# Bathurst Private Hospital

REFERRAL FOR BOOKED PROCEDURAL ADMISSION

## REFERRING DOCTORS

PLEASE **COMPLETE** SECTION 3 & 4 OF FORM
THANK YOU

## PATIENTS OR GUARDIANS

PLEASE **COMPLETE** SECTION 1, 2, 4 & 5 OF THE FORM

Please see your G.P. if you are unsure of anything about your medical history.

Once complete please forward to **Bathurst Private Hospital**
as soon as possible either in person, by mail, fax or email:

51 Gormans Hill Road Bathurst NSW 2795
PO Box 2207 Bathurst NSW 2795

**Fax:** (02) 6332 9147
**Email:** admin@bathurstprivate.com.au

IF YOU HAVE ANY QUESTIONS RELATING TO YOUR ADMISSION PLEASE CONTACT BATHURST PRIVATE HOSPITAL ON **02 6331 7766** DURING OFFICE HOURS OR YOUR DOCTORS SURGERY.

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ Male ☐ Female

Surname: Previous Name:

Given Name: Date of Birth: Age:

Address:

Town: State:

Mailing Address: Town: State:

Email (Compulsory):

Telephone (H): (W): Mob:

☐ Married ☐ Defacto ☐ Single ☐ Widowed ☐ Divorced Religion:

Country of Birth: Aboriginal or Torres Strait Islander - ***Please circle:***

1. Yes Aboriginal 2. Yes Torres Strait Islander 3. Yes Both 4. No Neither

Employment Status: ☐ Child ☐ Student ☐ Employed ☐ Unemployed ☐ Retired ☐ Home Duties

Language/s spoken at home: Interpreter required: ☐ Yes ☐ No

Have you been a patient in Bathurst Private Hospital before?: ☐ Yes ☐ No

**CONTACT PERSON**

Name: Relation to patient:

Telephone (H): (W): Mob:

Address: State

Medicare Number: M/Care Ref. No.: Exp. Date:

Have you reached your **Pharmacy Safety Net** this year? ☐ Yes ☐ No If yes, No. is:

Pensioner Number: DVA Card: Gold/White:

Health Fund Name: M/Ship No.: Excess $:

**WORKERS COMPENSATION**

Name Employer: Phone:

Address:

Insurance Company: Phone:

**Third Party Company** Phone:

**Overseas Visitor - Travel Insurance Company:** Phone:

**DOCTOR NOTIFICATION**

I do/do not consent to the notification of my local GP

Dr. _____

of my admission to hospital and the exchange of information relevant to my case.

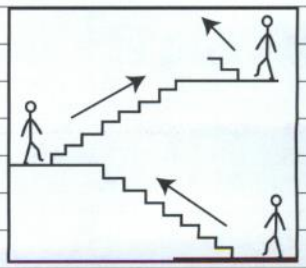
Signed: Date:

SURNAME:

TICK THE APPROPRIATE BOXES **IF YES, please give details to any questions**

What is your: Weight..... kg Height.....cm/ft inches

| | | |
|---|---|---|
| 1. | Any MAJOR ILLNESS (e.g. cancer, psychiatric treatment, kidney disease, rheumatoid arthritis) or DISABILITIES (e.g. blindness, deafness, intellectual)? | ☐ No ☐ Yes If Yes, please give details ..... ..... ..... |
| 1a. | Are you diabetic? | ☐ No ☐ Yes |
| 1b. | **If Diabetic, do you manage with:** | ☐ **Diet** ☐ **Tablet** ☐ **Insulin** |
| 2. | ALL PREVIOUS OPERATIONS? ..... ..... | ☐ No ☐ Yes If Yes, please give details ..... ..... |
| 3. | Have you, or a blood relative, ever had a problem with ANAESTHETICS? | ☐ No ☐ Yes If Yes, please give details ..... |
| 4. | Are you ALLERGIC to medicines, tapes, antiseptics, latex, rubber or foods? *(Please outline)* | ☐ No ☐ Yes ..... |
| 5. | Do you have any BREATHING/RESPIRATORY PROBLEMS (shortness of breath, cough, pneumonia TB, asthma, sleep apnoea). If yes, has your condition become worse in the last 3 months? | ☐ No ☐ Yes If Yes, please give details ..... ..... ..... |
| 5a. | Do you use home oxygen? | ☐ No ☐ Yes |
| 6. | Do you have, or have you ever had in the past, problems with your HEART? (High blood pressure, chest pain, angina, heart attack, rheumatic fever, murmurs). If yes, has your condition become worse in the last 3 months? | ☐ No ☐ Yes If Yes, please give details ..... ..... ..... |
| 6a. | Do you have a Pacemaker? | ☐ No ☐ Yes |
| 7. | Do you have heartburn, indigestion, hiatus hernia or reflux? | ☐ No ☐ Yes ..... |
| 8. | Do you have any (BLEEDING PROBLEMS?) (Easy bruising, excessive bleeding after dental extractions) | ☐ No ☐ Yes ..... |
| 9. | Have you ever had BLOOD CLOTS in the legs or lungs? | ☐ No ☐ Yes |
| 10. | Have you ever had a blood transfusion? | ☐ No ☐ Yes |
| 11. | Have you ever had a problem with epilepsy, stroke, leg or arm weakness, fits, faints or "funny turns"? | ☐ No ☐ Yes ..... |
| 12. | Have you ever had jaundice or hepatitis? | ☐ No ☐ Yes |
| 13. | Do you have limited neck or jaw movement? | ☐ No ☐ Yes |
| 14. | Could you possibly be pregnant? | ☐ No ☐ Yes If yes, number of weeks ..... |
| 15. | Have you had any test done for your GP or specialist in the last 6 months? | ☐ No ☐ Yes ..... |
| 16. | Do you smoke. If yes, how many per day? | ☐ No ☐ ..... per day |
| 16a. | Have you ever smoked? If Yes when did you stop? | ☐ No ☐ Yes ..... |
| 17. | Do you have more than 3 alcoholic drinks most days? | ☐ No ☐ Yes |
| 18. | Have you ever injected yourself with a substance not prescribed by a doctor? Specify _____ | ☐ No ☐ Yes |
| 19. | Can you normally walk without stopping: | |
| a) | more than 2 flight of stairs? | ☐ No ☐ Yes |
| b) | two flights of stairs? | ☐ No ☐ Yes |
| c) | one flight of stairs? | ☐ No ☐ Yes |
| d) | half a flight of stairs? | ☐ No ☐ Yes |
| e) | around the house? | ☐ No ☐ Yes |
| f) | greater than 50 metres? | ☐ No ☐ Yes |
| 19a. | Can you lie flat for 1 hour? | ☐ No ☐ Yes |



| SURNAME: | FIRST NAME: | DOB: |
|---|---|---|

30. Are you taking **ANY** medications/vitamins - over the counter, prescribed and/or herbs?
☐ Yes ☐ No If yes please specify:

| DRUG NAME & STRENGTH | HOW MANY? | TIME OF DAY? |
|---|---|---|
| | | |
| | | |
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| | | |

Name of local prescribing doctor..... Town.....

Name of your local pharmacy..... Town.....

| | | |
|---|---|---|
| 31. | Do you have a responsible adult to stay with you the night after you leave hospital? | ☐ No ☐ Yes |
| 32. | Do you have someone to collect you from hospital?<br>Contact name: ..... | ☐ No ☐ Yes If Yes, contact number<br>..... |
| 33. | Are you the primary carer for someone? If Yes, Specify | ☐ No ☐ Yes |
| 34. | Do you have: | |
| a) | Steps / Stairs | ☐ No ☐ Yes If Yes, how many ..... |
| b) | Hand rails in your bathroom / toilet? | ☐ No ☐ Yes Specify ..... |
| c) | A shower over the bath? | ☐ No ☐ Yes |
| 35. | Do you use / require? | |
| a) | Walking stick / Frame | ☐ No ☐ Yes |
| b) | Wheelchair | ☐ No ☐ Yes |
| c) | Assistance of one person | ☐ No ☐ Yes |
| 36. | Do you require a special diet? (e.g. Diabetic, Vegetarian, etc.) | ☐ No ☐ Yes Specify ..... |
| 37. | Do you require any help at home from: | |
| a) | Home Help | ☐ No ☐ Yes |
| b) | Meals on Wheels | ☐ No ☐ Yes |
| c) | District Nurse | ☐ No ☐ Yes |
| d) | Other (Please outline) | ..... |
| 38. | When you are discharged it is likely you will not be able to do some of the things around the home. With this in mind, do you feel you require contact details for home care services? | ☐ No ☐ Yes<br>.....<br>.....<br>..... |
| 39. | Do you have an Advanced Care Directive?<br>If yes please bring a copy with you to the hospital. | ☐ No ☐ Yes |
| 40. | Have you had any brain surgery between 1972-1989? | ☐ No ☐ Yes |
| 41. | Do you have a family history or relatives with CJD? (known as Mad Cow disease) | ☐ No ☐ Yes |
| 42. | Have you received any growth hormones prior to 1985? | ☐ No ☐ Yes |
| 43. | Have you suffered from a recent progressive dementia, (physical or *mental*) the cause of which has not been diagnosed? | ☐ No ☐ Yes |
| | **PLEASE COMPLETE IF THE PATIENT IS A CHILD** | |
| 44. | Was the child born prematurely? If so, how many weeks? | ☐ No ☐ Yes ..... weeks |
| 45. | Does your child have any problems with his/her HEART OR LUNGS OR ANY OTHER MEDICAL PROBLEMS?<br>Please give details ..... | ☐ No ☐ Yes |

**REVIEWED BY PRE-ADMISSION NURSE** ..... **(Signature & Date)**