ST VINCENT'S PRIVATE HOSPITAL
SYDNEY

CONDUCTED BY THE SISTERS OF CHARITY OF AUSTRALIA

MRN		Surname	
Other Names			
DOB	SEX	AMO	Ward

Office Use Only: Please enter information or affix Patient Information Label

Pre Admission Information Form

Please complete and return to the hospital as soon as possible by reply paid envelope, fax or email:

St Vincent's Private Phone: 8382 7111 Fax: 8382 7248 Email: SVPHS.PreAdmission@svha.org.au
Day Surgery Unit Phone: 8382 6300 Fax: 8382 6330 Email: SVPHS.DSUAdmin@svha.org.au

Admission Details – please print clearly

Date of Admission: ..... / ..... / ..... Admitting Doctor: .....

Type of Admission: Day Only ❑ Overnight ❑

Have you been a patient in St Vincent's Private or Day Surgery Unit before? No ❑ Yes ❑ If **YES** which year? .....

Patient Details

Title: ..... Surname: ..... Previous Surname (if applicable): .....

Given Names: ..... Preferred Name: .....

Date of Birth: ..... ./ ..... / ..... Sex: Male ❑ Female ❑

Residential Address: ..... Suburb: .....

State: ..... Postcode: .....

Postal Address the same as Residential: Yes ❑ No ❑

If **NO**, Postal Address: ..... Suburb: .....

State: ..... Postcode: .....

Telephone (Home): ..... Mobile: ..... Business: .....

Email address: .....

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

Religion: .....

Ethnicity: Aboriginal ❑ Torres Strait Islander ❑ Both ❑ Neither ❑

Country of Birth: ..... Year of arrival in Australia: [ ] ☐ N/A

Do you require an interpreter? No ❑ Yes ❑ If **YES**, main language spoken at home: .....

Medicare Details

Does patient have Medicare? Yes ❑ No ❑

If **YES**, Card number: ☐☐☐☐ ☐☐☐☐☐ ☐ No. beside patient on card: ☐ Valid to: ..... / .....

Hospital Account Details (select as applicable)

❑ Private Health Fund Fund name: ..... Membership number: .....

❑ Workers Compensation / Third Party Claim number (if known): .....

❑ Defence Force

❑ DVA Card number: ..... Card colour: Gold ❑ White ❑ Orange ❑

❑ Other .....

Pharmacy Entitlement Card(s) (select as applicable)

❑ Pension/Concession Card number: ..... Valid to: ..... / ..... / .....

❑ Safety Net Card Card number: ..... Valid to: ..... / ..... / .....

PLEASE TURN OVER AND COMPLETE BACK OF FORM

St Vincent's Private Hospital Sydney
ABN 99 269 630 262

PRE ADMISSION INFORMATION

MR56-V8

Family Doctor (GP)

Who is your family doctor / GP?.....

Practice Name:..... Phone number:.....

Address:..... Suburb: .....

Person to Contact / Person Responsible

Name: ..... Relationship to patient: .....

Address: ..... Suburb: ..... State: .....

Postcode: ..... Main phone number: ..... Additional phone number: .....

Next of Kin

Is Next of Kin the same as Person to Contact/Person Responsible? Yes ❑ No ❑

If **NO,** Name: ..... Relationship to patient: .....

Address: ..... Suburb: ..... State: .....

Postcode: .....Main phone number:..... Additional phone number : .....

Emergency Contact

Is there an additional person to contact in case of emergency? No ❑ Yes ❑

If **YES,** Name: ..... Relationship to patient: .....

Main phone number: ..... Additional phone number: .....

Preferred Accommodation (overnight patients only)

Whilst every effort is made to accommodate your request, we cannot always guarantee availability on day of admission.

Please indicate your preferred accommodation: Private Room ❑ Shared (2 bed) Room ❑

Declaration – to be signed by patient / person responsible

I certify that the above information is true to the best of my knowledge.

Signed: ..... Date: ..... / ..... / .....

Please print name: .....

Please indicate who has completed this form: Patient ❑ Person Responsible ❑

Day Surgery Unit Patients – if going home on the day of surgery

Please note that all patients going home on the day of surgery after having an anaesthetic (general or sedation) MUST have a responsible adult collect them from the Day Surgery Unit (DSU) and accompany them home.
As a guide most patients are discharged 4 hours after their admission. Either you or the DSU staff can contact your escort when you are ready to go home.
If you fail to comply with these safety requirements your surgery will be postponed until another day when you are able to provide an escort to take you home.

- I have arranged for a responsible adult to accompany me home Yes ❑
- I am aware that I should have someone stay with me overnight after surgery Yes ❑

Name of person collecting me: .....

Contact number(s) .....

*If you are **coming from outside of Sydney** please provide details of your accommodation in Sydney and contact number(s)*

Name: .....

Contact number(s) .....

Please complete and return to the hospital as soon as possible by reply paid envelope, fax or email:

St Vincent's Private	Phone: 8382 7111	Fax: 8382 7248	Email: SVPHS.PreAdmission@svha.org.au
Day Surgery Unit	Phone: 8382 6300	Fax: 8382 6330	Email: SVPHS.DSUAdmin@svha.org.au

Please note the Day Surgery Unit is located on Level 3 of St Vincent's Clinic

ST VINCENTS PRIVATE HOSPITAL

PATIENT HEALTH QUESTIONNAIRE

Do you require an Interpreter? ☐ **No**
Yes ☐ ***Language*** _____

Please return in reply-paid envelope or fax all pages for SVPH TO 02 8382 7248
DSU TO 02 8382 6330

Name _____
Address _____
_____
DOB _____ Doctor _____
Phone (H) _____ (M)_____
Date of Procedure;
EMAIL :

Please list any specialists, e.g. Cardiologist, Urologist or Physician that you have consulted recently

_____

Pathology / X ray / Other Imaging / Other Test TAKEN FOR THIS ADMISSION

1. Have you had blood tests / pathology / autologous blood taken for this admission? ☐ No ☐ Yes - if yes, **Company** .....When?.....
2. Have you had a recent ECG / Echocardiogram / Stress test? ☐ No ☐ Yes
   Where.....
3. Have you had any X-rays? ☐ No ☐ Yes CT Scans? ☐ No ☐ Yes MRI? ☐ No ☐ Yes

Do you have or have you ever had : ***Please tick √ the problem or symptom as appropriate***	***Do you have or have you ever had:*** ***Please √ the problem or symptom as appropriate***
☐ Chest pain ☐ Angina ☐ Heart attack ☐ Heart surgery ☐ Stent	☐ Bleeding disorder ☐ Anaemia ☐ Leukaemia ☐ Lymphoma
☐ Irregular heartbeat ☐ Murmur ☐ Palpitations ☐ Atrial Fibrillation	☐ Peripheral vascular disease ☐ Leg ulcer ☐ Varicose veins ☐ DVT
☐ Chest pain ☐ Funny indigestion pain	☐ Indigestion ☐ Ulcer Trouble
☐ Rheumatic Fever	☐ Acid Reflux ☐ Heartburn
☐ Heart failure ☐ Fluid on the lungs ☐ Swollen legs or ankles	☐ Gall Bladder Trouble ☐ Ulcerative colitis ☐ Crohn's Disease
☐ High blood pressure ☐ Low blood pressure	☐ Muscle weakness ☐ Auto immune disease ☐ Myasthenia ☐ Multiple Sclerosis
☐ Obstructive sleep apnoea ** *Please bring CPAP machine to hospital with you if in use.*	☐ Stroke ☐ Mini-stroke (TIA) ☐ Limb weakness ☐ Paralysis
☐ Asthma ☐ Bronchitis ☐ Emphysema	☐ Fits, ☐ Fainting ☐ Funny Turns ☐ Epilepsy
☐ Collapsed lung	☐ Thyroid disorder ☐ Cushing's disease
☐ Have you had a cold or flu recently	☐ Are you or could you be pregnant?
Medical Devices /Implants / Replacements	☐ Are you or could you be HIV +ve
☐ Pacemaker ☐ Defibrillator	**Kidney Trouble**
☐ Artificial heart valve ☐ Cochlear implant	☐ Dialysis
☐ Spinal Stimulator ☐ Pain infusion device	☐ Failure
☐ Hip Replacement ☐ Knee Replacement	☐ Stones
	☐ Infection
☐ Rheumatoid disease ☐ Arthritis	**Diabetes ☐ Type 1 or ☐ Type 2**
Any Form of Cancer?	Controlled by: ☐ Diet
Type:	☐ Tablets
.....	☐ Insulin
Year diagnosed	Year Diagnosed:
☐ Have you had any Lymph nodes removed ☐ Do you have Lymphoedema If yes, which body part is affected?	☐ Organ Transplant *Type* ..... *Year*
Liver problems: ☐ Cirrhosis ☐ Jaundice Hepatitis: ☐ A ☐ B ☐ C ☐ D ☐ E Year Diagnosed.....	☐ Do you have Creutzfeldt-Jacob Disease CGD ☐ Were you given Human Pituitary Growth Hormone prior to 1985 ☐ Did you have neurosurgery prior to 1985
☐ Do you have a fear of falling? ☐ Have you had a fall recently? *Did you injure yourself – if yes how?*	☐ Have you ever had a blood transfusion? If yes, year:

OTHER RELEVANT MEDICAL HISTORY

Do you have any pain: ☐ if yes, where is the pain? .....

Can you tell us about your pain: .....

Mental Health: do you suffer from or have you been treated for:

☐ Cognitive impairment ☐ Dementia ☐ Alzheimer's Disease ☐ Anxiety ☐ Mood disorder;
☐ Panic attack ☐ Depression ☐ Psychosis ☐ Other

Who is your treating doctor: .....

Please list any medication you are taking for this condition ..... .

SURGICAL HISTORY

Operation	Year	Operation	Year

INFECTION CONTROL

Do you have OR had MRSA / VRE or other Multi-Resistant infection? Specify: .....

Year..... Hospital location.....Body Location .....
Have you recently been a patient in an overseas hospital? If so, which country .....
Have you had or been in contact with someone who has gastroenteritis or Chicken Pox in last 14 days?
Details: .....
Do you currently have an infection? Where? .....
Have been on antibiotics for over 4 weeks of the last 4 weeks? ☐ Why? .....

PREVIOUS DRUGS TAKEN – have you ever taken

Drugs for Diabetes	☐	Drugs for Asthma	☐
Drugs for Heart Trouble	☐	Drugs for Arthritis / Anti-inflammatories	☐
Drugs for high Blood Pressure	☐	Drugs Nerves, Sleeplessness, Depression	☐
Do you take any blood thinning therapy? e.g. Warfarin, Coumadin, Plavix, Iscover, Aspirin	☐	Any cortisone or steroids in the last 6 months?	☐

CURRENT MEDICATIONS YOU ARE TAKING

Please list all the Medications/Tablets/Eye Drops or Injections that you normally take Including any oral contraceptives, Naturopathic Remedies, Vitamins, or Products from the Health food Store OR any "Recreational Drugs"

Please enter the details below from the instructions on the bottle

Medication	Strength mg/microg Units / mls	Route e.g. oral	Dose	Frequency e.g. AM / PM Or NIGHT	Date Instructed to cease	Date & time last taken

ANAESTHETIC HISTORY (please tick if Yes)

☐ Have you had any problems with general anaesthetic: *e.g. difficult Intubation or Malignant Hyperthermia*
Details: .....
☐ Any blood relative had problems with anaesthetic ☐ No ☐ Yes
Details: .....
☐ Have you had any problems with local anaesthetic ☐ No ☐ Yes
Details: .....
Is there any limitation in the movement of your neck or jaw? ☐ No ☐ Yes
Details .....

SENSITIVITIES & ALLERGY and / or ADVERSE REACTIONS

Do you have any allergies? If **No** please tick ☞ ☐ **I HAVE NO KNOWN ALLERGIES**

If you do have allergies please list the trigger and reaction

☐ **Medication**
Drug name: **Reaction**
.....

.....

.....

☐ **Latex** (e.g. balloons/gloves) **Reaction**

.....

☐ **Other e**.g. tape, band aids **Reaction**
.....

☐ **Do you have FOOD INTOLERANCE or ALLERGY? Give exact food and reaction**
.....
.....

WEIGHT AND HEIGHT

What do you weigh (approx) .....kg (or..... .....Stone ..... Pounds)

How tall are you? (approx) ..... cm (or ..... Feet .....Inches

DIET

Do you have any eating difficulties or special eating / dietary needs? (Please tick) Yes ☐
If yes, please indicate .....

Do you require assistance with meals? ☐ Packets opened ☐ Cut up ☐ Special Utensils
☐ Help with eating

Are you on a special diet ☐ Yes ☐ No If yes, what type of diet .....

.....
Has your weight change much in the past few months ☐ Yes ☐ No ☐ Don't know...

If yes, over many months? .....What has brought about this change?
.....

HEALTH & LIFESTYLE	*Y*	
Do you smoke	☐	If Yes, how many cigarettes or pipes do you smoke a day?
Have you ever smoked	☐	If Yes, when did you give up?
Do you drink Alcohol	☐	Type and amount..... Frequency..... Any free days?
Have you had a history of alcohol withdrawal? ☐ No ☐ Yes Do you anticipate problems when stopping alcohol? Details:		

FUNCTIONAL ASSESSMENT

Do you have: (Please tick)

ORAL: ☐ Dentures (partial/full, upper/lower) ☐ Crowns/bridges ☐ Loose teeth/Implants/Caps
☐ Decayed teeth ☐ Mouth Ulcers ☐ Swallowing ☐ Speech difficulties

HEARING: ☐ Hearing Aid ☐ Cochlear Implant

SIGHT: ☐ Glasses ☐ Contact lens ☐ Intra-ocular lens ☐ Prosthetic Eye

MOBILITY: ☐ Artificial limb ☐ Crutches ☐ Leg Brace ☐ Walking Stick
☐ Hip or ☐ Knee Replacement ☐ Ankle Replacement ☐ Shoulder Surgery
☐ Wheelchair ☐ Require assistance with Lifter

Do you have a:

☐ Colostomy ☐ Ileostomy ☐ Neobladder ☐ Urostomy / Ileal Conduit
☐ Peg tube ☐ Tracheostomy

Any problems with:

☐ Frequency ☐ Incontinence ☐ Nocturia ☐ Urgency ☐ Poor Flow
☐ Diarrhoea ☐ Irritable Bowel ☐ Constipation

Do you:

☐ Self Catheterise ☐ Have an indwelling catheter ☐ Have a Supra-Pubic Catheter

Do you need assistance with: (please tick)

☐ Bathing / Personal Hygiene ☐ Dressing ☐ Repositioning in Bed ☐ Walking

SKIN PROBLEMS

Do you have any problems with: please detail: ☐ Ulcers ☐ Pressure Sores ☐ Cuts/bruises
Other .....
.....

DAY SURGERY DISCHARGE PLAN (Patient who are NOT staying overnight)

All patients who have an anaesthetic (general or sedation) ***MUST*** *have a responsible adult collect them from the Day Surgery Unit (DSU) & accompany them home.*

How are you getting home? .....

Who is staying with you overnight? .....Phone.....

PLANNING FOR YOUR DISCHARGE

Do you live alone? ☐ Yes ☐ No

Are you a carer for someone else? ☐ Yes

If yes to either question, please provide details about any assistance you might require after discharge to care for yourself or the person you care for:

Services used BEFORE Admission *(please tick ✓ appropriate box)*	***Destination on Discharge from SVPH***
☐ Community Nurse	☐ Home alone
☐ Assistance with Cleaning	☐ Home with family and/or friends support
☐ Assistance with Hygiene	☐ Hostel / retirement village or nursing home
☐ Assistance with Shopping	☐ Rehabilitation facility
☐ Respite in the Home	☐ DVA Discharge program
☐ Privately delivered meals	☐ Extended Care Program (ECP)
☐ Meals on Wheels	Other (please specify)
☐ Travel Assistance	
Other (please specify)	

Services Requested on Discharge

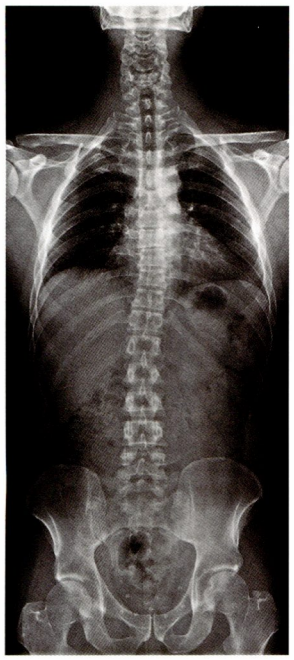
☐ *Community Nurse* ☐ Meals on Wheels ☐ Domestic Help Other: .....

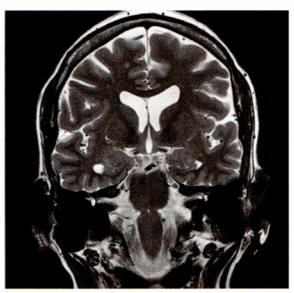
Signed ..... ☐ Patient or ☐ Person Responsible

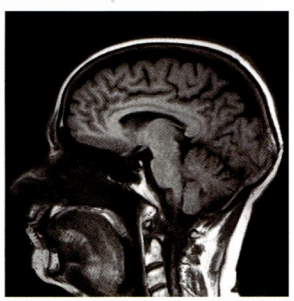
Date ..... Please indicate who has completed this health questionnaire

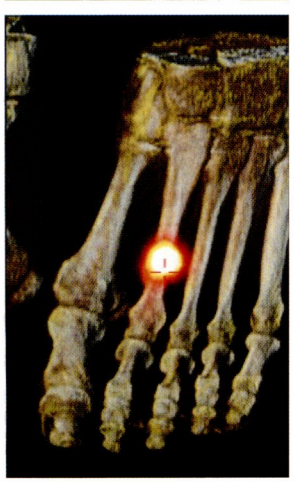
St Vincent's Clinic
Medical Imaging
& Nuclear Medicine

Inpatient medical imaging information









During your stay at St Vincent's Private Hospital, your doctor may request that you have medical imaging (Radiology) examinations.

What is medical imaging?

Medical imaging includes all radiology examinations such as x-rays, CT scans, MRI, Ultrasound, some procedures such as biopsies and Nuclear Medicine.

Who will perform my medical imaging examinations?

Any medical imaging required whilst you are an inpatient of St Vincent's Private Hospital will be performed by St Vincent's Clinic Medical Imaging and Nuclear Medicine. We provide a comprehensive, fully supervised and accredited (RANZCR/NATA) service.

Medical imaging is a specialist medical service. Your medical imaging will be performed by skilled technical staff known as radiographers and sonographers. A specialist medical doctor known as a Radiologist will make a diagnosis and report on your examination. The Radiologist will also review and discuss your imaging with your referring doctor as required. Your imaging will be available to your referring doctor and the ward whilst you are an inpatient.

If you are having a radiological procedure, such as a biopsy, a Radiologist will perform the examination with the assistance of specialised nursing or technical staff.

How, when and why do I have medical imaging performed?

Most of your medical imaging will be performed with your immediate knowledge and following explanation from our staff. There will be some circumstances where you are sedated, anaesthetised or unconscious, such as when you are in theatre, post operative recovery ward or ICU, where medical imaging is required. Under these circumstances you may not be aware that medical imaging has been performed. All medical imaging examinations are specifically requested by your doctor as a necessary part of your care.

Is medical imaging included in my hospital accounts?

NO. **Medical imaging** is a specialist medical service and **is billed separately from your hospital accounts**.

What does medical imaging cost?

St Vincent's Clinic Medical Imaging and Nuclear Medicine fees are set at an amount that ensures the highest standard of care is provided to you during your hospital stay.

Fees associated with inpatient medical imaging & nuclear medicine are payable by patients with a portion of the fees being rebated by Medicare and private health funds. Unfortunately, for most items the full cost of providing these services are not covered by the rebates as Medicare, and most of the private health funds, have not increased their rebates for Radiology since 1998. This freeze on rebates has occurred over a period when technology, staff and compliance costs have increased significantly. As a result there are increased out-of-pocket expenses (gap payments) for patients. This amount will vary between health funds and individual cover. Please contact your health fund if you require further information.

For further information regarding the payment of your account please see over, or contact St Vincent's Clinic Medical Imaging and Nuclear Medicine.

St Vincent's Clinic Medical Imaging & Nuclear Medicine
Level 5, 438 Victoria Street,
Darlinghurst NSW 2010

T: 8382 6265
or email: accounts@svmi.com.au

What to do with your account

Inpatients

- You will be sent accounts for the medical imaging you received whilst in hospital.
- In most cases a claim to Medicare and your health fund will have been lodged on your behalf.
- For most items there will be an out-of-pocket expense.
- Medicare and your private health fund will send you cheques for any applicable rebates.
- Please forward these cheques plus your payment of the out-of-pocket amounts to:

  Accounts Department
  St Vincent's Clinic Medical Imaging &
  Nuclear Medicine
  Suite 501
  438 Victoria Street
  DARLINGHURST NSW 2010

Please note Medicare and health fund cheques are not accepted as full payment. Please ensure any out-of-pocket amounts are also paid.

FULL PENSIONER/HEALTH CARE CARD HOLDERS (NOT SENIORS)

In many cases St Vincent's Clinic Medical Imaging and Nuclear Medicine will subsidise the cost for full pensioners and Health Care Card Holders. For the majority of examinations there will be no out of pocket expense. This does not apply to Seniors Health Card Holders.

In most cases fees will not exceed the schedule fee amount set by the government in the Medical Benefits Schedule (MBS).

DVA GOLD CARD

Invoices will be sent directly to the Department of Veterans' Affairs for payment. Should you receive an account in error, please contact us on (02) 8382 6265 with your details.

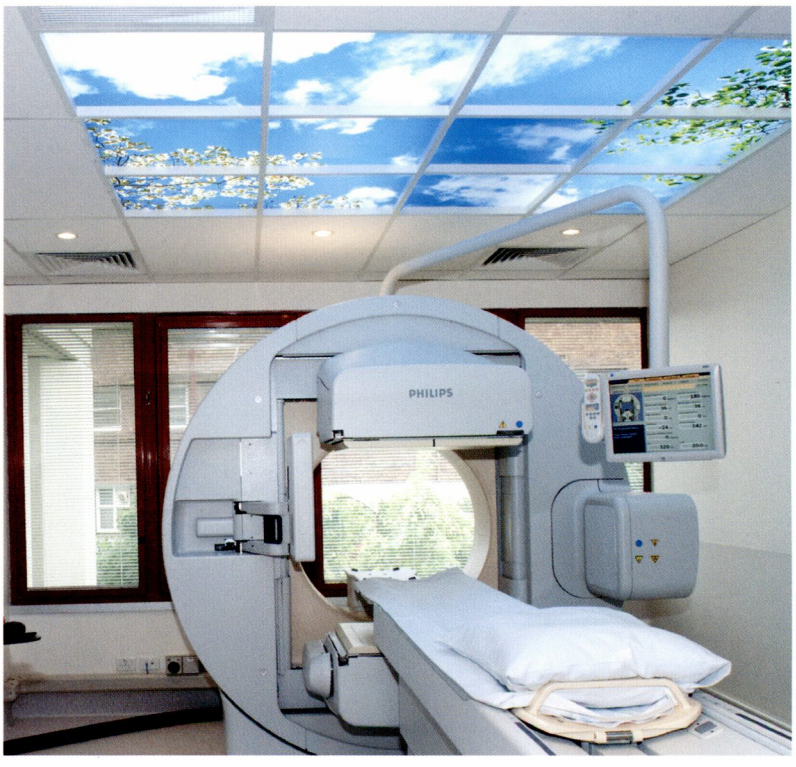
WORKERS' COMPENSATION

There are no Medicare or health fund rebates for Workers' Compensation cases. An account will be issued to the insurer or employer accepting liability for payment of your examination. You will be responsible for full payment if Workers' Compensation approval has not been granted.

OVERSEAS VISITORS

Special arrangements are required for inpatient services provided to overseas visitors. Prior to your admission, please contact St Vincent's Private Hospital Accounts on (02) 8382 7404, or our Accounts staff on (02) 8382 6265.

We accept payment by credit card, EFTPOS, cheque or money order. Credit card payment is also accepted.



St Vincent's Clinic
Medical Imaging
& Nuclear Medicine

ST VINCENT'S CLINIC MEDICAL IMAGING & NUCLEAR MEDICINE
INFORMED FINANCIAL CONSENT

Dear Patient

St Vincent's Clinic Medical Imaging & Nuclear Medicine (SVCMI&NM) is a private practice that provides specialist Medical Imaging (Radiology) services to inpatients of St Vincent's Private Hospital. Medical Imaging is reviewed, diagnosed and reported on by a Radiologist, a specialist doctor in the field of Medical Imaging.

Depending on the type of procedure or operation you are having, your doctor may require one or more examinations. For example, some operations are guided by image intensification in the operating theatre to guide the surgeon. Other examinations are done prior to and after surgery to check on progress. During your stay in hospital, it may be necessary for other examinations to be completed – in some cases examinations may be completed when you are under an anaesthetic or unconscious.

It is important to understand that any examinations that are performed have been requested by your medical specialist.

Our fees are set at a level that ensures the highest standard of care is provided to patients. Health fund rebates vary from fund to fund.

Unfortunately, the rebates paid by both Medicare and private health funds for medical imaging **have not increased since 1998**. Since 1998 there have been significant increases in wages, equipment and infrastructure costs. It is not possible for our practice to provide a quality service without any increase in revenue and therefore our fees entail a **gap payment.** SVCMI&NM subsidise the cost for full Pensioners and for the majority of examinations for full Pensioners there will be no out-of-pocket expense.

For examinations without a Medicare rebate, or in certain circumstances where scheduled item numbers performed on the same day are not permitted by Medicare, you are responsible for payment of the full fee.

If you want to know the cost of your specific Medical Imaging examination, prior to your examination, please call our Bookings staff on **8382 7530**. If calling as an inpatient, please dial extension 7530 from your room.

We would encourage you to raise any queries you have in relation to your rebate with your health fund.

Yours sincerely

DR SHARYN ROTHWELL
Managing Partner, SVCMI&NM

INFORMED FINANCIAL CONSENT

I understand that the Medical Imaging examinations ordered by my doctor may incur out-of-pocket expenses for which I am responsible and agree to pay. I consent to relevant claims being lodged on my behalf to Medicare and my Health Fund.

Patient Name: _____

Patient Signature: _____ Date: _____