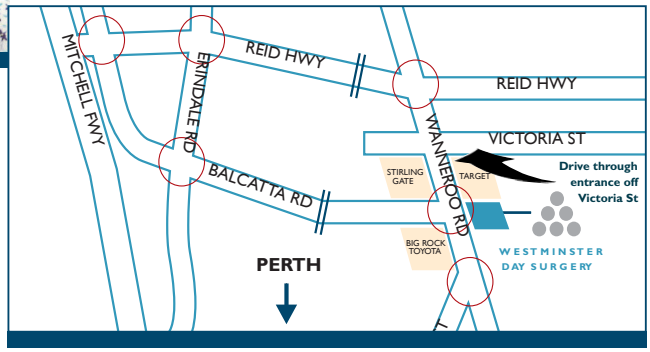
PATIENT ADMISSION INFORMATION

WESTMINSTER
DAY SURGERY



Phone: 9349 5555 Fax: 9344 1744
Email: admin@westminsterdaysurgery.com

1ST FLOOR, 476 WANNEROO ROAD, WESTMINSTER
JUNCTION OF WANNEROO & BALCATTA ROADS

ENTRY: **From West:** Via lights on Wanneroo and Balcatta Roads.
From South: Via lights on Wanneroo and Victoria Streets, drive through shopping centre car park

We wish to acknowledge the custodians of this land, the Wadjuk people of the Nyoongar nation and their Elders, past, present and future. Westminster Day Surgery acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.
Last reviewed: Jan2019

PATIENT ADMISSION INFORMATION

Please read the booklet and complete the PATIENT ADMISSION FORM, PATIENT HEALTH QUESTIONNAIRE and PATIENT CONSENT TO TREATMENT OR INVESTIGATION. Once completed, detach the first two pages of this booklet and retain for your reference and forward the last two pages to the hospital 5-7 days prior to your admission date.

DATE / ARRIVAL TIME OF PROCEDURE _____

WHAT TO EXPECT AT WESTMINSTER DAY SURGERY

Westminster Day Surgery is accredited to the National Safety and Quality Health Service Standards and aims to ensure its systems maintain and improve the reliability, safety and quality of the care provided to its patients. The hospital is invested in partnering with consumers so that the design, delivery and evaluation of its systems are made with patient involvement, fostering a culture whereby patients are given the opportunity to be partners in their own care.

Your hospital experience is important to us. Please alert us if you do not understand any of the information we have communicated to you, or if you require further explanation or instructions.

We particularly value your feedback. If during your stay you have any issues or concerns, please do not hesitate to inform a hospital staff member or your treating doctor. Feedback forms are available upon request as well as in the Admission Waiting Area and from the hospital's website www.westminsterdaysurgery.com

ADMISSION

On your admission our receptionist will greet you and finalise admission procedures. You will then be collected from reception by a nurse and taken to the change room. A pre-operative interview will be conducted and an outline of your stay explained.

When the doctor is ready for you, the anaesthetic nurse will collect you and walk with you into the theatre, where you will be cared for by a team of professional nurses in conjunction with your doctor and anaesthetist. You will wake in the relaxed environment of our specialised recovery area where your progress will be monitored until you are ready to go home.

Your doctor will give an arrival time when booking your procedure.

Confirmation of this time can be obtained by contacting the Day Surgery on the weekday prior to surgery.

NB: If you develop a cold or an illness prior to admission, please contact your doctor for advice.

Westminster Day Surgery has facilities and staff available should your surgery require you to stay overnight. If this is likely, we will notify you of what to bring to hospital and what time you will need to be collected the following day.

ON THE DAY OF ADMISSION

- Shower or bathe prior to arrival
- Wear comfortable, loose clothing, cotton underwear and socks.

BRING WITH YOU:

- A list of your current medications
- Medications which may need to be taken immediately following the procedure (eg insulin)
- Private Health membership details
- Medicare card
- X-Rays (if required by the doctor)

Please do not bring any valuables with you as the Day Surgery accepts no responsibility for lost or stolen items.

FASTING

GENERAL ANAESTHETIC

Your Anaesthetist may give you specific instructions otherwise, **DO NOT EAT OR DRINK ANYTHING** if you are having a general anaesthetic or sedative, for at least 6 hours prior to your procedure - **DO NOT EAT SWEETS OR CHEWING GUM - DO NOT DRINK WATER.**

You may resume eating and drinking post operatively as soon as you are able.

SMOKING

Westminster Day Surgery is a smoke free environment. We strongly advise against smoking for at least 24 hours prior to your procedure.

INTRAVENOUS SEDATION

Your Anaesthetist/Gastroenterologist may give you specific instructions otherwise, **DO NOT EAT OR DRINK ANYTHING** if you are having a general anaesthetic or sedative, for at least 6 hours prior to your procedure - **DO NOT EAT SWEETS OR CHEWING GUM - DO NOT DRINK WATER.**

LOCAL ANAESTHETIC

No fasting is required unless specified by your Doctor.

DISCHARGE

GENERAL ANAESTHETIC

Patients are able to go home once they have met the discharge criteria.

It is important when undergoing a day only procedure that you are driven home by an adult who is able to stay with you for the next 24 hours.

Our staff can assist with the estimated time of your discharge so travel arrangements can be made. Detailed instructions to assist you over the next 24 hours are provided to you by the recovery nurse, including your next doctors appointment. A written copy will be given to you on discharge.

We will endeavour to telephone you within 48 hours to ensure your recovery has been without complications and to answer any questions you may have. If you do not wish to receive a POST OPERATIVE telephone call please notify the staff.

LOCAL ANAESTHETIC

Patients are usually able to go home immediately. However, in some cases a 30 minute resting period is required.

DRIVING

For safety reasons, we advise that you do not drive a car for at least 24 hours following your anaesthetic. Please arrange for a responsible adult to collect and stay with you for the next 24 hours.

PARKING

There is ample free parking available on-site.

FEES/HEALTH FUND EXCESS

If you are insured please contact your health fund to ensure you are covered for your procedure.

Each hospital visit will generate these charges:

1. Hospital Account
2. Account from Surgeon
3. Account from Anaesthetist
4. Account from Pathology company if specimens taken during procedure.

FOR THE HOSPITAL ACCOUNT

- For privately insured patients and DVA Gold card holders the hospital claim is sent directly to the health fund or DVA by Westminster Day Surgery on your behalf. Depending on your level of cover you may be required to pay a health fund excess or a fee for other services that are restricted/excluded from your cover, on the day of admission.
- Workers' Compensation and DVA White card holders require approval from the insurer prior to admission. The hospital claim will be sent directly to the insurer or DVA on your behalf.
- Uninsured patients are required to pay the total estimated hospital fee on admission.
- The hospital accepts cash, Eftpos, bank cheque and major credit cards (exc. Amex and Diners cards)
- Medicare benefits do not apply to the hospital account.
- The surgeon and anaesthetist are to be contacted directly in regards to their accounts.

RIGHTS AND RESPONSIBILITIES AS A PRIVATE PATIENT

- Please notify Westminster Day Surgery as soon as possible if you are unable to arrive at the scheduled time, or if you wish to postpone or cancel your admission.
- Supply those caring for you with complete and accurate information concerning your health, medical history and medications.
- Respect the rights of other patients, visitors and staff and the property of the hospital and other persons.
- Inform those caring for you when you do not understand explanations.
- You are responsible for paying your Doctor's fees and hospital accounts.
- You are entitled to be treated with care and dignity.
- You are entitled to know what services are available.
- You are entitled to a clear explanation by your Doctor of:
  - your condition, problem or disease
  - any planned treatment or investigation
  - any alternative procedures available
  - possible side-effects or after-effects
  - chances of success and any serious risks involved
- As is the case with all medical treatment, you are entitled to ask for a second opinion.
- Your consent is required before any treatment can commence. By having yourself admitted to the hospital, you have implied general consent for treatment. Please read the Consent form and only sign if you feel suitably informed. You may withdraw consent and refuse further treatment at any time.
- Before any treatment is commenced, you are entitled to know in detail the likely costs that may be involved in any treatment or alternatives.
- You have the right to know the identity and professional status of individuals providing services to you.

WESTMINSTER
DAY SURGERY

Privacy Notice

Your Privacy as a Patient at Westminster Day Surgery

The Privacy Act 1988

Westminster Day Surgery respects and upholds your rights to privacy protection according to the Australian Privacy Principles (APPs) contained in The Privacy Act 1988. The APPs outline how all private health service providers must handle, use and manage personal information. The hospital's Privacy Policy is available for download on our website or a copy may be provided to you on request. Below is a summary of important points regarding your personal information.

Collection of Personal Information

Westminster Day Surgery collects your personal information and in particular your health information to provide you with a quality health service. The information will normally be collected directly from you and your referring Doctor, but in an emergency situation, when we are unable to obtain your prior consent, we may need to collect personal information from relatives or other sources.

Use and Disclosure of Personal Information

Under The Privacy Act, Westminster Day Surgery may use patient information for the primary purpose it was collected, i.e. to provide you with a health service and for directly related secondary purposes which may include such activities as hospital management, hospital funding including processing private health fund claims on your behalf, service-monitoring, complaint handling, planning, hospital licensing and accreditation, quality improvement, and financial and clinical audit. Wherever possible the hospital will de-identify the information prior to use.

Westminster Day Surgery will not disclose patient information without patient consent except on a confidential basis to agents that are used in the ordinary operation of its business. Patient information is not disclosed to overseas recipients without written patient consent.

The hospital is required by law to provide the Government of Western Australia, Department of Health and your Health Fund or Department of Veterans' Affairs (for DVA members), with identified data for each admission to hospital.

Westminster Day Surgery may disclose personal information when it is required or authorised by or under an Australian law or a court/tribunal order, or if the information is reasonably necessary for enforcement related activities conducted by, or on behalf of, an enforcement body.

Access to and Correction of Personal Information

You may obtain access to the personal information we hold about you. To assist us, we suggest you complete a 'Westminster Day Surgery Request to Access Patient Information form' or provide us with a signed written request. We will provide you with a suitable range of choices as to how you may access the information. We may impose a charge for processing your request. Your request will be responded to within 30 days of receipt. If you believe that the personal information the hospital holds about you is inaccurate, out of date, incomplete, irrelevant or misleading, you may request amendment of it. If the hospital is satisfied that the information it holds is incorrect, it will take reasonable steps to correct that information.

Withholding Sensitive Information

Under the Act you may withhold sensitive information. Depending of the circumstance and the extent to which sensitive information is withheld, Westminster Day Surgery may decide not to admit or treat you, where it considers the information provided is not comprehensive enough to provide you with a quality health service.

Privacy Questions/Complaints

Any questions about our personal information handling practices or any complaint regarding treatment of your privacy by Westminster Day Surgery can be made in writing addressed to:

Chief Executive Officer, Westminster Day Surgery, 476 Wanneroo Road, Westminster WA 6061

Email: admin@westminsterdaysurgery.com

Ph: (08) 9349 5555

F: (08) 9344 1744

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

WESTMINSTER
DAY SURGERY

PATIENT ADMISSION FORM

It is important that you complete this form and either post it to 476 Wanneroo Road, Westminster 6061, or Fax it 9344 1744 to the hospital 5-7 DAYS PRIOR to admission, then please bring original document on day of admission.

SECTION A **THIS SECTION TO BE COMPLETED BY DOCTOR**

DOCTOR'S NAME: TELEPHONE NO.:

ADMISSION DATE: / / TIME:

ADMISSION DIAGNOSIS:

PROCEDURE: PROCEDURE DATE: / /

CMBS ITEM No's.: ANAESTHETIC: ☐ GENERAL/REGIONAL ☐ SEDATION ☐ LOCAL

SECTION B **THIS SECTION TO BE COMPLETED BY PATIENT**

PATIENT DETAILS: Mr☐ Mrs ☐ Miss ☐ Other _____

Patient Surname: _____

Given Name(s): _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Residential Address: _____

_____ Postcode: _____

Postal Address (if different from above): _____

_____

Phone: (H) _____ (W) _____

(Mobile): _____ Email: _____

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

Employment Status: Employed ☐ Unemployed ☐ Student ☐ Home Duties ☐ Retired ☐ Child not at school ☐ Pensioner ☐ Other _____

Religion: _____

Country/State of Birth: _____

Preferred Language: English ☐ Other _____

Are you of Torres Strait Islander descent? Yes ☐ No ☐

Are you of Aboriginal descent? Yes ☐ No ☐

NEXT OF KIN OR GUARDIAN:

Relationship to patient: _____

Name: _____

Address: _____

_____ Postcode: _____

Phone: (H) _____ (W) _____

(Mobile): _____

Name of person collecting you at discharge:

_____ Phone: _____

Relationship to patient: _____

IMPORTANT:

Have you been a patient at Westminster Day Surgery previously?

Yes ☐ No ☐ If yes, during which year? _____

Please state surname at previous admission if different from above.

_____

MEDICARE NUMBER:

Medicare Card Position No.: _____ Expiry Date: _____

HEALTH INSURANCE DETAILS:

Fund Name: _____

Membership No.: _____

DEPARTMENT OF VETERANS' AFFAIRS DETAILS:

DVA File No.: _____

DVA Card Colour: Gold ☐ White ☐

ADMISSION FOR: *(please tick)* Workers Compensation ☐ MVIT ☐

Date of Accident: _____

State where accident occurred (e.g. WA, QLD): _____

Claim Number: _____

Employers Name: _____

Address: _____

_____ Phone No.: _____

Insurance Co.: _____

Phone No.: _____ Fax No.: _____

Have you been a patient or worked in a health care facility outside the state of Western Australia in the past twelve months?

Yes ☐ No ☐ If yes, which hospital? _____

Have you read and understood the information contained in this booklet including fees and your rights and responsibilities?

Yes ☐ No ☐

PERSON OR PARTY RESPONSIBLE FOR PAYMENT

(Do not complete if person is the patient)

Surname: _____

Given Names: _____

Address: _____

_____

_____ Postcode: _____

Relationship to Patient: _____

Phone (H): _____ (W): _____

REFERRING GP: _____

Address: _____

Phone No.: _____

• Please contact the Day Surgery prior to admission if your weight exceeds 125 kilos. • Please complete the Consent Form with your Doctor.

WESTMINSTER DAY SURGERY

PATIENT HEALTH QUESTIONNAIRE

SURNAME	UMRN
GIVEN NAMES	
D.O.B.	SEX
DOCTOR'S NAME	
ATTACH PATIENT ID LABEL	

PATIENT / GUARDIAN TO COMPLETE ALL SECTIONS BELOW

ALLERGIES
(please tick and specify allergic reaction)

- ☐ Nil
- ☐ Medications _____
- ☐ Latex _____
- ☐ Sticking Plaster / Tapes _____
- ☐ Dyes / Lotions _____
- ☐ Foods _____

CURRENT MEDICATIONS
(please list all medications you are currently taking)

- ☐ Nil

_____

_____

_____

_____

_____

MEDICAL HISTORY (Do you have a history of, or do you currently have, any of the following conditions? Please tick all relevant boxes)

☐ Nil Medical Conditions

☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ On Insulin ☐ On Tablets ☐ Your Normal BSL: _____ mmols

- ☐ High Blood Pressure
- ☐ Heart Attack / Angina
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Rheumatic Fever
- ☐ Respiratory Disease
- ☐ Asthma
- ☐ Emphysema / Airway disease
- ☐ History of smoking
- ☐ Current smoker: _____ a day
- ☐ Currently pregnant
- ☐ Cold / Flu in the past week
- ☐ Stroke
- ☐ Blood disorder / clots
  Specify: _____
- ☐ Von Willebrands Disease
- ☐ Currently taking blood thinning medication
- ☐ Kidney Disease
- ☐ Urinary / bowel problems
  Specify: _____
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Epilepsy
- ☐ CJD (Cruetzfeldt Jakob Disease)
- ☐ Human Growth Hormone Supplement
- ☐ Mental health conditions
  Specify: _____
- ☐ Confusion / Dementia / Cognitive Impairment
  Specify: _____
- ☐ Sleep Apnoea _____
- ☐ Malignant Hyperthermia
- ☐ Alcohol intake: _____ a day
- ☐ History of multi-drug resistant organisms - MRSA/VRE/CRE
- ☐ Skin Abnormalities
  Specify: _____
- ☐ History of Fall in last 12 months
- ☐ Mobility difficulties
  Specify: _____
- ☐ Require Glasses / Hearing Aid

Current weight: _____ Current height: _____

Please contact Westminster Day Surgery prior to admission if your weight exceeds 125 kilos

Other relevant problems _____

_____

Previous operations _____

Have you or an immediate family member ever suffered with complications relating to an Anaesthetic? ☐ No ☐ Yes

If yes, please specify: _____

Do you have an Advanced Care Directive in place? ☐ No ☐ Yes If yes, please bring a copy with you on the day of admission.

Special dietary requirements _____

DECLARATION (please complete and sign below)

I hereby: (Please tick)

- ☐ agree to other health professionals involved in my care, outside the vicinity of this hospital accessing information from my medical record.
- ☐ acknowledge having read and understood Westminster Day Surgery patient information handling practices as detailed in this Patient Admission Information form and consent to the collection, use and disclosure of my personal information in accordance with the Privacy Act.
- ☐ acknowledge that my Doctor has advised me about any prosthesis or medical devices planned to be used in my procedure and whether I will have to pay the gap, the likely amount of the gap and the availability of gap free alternatives and understand that the hospital will charge me for any prothesis gap payment required and that I will be liable to pay the charge.
- ☐ authorise a pre-admission phone call to be made by Nursing staff to myself.
- ☐ declare that I have understood the information provided to me in this booklet and that the information I have provided is true and correct

Patient/Guardian Signature: _____ Date: _____

Nurse confirmation (Name/Signature:) _____ Date: _____

WESTMINSTER
DAY SURGERY

PATIENT CONSENT TO TREATMENT OR INVESTIGATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	GENDER
DOCTORS NAME	
ATTACH PATIENT ID LABEL	

Please read the information below carefully and tick each item to indicate you have understood and agree with the information provided to you by your doctor. Any specific concerns should be discussed with your doctor or proceduralist prior to signing at the end of the page and overleaf. Please note, a 'No' response may prevent you from being admitted to hospital.

a) ☐ Yes ☐ No	The doctor has explained my medical condition and prognosis to me. The doctor has also explained the relevant diagnostic treatment options that are available to me and their associated risks, including the risk of not having the procedure.
b) ☐ Yes ☐ No	The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
c) ☐ Yes ☐ No	I understand that the result/outcome of the treatment/procedure cannot be guaranteed.
d) ☐ Yes ☐ No	I agree that tissue samples and blood removed as part of the procedure or treatment can be used for diagnosis and audit, stored or disposed of sensitively by the hospital.
e) ☐ Yes ☐ No	I consent to undergo the procedure/s or treatment/s as documented on this form.
f) ☐ Yes ☐ No	I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
g) ☐ Yes ☐ No	I agree for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit. When reporting all information will be de-identified.
h) ☐ Yes ☐ No	I understand that if immediate life-threatening events happen during the procedure, I will be treated according to established medical procedure.
i) ☐ Yes ☐ No	I acknowledge that visitors such as students and representatives of manufacturers of medical equipment and surveyors from accrediting bodies may be in the theatre during my procedure and I consent to their being present.
j) ☐ Yes ☐ No	If a staff member is exposed to my blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested.
k) ☐ Yes ☐ No	I consent to a blood transfusion, if needed.
Patient's Full Name:	_____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PATIENT CONSENT TO TREATMENT OR INVESTIGATION HR200

WESTMINSTER
DAY SURGERY

PATIENT CONSENT TO TREATMENT OR INVESTIGATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	GENDER
DOCTORS NAME	
ATTACH PATIENT ID LABEL	

I,_____ Date of birth: _____
(Name)

Consent to the procedure of _____
(No abbreviations, please print)

_____

Being performed on _____
(If not self state patient's name and relationship)

_____

The nature and purpose of which has been explained to me by _____

_____
(Medical Practitioner)

Patient's Signature: _____ **Date**: _____

Parent/Guardian Signature: _____ **Date**: _____

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure:

- ☐ I have informed the patient of the treatment options available, and likely outcomes of each treatment option, including known benefits and possible complications.
- ☐ I have recommended the treatment/procedures/investigations noted above on this form.
- ☐ I have explained the treatment/procedures/investigations, identified above, and what it entails to the patient.

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are documented below.

Special instructions on admission

Signature of doctor/proceduralist obtaining consent

Full Name (please print): _____

Signature: _____ **Date:** _____

Consent checked and correct on day of procedure

Signature: _____ **Date:** _____