00 pm and 3.00 pm to 8.00 pm

Patient Email Service

Relatives or friends wishing to contact patients by email should direct messages to:

hospitalpatients@mercyare.com.au

Pastoral Care

Pastoral and Spiritual Care Services are available to ensure your emotional and spiritual comfort.

Discharge Time

Discharge time for inpatients is 10.00 am. Please arrange for a responsible adult to collect you after your procedure or discharge from the ward and transport you home safely.

Day Patients are not permitted to drive or travel unescorted on public transport after any procedure if sedation has been given and need to organise transport for 2 hours after the procedure. Endoscopy unit patients will be in hospital 3-5 hours. A nurse will contact your nominated driver once you are ready to be discharged.

Discharge against Medical Advice.

Whilst you are within your rights to discharge yourself against medical advice, you would be required to sign documentation that absolves the Hospital of any responsibility.

Prior to Admission

Please ensure you have completed all the forms and returned them to the "Admission Office" as soon as possible. Make an appointment to complete any pathology, X-ray or other tests ordered by your Doctor. Please follow the fasting instructions provided by your Doctor (e.g. no water, food or chewing gum 6 hrs before your procedure). On arrival check in at the Hospital/Endoscopy Reception. Staff will ensure that all your paperwork is completed and organise your transfer to a Ward/Unit.

ADMITTING DOCTOR TO COMPLETE

Doctor's Name _____ Admission Date _____ Operation / Procedure Date _____ Expected Date of Delivery _____ / _____ / _____	Tick appropriate box <input type="checkbox"/> Day Surgery (No private rooms) <input type="checkbox"/> Endoscopy Unit (No private rooms) <input type="checkbox"/> Out Patient / Uro / Flexi (No private rooms) <input type="checkbox"/> In Patient <input type="checkbox"/> Family Birthing Unit Attended Pre Natal Clinic _____ / _____ / _____
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PATIENT/GUARDIAN TO COMPLETE

Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other _____ Surname: _____ Given Name(s): _____ Date of Birth: _____ Sex: _____ Marital Status: _____ Address: _____ _____ _____ Postcode: _____ Mobile: _____ Telephone (H): _____ (W): _____ Religion: _____ Country / State of Birth: _____ Occupation: _____ Are you Aboriginal/Torres Strait Islander origin? Y <input type="checkbox"/> N <input type="checkbox"/>	<ul style="list-style-type: none"> Have you been a Patient, Employee or Resident in a Hospital in the past 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, where? _____ Is there is a history of Creutzfeldt Jakob Disease (CJD) in your family? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you ever had Human Pituitary Growth Hormones? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have Private Health Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> <p>PLEASE NOTE: UNINSURED PATIENTS ARE REQUIRED TO PAY THE ESTIMATED FEES ON ADMISSION.</p> <p>Please verify your level of cover with your Health Fund prior to admission.</p> Name of Health Fund: _____ Table: _____ Excess Amount: _____ Membership No: _____ Contributor's Name: _____ Medicare No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Card Ref No. <input type="checkbox"/> Valid to <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
Have you been a Patient at Mercy Hospital Mount Lawley before? (Formerly St Anne's Mercy Hospital) Yes <input type="checkbox"/> No <input type="checkbox"/> YEAR <input type="text"/> Surname at previous admission: _____	If you hold a Pharmaceutical Concession Card, please tick appropriate box. Pensioner Health Benefit <input type="checkbox"/> Health Care Card <input type="checkbox"/> Safety Net Card <input type="checkbox"/> Card No.: _____ Expiry Date: _____ Veteran Affairs Card Holder: Gold <input type="checkbox"/> White <input type="checkbox"/> File No.: _____
Contact Person/Next of Kin Name: _____ Relationship to Patient: _____ Address: _____ _____ Postcode: _____ Telephone (H): _____ (W): _____ Mobile: _____ Perth Contact Phone: _____	Insurance Particulars (Where applicable) Workers Compensation <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Date of Accident: _____ Claim No.: _____ Employers Name: _____ Address: _____ Insurance Company Name: _____
General Practitioner: _____ Address: _____ _____ Telephone: _____	Tick Accommodation Requirements (Subject to Availability) Private Room <input type="checkbox"/> Shared Room <input type="checkbox"/> Day Case <input type="checkbox"/> Note: Workers Compensation/Motor Vehicle does not cover a private room.

PRE-ADMISSION FORM

ADMITTING DOCTOR TO COMPLETE



PRE-ADMISSION SUMMARY

Doctor _____

Please Use ID Label When Available

SURNAME	MRN
GIVEN NAMES	
D.O.B.	SEX
DOCTORS NAME	

AFFIX ID LABEL HERE

Admission Diagnoses

1.
2.

Day of Operation

Date of Operation

Admission Date.....Day of Op / 1 Day of Pre-op

Admission Time..... 0630 / 0930 / 1300

Expected number of nights in hospital.....

Operation(s) Procedure(s) to be Performed

.....

.....

MBS Item No(s)

.....

.....

Relevant Past History

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MRSA Status OK Swabs Pending

Drug Allergies / Reactions

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Investigations / Special Requirements on Admission or Pre-op (Tick where appropriate)

- | | | |
|---|---|--|
| Nil <input type="checkbox"/> | U & E / Creatinine <input type="checkbox"/> | LFTs Cardiac Enzyme <input type="checkbox"/> |
| FBC <input type="checkbox"/> | X-match-Units <input type="checkbox"/> | Autologous Blood arranged <input type="checkbox"/> |
| Group and hold Serum <input type="checkbox"/> | CXR <input type="checkbox"/> | ECG <input type="checkbox"/> |
| MSU for MC & S <input type="checkbox"/> | | |

Other:

Authorising Doctor's Signature:

Urgent Medication (To be transcribed onto Medication chart MR120)

Medication & Strength	Dose	Route	Frequency

Special Instructions


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PRE-ADMISSION SUMMARY

ADMITTING DOCTOR AND PATIENT/GUARDIAN TO COMPLETE

IF ENDOSCOPY PATIENT PLEASE COMPLETE PAGE 6

 <p style="text-align: center;">MERCY HOSPITAL MOUNT LAWLEY <i>Bringing compassion to life</i></p> <p style="text-align: center;">CONSENT TO TREATMENT SURGICAL PATIENT ONLY</p>	Please Use ID Label When Available	
	SURNAME	MRN
	GIVEN NAMES	
	D.O.B.	SEX
	DOCTORS NAME	

I, _____ here by consent to the following operation(s):

being performed upon myself or patient's name: _____

The nature and effect of the above operation(s) have been explained to me by Dr _____

I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) stated above and required post-operative treatment.

In conjunction with the above stated operation(s), I consent to the administration of such anaesthetics, medicines, blood transfusions or other forms of treatment as may be considered by the anaesthetist / doctor to be necessary or advisable.

Signature of Patient/Guardian Date

CONFIRMATION

I, _____ have explained to the patient / personal legally responsible for the patient the nature, benefits and risks of the above operation(s) and in my opinion he/she understands this explanation.

Signature of Doctor Date

CONSENT TO BLOOD TEST

If any staff member or doctor is injured and exposed to my (or my child's) blood or other body fluid, then I GIVE MY CONSENT for blood to be collected and tested for infectious agents, including Hepatitis and HIV antibody.

I understand:

1. That I will be informed that blood has been taken for testing
2. The results of the test will be made available to me, the staff member and / or the doctor concerned and the Infection Control Nurse (or his/her deputy.)
3. All staff and doctors are bound by Hospital Policy to maintain confidentiality in regard to the test results.

Signature of Patient/Guardian Date



CONSENT TO TREATMENT - SURGICAL PATIENT ONLY

ADMITTING DOCTOR AND PATIENT/GUARDIAN TO COMPLETE



CONSENT TO TREATMENT ENDOSCOPY PROCEDURE ONLY

Please Use ID Label When Available

SURNAME	MRN
GIVEN NAMES	
D.O.B.	SEX
DOCTORS NAME	

AFFIX ID LABEL HERE

I, _____
of _____
or name of Guardian

- request and consent to
- Gastroscopy (with or without polypectomy)
 - Colonoscopy (with or without polypectomy)
 - Dilatation
 - Other _____

Please place an X in each box indicating your consent - any boxes left blank will denote that consent is withheld

being performed upon myself or patient's name _____
(for Guardian).

I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) stated above and required post-operative treatment.

In conjunction with the above stated operation(s), I consent to the administration of such anaesthetics, medicines, blood transfusions or other forms of treatment as may be considered by the anaesthetist / doctor to be necessary or advisable.

I have read and understood the patient information brochure and have retained a copy.
I understand why I am having this procedure and both the risks and benefits are clear to me.
I understand that I should not drive, operate machinery or make important personal or business decisions for 24 hours.
I understand that I should not travel alone on public transport for 24 hours.

I GIVE MY CONSENT to the collection and testing of blood for communicable diseases including Hepatitis and HIV antibody, in the event of exposure of a staff member to blood or body fluids during the course of treatment.

Signature of Patient/Guardian _____
Date

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure)

I have explained to the Patient / Guardian the nature, benefits and risks of the above treatment, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature of Doctor _____
Date

Print Name:

CONSENT TO TREATMENT - ENDOSCOPY PROCEDURE ONLY

APPLICABLE TO ENDOSCOPY PATIENT ONLY

PATIENT/GUARDIAN TO COMPLETE



SURGICAL / MEDICAL PATIENT HISTORY

Please Use ID Label When Available

SURNAME	MRN
GIVEN NAMES	
D.O.B.	SEX
DOCTORS NAME	

AFFIX ID LABEL HERE

Reason for Admission

Current Problem

Do you have any questions relating to your admission / surgery / procedure / treatment?

Are you using any Support Services? If yes: Please specify

Have you previously been hospitalised Yes (Please specify below) No

Year	Condition / Procedure	Year	Condition / Procedure

Do you take any regular prescribed / non prescribed / recreational medications? (tablets, pills, injections, puffers, aspirin, natural therapies, other)

Name of Medicine/tablets	Dose /Amount	Time Taken	Name of Medicine/tablets	Dose/Amounts	Time Taken

Do you have any allergies/unusual reactions? Yes No If yes, what are they?
(Medicine, tablets, sticking plaster, food, anaesthetics, other) What type of reaction?

Item	Type of Reaction

PATIENT/GUARDIAN TO COMPLETE



SURGICAL / MEDICAL PATIENT HISTORY

Please Use ID Label When Available

SURNAME	MRN
GIVEN NAMES	
D.O.B.	SEX
DOCTORS NAME	

AFFIX ID LABEL HERE

Please tick ✓ if you have ever had any of the following:	Yes	No
Heart condition (e.g. hearts attack, chest pain, angina etc)?		
Blood pressure problems?		
Blood clots/bleeding disorder? clots legs/lungs or bruise easily?		
Blood Disorders? (leukaemia, anaemia etc)?		
Asthma/shortness of breath?		
Pneumonia/ Tuberculosis (TB)?		
Gastricreflux/hiatus hernia/ heartburn/ indigestion/stomach ulcer		
Organ transplant/ (receiving/giving)		
Significant neck/back injury problems?		
Sleep Apnoea/CPAP machine		
Have you ever had Prednisolone/Cortisone/Steroids?		
Any family conditions? (e.g. Thalassaemia/Muscular Dystrophy)		
Do you drink alcohol? If yes: Type.....Daily amount.....		
Diabetes (Type 1/Type 2)?		
Stroke?		
Previous blood transfusion?		
Vision/hearing problems?		
Chronic Bronchitis/ Emphysema?		
Hepatitis/ Liver condition?		
Kidney disease? (stones/dialysis)		
Epilepsy/Fits/Blackouts/Fainting?		
Depression/Anxiety?		
Thyroid disorder?		
Any other serious illness?		
Intellectual impairment?		
Do you smoke cigarettes/other?		

Weight..... Height..... Specific Dietary Requirements.....

HOSPITAL USE ONLY (PATIENT DO NOT TICK)	ASA Category	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
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