

People caring for people



Admission Booklet

Thank you for choosing Masada Private Hospital



MASADA
PRIVATE HOSPITAL

PAGE 2 INSIDE LEFT OF BACK COVER = UNPRINTED



Welcome to Masada Private Hospital

If you need assistance to complete the forms or have any questions regarding your admission, please phone the Hospital, or come to the Hospital reception desk and we will be pleased to help you.

Admission Office 03 9038 1308 (BH)



26 Balaclava Road, East St. Kilda Vic 3183
Ph: (03) 9038 1300 Fax: (03) 9038 1309
www.masadaprivate.com.au
www.ramsayhealth.com.au

***IMPORTANT : FORMS MUST BE RETURNED IMMEDIATELY TO CONFIRM BOOKING
AT LEAST 4 DAYS PRIOR TO ADMISSION***

Our experienced and dedicated staff look forward to caring for you during your stay.

Masada Private Hospital Patient Information

On the Day of Admission

Please bring with you:

- All current medication in their original containers (no dosette boxes)
- All current x-ray or scans
- Toiletries /sleeping attire
- Reading material
- Mobility aids

On the day of admission DO NOT (unless your Doctor gives you special instructions):

- Eat or drink anything after midnight for morning surgery
- Eat or drink anything after 7am for afternoon surgery (prior to 7 am have a light breakfast eg. tea and toast)
- Smoke, chew gum or suck lollies
- Wear jewellery (wedding ring and watch are permitted)
- Wear make-up or nail polish

Admission time

- Please arrive at Masada Private Hospital at the time indicated by your Doctor's room and report to the main reception desk

Day Procedure Patient (additional information)

- Please shower on the day of admission before coming to the Day Procedure Unit
- Wear garments that are comfortable and easy to remove
- Check with your Nurse before informing relatives/ friends regarding the time that you should be picked up. You need to be discharged into the care of a responsible adult who can stay with you overnight
- You must not drive a car until the day following your operation/ procedure or anaesthesia (your motor vehicle insurance may not cover you)
- If planning to go home by taxi you must organise your own escort
- Due to space restrictions at reception, we would appreciate it if you only bring one support person

Information about the Hospital

Visiting Hours

The hospital visiting hours are 2:00pm - 8pm daily.
Maternity Ward from 2pm- 3pm and 7pm- 8pm.

Parking

Limited parking is available on site. Street parking: Day and time restrictions apply.

Meals

The Masada aims to provide a choice of meals and supply special diets where it is in the interest of your medical care. To comply with Victorian Legislation and the Food Act, patients and visitors are not permitted to consume their own food on the premises.

If you have any enquiries, the Hotel Service Manager would be happy to discuss this with you and can be contacted through main reception.

Discharge Information

- **DISCHARGE TIME IS 9:30 AM**

(Excluding Day Procedure patients who will be informed of their approximate discharge time on admission).

- You should arrange for someone to drive and escort you home
- Check with your Nurse/ Doctor about continuing medication, follow-up appointments, etc.

- Please do not forget to collect any X-rays or medications brought with you on admission
- Please contact your Nurse if you have any concerns, problems or suggestions during your stay

Patient Account Information

Accounts/Fees

If you are a member of a Health Fund, it is important prior to your admission, to check with it regarding the following:

- a) That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation.
- b) If an excess is payable on admission.
- c) If you have been a member of your Health Fund for less than 12 months your fund may not accept liability for the cost of this admission eg. if your condition or any symptoms of your condition existed prior to your joining. If there is a question regarding pre-existing symptoms, your health fund has the option to obtain details in this regard from your GP or specialist.

Pharmacy and pathology, imaging and X-ray may attract additional charges. Sundry item charges are payable on discharge. Please note that the medical and allied health practitioner's fees may be billed separately by the practitioner.

An in-house Hospital Services fee of \$25.00 applies to all private patient admissions. This fee covers your usage of:

- Wifi access
- All local/ STD telephone calls
- Foxtel

Payment Procedure

- **Private Patients** - the portion of your estimated hospital account not covered by your health fund, eg. an excess, must be paid on admission. Any additional costs incurred during your stay are payable prior to discharge. eg. Discharge pharmacy costs and some investigations
- **DVA Patients** - the hospital will lodge a claim on your behalf. Any additional costs incurred during your stay are payable prior to discharge. eg. Discharge pharmacy costs and some investigations
- **Work Cover Patients** - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed
- **Third-Party Patients eg. TAC** - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed
- **Self-Insured Patients** - total payment (aside from any ancillary charges) must be made on admission
- Other costs which may be incurred during your stay are payable on discharge. Please bring provision for payment of these fees on admission to hospital

Payment may be made by cash, cheque, credit cards (Mastercard, Visa) or Eftpos.

Valuables

It is strongly recommended that you do not bring jewellery or large amounts of money to Hospital.

If this is unavoidable, please arrange with the Reception staff or your Nurse to have it put into safe custody. Masada Private Hospital does not accept responsibility or liability for any items brought into the hospital.

Masada Private Hospital Patient Rights & Responsibilities

As a patient of Masada Private Hospital we encourage you to be informed of your rights and responsibilities.

If, during your stay, you or your family have any concerns, please direct them to the Nursing Unit Manager or the Director of Clinical Services.

Patient's Rights

You have:

...**the right** to considerate and respectful care, regardless of your beliefs and ethnic, cultural and religious practices;

...**the right** to know the name of the Doctor who has primary responsibility for co-ordinating your care, and the identity and functions of others who are involved in providing care;

...**the right** to seek a second opinion and to refuse the presence of any health care workers who are not directly involved in the provision of your care;

...**the right** to receive information from your Doctor in non-technical language, regarding your illness, its likely course, the expected treatment, the plans for discharge from the Hospital and for follow-up care;

...**the right** to receive from your Doctor a description of the proposed treatment, the risks, the various acceptable alternative methods of treatment, including the risks and advantages of each, and the consequences of receiving no treatment, before giving consent to treatment. Also, unless the law prohibits, you may refuse a recommended treatment, test or procedure, and you may leave the Hospital against the advice of your Doctor at your own risk after completion of Hospital discharge forms;

...**the right** to be informed of the estimated costs prior to any treatment;

...**the right** to refuse participation in any medical study or treatment considered experimental in nature. You will not be involved in such a study without your understanding and permission;

...**the right** to confidentiality and privacy. Details concerning your medical care, including examinations, consultations and treatment are confidential. No records or information pertaining to your care will be released without your permission, or the permission of your representative, unless such a release is required or authorised by law or necessary to enable another health care worker to assist with your care;

...**the right** to know, before your discharge from the Hospital, about the continuing health care you may require, including the time and location for appointments and the name of the Doctor who will be providing the follow-up care. You also have the right to assistance with discharge planning by qualified Hospital staff to ensure appropriate post-Hospital placement;

...**the right** not to be restrained, except as authorised by your Physician or in an emergency when necessary to protect you or others from injury;

...**the right** to associate and communicate privately with people of your choice and to send and receive your personal mail unopened unless medically contra-indicated. At your request, you have the right to be visited by members of the Clergy at any time. You have the right to daily visiting hours established in accordance with Hospital requirements;

...**the right** to retain and use your personal clothing and possessions as space permits, unless to do so would infringe on the rights of other patients or unless medically contra-indicated;

...**the right** to expect safety where practices and environment are concerned;

...**the right** to privacy for visits during established patient visiting hours;

...**the right** to make a comment or a complaint about the treatment or the quality of the health care services or care without fear that you will be discriminated against; and

...**the right** to have your dietary and other special needs considered.

Patient's Responsibilities

You have:

...**the responsibility** to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health;

...**the responsibility** to report unexpected changes in your condition to the responsible practitioner;

...**the responsibility** for reporting if you do not comprehend a contemplated course of action or what is expected of you;

...**the responsibility** for following the treatment plan recommended by the practitioner primarily responsible for your care. This may include following instructions of nurses and allied health personnel as they carry out the co-ordinated plan of care and implement the responsible practitioner's orders;

...**the responsibility** for keeping appointments and, when unable to do so for any reason, for notifying the responsible practitioner or the health care facility;

...**the responsibility** for providing information concerning your ability to pay for services;

...**the responsibility** for accepting the consequences of your actions if you refuse treatment or do not follow the practitioner's instructions;

...**the responsibility** for being considerate of the rights of other patients and health care facility personnel and for assistance in the control of noise, smoking and the numbers of visitors; and

...**the responsibility** for being respectful of the property of other persons and of the health care facility.

Masada Private Hospital Privacy Policy

Masada Private Hospital is bound by the National Privacy Principles under the Privacy Act 1988 (Cth) and other relevant laws about how private health service providers handle personal information. We are committed to complying with all applicable privacy laws which govern how Masada Private Hospital collects, uses, discloses and stores your personal information.

The Privacy Statement sets out in brief how Masada Private Hospital will handle your personal information. For further information or to receive a copy of our full Privacy Policy, please ask a staff member, visit our website: www.ramsayhealth.com.au or telephone the Hospital and ask to speak with our Policy Officer. You can also write to our Privacy Officer to request more information.

Ramsay Health Care will collect your personal information for the purpose of providing you with health care and for directly related purposes. For example, Ramsay Health Care may collect, use or disclose personal information:

- for use by a multidisciplinary treating team;
- to liaise with health professionals, Medicare or your health fund;
- in an emergency where your life is at risk and you cannot consent;
- to manage our hospitals, including for processes relating to risk management, quality assurance and accreditation activities;
- for the education of health care workers;
- to maintain medical records as required under our policies and by-law; or
- for other purposes required or permitted by law

Personal information may be shared between Ramsay Health Care facilities to coordinate your care. We also outsource some of our services. This may involve us sharing your personal information with third parties. For example, we outsource the conduct of our patient satisfaction surveys to a contractor who may write to you seeking feedback about your experience with Masada Private Hospital. We may also outsource the archiving of our medical records to a contractor. Where we outsource our services we ensure that third parties have obligations under their contracts with Ramsay Health Care to comply with all laws relating to the privacy and confidentiality of your personal information.

Ramsay Health Care will usually collect your personal information directly from you, but sometimes may need to collect it from someone else (for example, a relative or another health service provider). We will only do this if you have consented or where your life is at risk and we need to provide emergency treatment.

We will not use or disclose your personal information to any other persons or organisations for any other purpose unless:

- you have consented;
- the use or disclosure is for a purpose directly related to providing you with health care and you would expect us to use or disclose your personal information in this way;
- we have told you that we will disclose your personal information to other organisations or persons; or
- we are permitted or required to do so by law

Access to your health information

You have a right to have access to the health information that we hold in your health record. You can also request an amendment to your health record should you believe that it contains inaccurate information. Should you wish to obtain access to your health record you can ask for our Privacy Officer who can give you more detailed information about how to obtain access to your health record.

If you have a complaint about privacy issues

If you have a complaint about our information handling practices or feel that the privacy of your health information has been interfered with you can lodge a complaint with our Privacy Officer or directly with the Commonwealth Privacy Commissioner.

Our Privacy Officer is happy to discuss any complaint you may have about the management of your health information or to answer any questions you have about our health information management practices and our Privacy Policy. All complaints will be dealt with fairly and as quickly as possible.

Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
Ph: (03) 9038 1300 Fax: (03) 9038 1309

REGISTRATION FORM

**Patient to complete and forward to
Patient Services in envelope provided
at least 4 days prior to admission**

Unit Record Number:

Admission Number:

Family Name: _____

Given Names: _____

Date of Birth: Age: Sex:

OR USE LABEL

Admitting Doctor: _____ Procedure: _____ Date of Procedure: ____ / ____ / ____

Admission Type: Day Case Overnight Time of Admission: _____ Date of Admission: ____ / ____ / ____

PERSONAL DETAILS

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

Given Names: _____ Preferred Name: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ (Business): _____ Mobile: _____

Sex: Male Female Date of Birth: ____ / ____ / ____ Age: _____

Marital Status: Single Married De facto Separated Divorced Widowed

Occupation: _____ Religion: _____

Are you an Australian Resident? Yes No Country of Birth: _____ **If Australia, specify state:** _____

Are you of Aboriginal/Torres Strait Islander (TSI) descent? No Yes, Aboriginal Yes, TSI Yes, both Aboriginal & TSI

PERSON TO CONTACT (Next of Kin)

Name: _____ Relationship to patient: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ (Business): _____ Mobile: _____

Name: _____ Relationship to patient: _____

Telephone (Home): _____ (Business): _____ Mobile: _____

ENTITLEMENTS

Medicare Card No.: Medicare Reference No.: _____ Medicare Expiry Date: _____

Pension/Health Care Card No.: Expiry Date: _____

Safety Net No.:

Repatriation (DVA) No.: Card Colour: White Gold Other _____

Do you have Ambulance cover? No Yes Membership No.: _____

Card Sighted? (hospital use only) No Yes

PREVIOUS HOSPITALISATION

Have you previously been treated at this Hospital? No Yes Year: _____

Is this admission for a child? No Yes

Have you been hospitalised within 7 days prior to this admission? No Yes

Which Hospital? _____

PREFERRED ACCOMMODATION (overnight patients only)

**Whilst every effort is made to accommodate your request, we cannot guarantee availability on the day of admission.
Note: Veterans Affairs, Workcover and Third Party Patients are covered for shared Room Accommodation only –
a separate charge may apply for a single room. Please check level of health insurance cover if requesting a single room.**

Shared Room Single Room

DETACH ALONG PERFORATION

REGISTRATION FORM

MR 001A

GP / LOCAL DOCTOR

Full Name of GP: _____

GP Address: _____

GP Telephone: _____ GP Facsimile: _____ GP Email: _____

HOW WILL THIS ADMISSION BE CLAIMED (Please tick ✓)

- Private Health Insurance – Please complete Sections A and C
- Repatriation / Department of Veterans' Affairs (DVA) – Please complete Entitlements and Section C
- Workcover / Third Party / TAC – Please complete Sections B and C
- Uninsured – Please complete Section C only

SECTION A – PRIVATE HEALTH INSURANCE

Fund Name: _____ Membership No.: _____ Date Joined: ____ / ____ / ____

Has this level of cover changed in the last 12 months? No YesType of cover: Single Family Other _____ Level of cover (if known) _____Do you have an excess? No Yes Amount \$ _____ Have you paid an excess this year? No Yes Amount \$ _____**SECTION B – WORKCOVER / TAC or THIRD PARTY**(Please tick one box) Workcover Third Party TAC

The approval letter for this admission (from your insurance company / TAC) must accompany this form.

Insurance Company Details: Name of Insurance Company: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: _____ Claim No.: _____ Authorised by: _____

Has your insurance company / TAC accepted liability? Yes No Please specify reason (if no): _____

Date of Accident: ____ / ____ / ____

Workcover Patients Only – Employer Details: Name of Employer: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Business): _____

Has your employer completed a Report of Injury Form? No YesHave you completed a Workcover Claim Form? No Yes**SECTION C – PERSON RESPONSIBLE FOR ACCOUNT**Is the Patient responsible for this account? No (Complete this section) Yes (Go to next section)

Name: _____ Relationship to patient: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ (Business): _____ Mobile: _____

PAYMENT OF ACCOUNT – all patients to complete

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of person responsible for account: _____ Date: ____ / ____ / ____

DETACH ALONG PERFORATION

Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
Ph: (03) 9038 1300 Fax: (03) 9038 1309

PATIENT HEALTH QUESTIONNAIRE

Patient to complete and forward to Patient Services in envelope provided at least 4 days prior to admission

Unit Record Number:

Admission Number:

Family Name: _____

Given Names: _____

Date of Birth: Age: Sex:

OR USE LABEL

PATIENT TO COMPLETE

Have you been an inpatient at Masada Private Hospital in the last 3 months?

No, then please complete Sections D, E and F.

Yes, then please complete medication section, update areas in Section D and complete Sections E and F.

Interpreter required? No Yes Language _____

Form completed by? Patient Parent Relative, specify _____ Staff Member

REASON FOR ADMISSION

MEDICAL AND SURGICAL HISTORY List the operation and major illnesses and date (Attach list if insufficient space)

MEDICATIONS Please circle Yes or No to the following questions and provide details as necessary	Staff Use Only Initial & Date all actions		
---	---	--	--

Blood thinning medication <input type="checkbox"/> Aspirin <input type="checkbox"/> Warfarin <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Plavix/Iscover	No	Yes	If yes, specify If recently ceased date last taken	On admission record date & time of last dose taken
Steroids or Cortisone tablets / injections in the last 6 months	No	Yes	If yes, specify If recently ceased date last taken	Notify surgeon & anaesthetist if applicable

Please list ALL current medications (Attach list if insufficient space)

Include prescription or non-prescription and complementary medicines. Some complementary medicines thin the blood or interact with medication, so it is important to discuss with your doctor before coming to hospital.

Please bring to hospital ALL medications you are currently taking including complementary therapies in the dispensed packaging, plus any repeat / authority prescriptions.

Name	Name	Name

Any other doctors / specialists, other than your GP who you are currently consulting

Name	Specialty	Phone Number

DETACH ALONG PERFORATION

PATIENT HEALTH QUESTIONNAIRE MR 001A(i)

PATIENT HEALTH QUESTIONNAIRE (Continued)

Patient Name: _____

PATIENT TO COMPLETE

MEDICAL HISTORY Please circle Yes or No to the following questions and provide details as necessary				Staff Use Only Initial & Date all actions	
Allergies or sensitivities (to medication, foods, tapes, solutions, latex, rubber, other)	No	Yes	Details	If yes, document on medication chart and anaesthetic record	
Anaesthetic reactions	No	Yes	Details	If yes, document on anaesthetic record	
Family history of anaesthetic reactions	No	Yes			
Blood transfusions	No	Yes	Date of last transfusion / /	If yes, document on anaesthetic record	
Blood transfusions reaction	No	Yes	Type of reaction		
Sleep problems	No	Yes		If yes, document on anaesthetic record	
Sleep apnoea	No	Yes	Bring CPAP machine to hospital if used		
Implanted devices/prosthesis (eg joint/heart valve/lapband/cosmetic/stents/pacemaker - last checked / /	No	Yes	Specify		
Blood tests / autologous blood / EGC or other pathology taken for this admission	No	Yes	When	If yes, results available or in medical record	
Pregnant	N/A	No	Yes	Date of last period / /	If yes, advise anaesthetist
Breastfeeding	N/A	No	Yes	If yes, is Doctor aware of this <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol intake	No	Yes	Amount Frequency		
Have you ever smoked?	No	Yes	Details		
Permanent teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Any recent dental problems? If yes, details	No	Yes	Specify	Record on pre-op checklist. Dentures with patient?	
Correct or recent cough / cold / sore throat	No	Yes	Currently taking antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor aware <input type="checkbox"/> Yes <input type="checkbox"/> No	Inform surgeon/anaesthetist	
Heart attack / angina / cardiac disease	No	Yes	Details		
High blood pressure	No	Yes	Details		
Palpitations / irregular heartbeat / heart murmur	No	Yes	Specify		
Rheumatic fever	No	Yes			
Blood disorders / bleeding problems / bruise easily	No	Yes	Details	Ensure surgeon / anaesthetist aware	
Clot in legs / lungs	No	Yes	Specify	Ensure surgeon / anaesthetist aware	
Lung disease	No	Yes	Details - Do you use <input type="checkbox"/> Nebuliser <input type="checkbox"/> Puffer <input type="checkbox"/> Home oxygen	Suggest referral to physiotherapist if appropriate	
Speech / swallowing problems	No	Yes	Specify	Refer to dietitian and / or speech pathology	
Stroke / mini stroke	No	Yes	Details		
Multiple Sclerosis / Motor Neurone Disease / Parkinsons Disease / Palsy	No	Yes	Specify		
Faints / black outs	No	Yes	Details	Complete Risk Assessment	
Epilepsy / fits / seizures	No	Yes	Details - Last seizure	Warning signs / precipitating factors	
Short term memory loss / confusion	No	Yes	Details		
Mental illness / nervous breakdown / anxiety attacks / depression / psychosis / dementia	No	Yes	Details		

DETACH ALONG PERFORATION

PATIENT HEALTH QUESTIONNAIRE (Continued)

PATIENT TO COMPLETE

MEDICAL HISTORY Please circle Yes or No to the following questions and provide details as necessary				Staff Use Only Initial & Date all actions	
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Name of Doctor looking after diabetes	No	Yes	Managed by <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin <input type="checkbox"/> Pump	Check with Doctor re pre-operative management. Arrange appropriate diet.	
Liver disease / hepatitis	No	Yes	Details		
Kidney / bladder problems / incontinence / frequency / urgency / conduit	No	Yes	Specify		
Cancer	No	Yes	Site Date diagnosed / / <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy		
Skin conditions / existing wounds / fistula pressure areas / ulcers / broken skin or reddened skin due to friction or pressure	No	Yes	Describe		
Fall in the last 12 months	No	Yes	Details	Refer falls prevention guidelines	
Mobility aid eg. frame / stick	No	Yes	Specify	Are aids with patient?	
Impairment of <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Speech	No	Yes	Specify aids used		
Any other medical condition	No	Yes	Specify		

NUTRITIONAL ASSESSMENT

Food intolerances or allergies No Yes Describe / specify reaction: _____

Special dietary needs No Yes Specify: _____

Do you require assistance with meals? No Yes Tick below if applicable

Cut up Packets opened Special utensils Assistance with eating

ACTIVITY ASSESSMENT

Do you cope independently with daily living activities eg. showering, dressing, walking.

Yes No, specify assistance required: _____

DISCHARGE ASSESSMENT - tick where appropriate and provide details

Living arrangements: Alone With carer With family Other, specify: _____

Home environment: House / flat / apartment Hostel Nursing home Retirement Village
 Other, specify: _____

At home are there? Steps Stairs Ramps / rails External toilet Separate shower
 Shower over bath **Handrails in:** Bathroom Toilet

Support Services at home Spouse / partner Family / friends Personal carer Delivered meals Home help
 Shopping Home nursing Palliative care Personal alarm Not required
 Care package **Case Manager:** _____ **Phone:** _____

Do you plan to return to your current accommodation directly from hospital? Yes No

Specify plans: _____

Do you care for others at home? No Yes, specify: _____

Note discharge time is between 8am and 10am

Person collecting you from hospital Name: _____ Phone: _____

Name of responsible adult who will care for you: _____ Phone: _____

DETACH ALONG PERFORATION

Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
Ph: (03) 9038 1300 Fax: (03) 9038 1309

CONSENT FOR TREATMENT

Patient and Doctor to complete and forward to Patient Services in envelope provided at least 4 days prior to admission

Unit Record Number:

Admission Number:

Family Name: _____

Given Names: _____

Date of Birth: Age: Sex:

OR USE LABEL

PART A – To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed: _____ and/or _____ / _____
Print name of patient Guardian/person responsible (if applicable) Relationship (father, mother/wife etc)

of his/her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risks of the following recommended operation/procedure(s).

Procedure/Reason for Admission: _____

• Procedure site: _____

• Procedure side of body Right Left

Patient does NOT consent to having a blood or blood products transfusion

Interpreter used: Name of RHC accredited Interpreter: _____ Language: _____
(Please print)

Sight Translated (NSW) Verbally Interpreted (NSW)

Treating RHC Accredited Practitioner: _____ / _____ / _____
Signature Print Name Date

PART B – To be completed by the PATIENT / person responsible

Doctor _____ and I have discussed treatment of my/patient's condition (as above).
Print name of Treating THC Accredited Practitioner

I acknowledge that I have consented to admission to this facility for the following Operation/Procedure:

Reason for admission procedure consented to (side and site as applicable)

- The administration of medicine/blood transfusion may be needed in association with this admission/operation/procedure(s) and that these carry risks which have been explained to me/the patient by the Accredited Practitioner above.
- Ramsay employees administer care/treatment under the treating practitioner's direction, or in an emergency, medical and nursing care will also be delivered as required.

I acknowledge that:

- I understand the explanation the practitioner gave me as to the need, benefits, risks and complications related to this admission/operation/procedure(s) as discussed by my practitioner above.
- I have had the opportunity to ask questions and these have been answered in a way I understand by the practitioner above.
- I have read/seen/heard and understand the following information sheet(s)/multimedia presentation(s) where applicable which explains the operation/procedure(s) and the risks involved.

Insert the name(s) of information sheets(s)/multimedia presentation(s) where applicable

(Delete this section if not applicable)

- I am able to withdraw this consent in writing at anytime prior to the commencement of treatment/procedures.

Patient / Responsible person(s) Signature

Date

Print Name of Patient / Person Responsible

If person responsible signs, state relationship to patient eg. mother/father/husband

DETACH ALONG PERFORATION

CONSENT FOR TREATMENT

MR 003B

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Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
Ph: (03) 9038 1300 Fax: (03) 9038 1309

MEDICAL ORDERS

Doctor to complete and forward to Patient Services in envelope provided at least 4 days prior to admission

Unit Record Number:

Admission Number:

Family Name: _____

Given Names: _____

Date of Birth: Age: Sex:

OR USE LABEL

TREATMENT ORDERS ON ADMISSION

TESTS ON ADMISSION

ADMISSION MEDICATIONS

Date & Time	Medication Order			Date Time to be given	Prescribing Doctor
	Drug Name				Doctor Name
	Dose	Freq	Route	Doctor Signature	

Nursing Staff - please copy as a 'phone order' onto Medication Chart

REGISTRATION FORM – Doctor's Office to Complete

You are scheduled to be admitted to Masada Private Hospital. Please present to: Main Reception Day Procedure Centre

Date of admission: ____ / ____ / ____ Time of admission: _____

Reason for admission: _____

Admitting Doctor: _____

PATIENTS PLEASE PUT THESE DETAILS IN YOUR DIARY

DETACH ALONG PERFORATION

NURSE TO COMPLETE ADMISSION ASSESSMENT x2 PAGES OVERLEAF UPON PATIENT ADMISSION

MEDICAL ORDERS

MR 001A(ii)

NURSING ADMISSION ASSESSMENT (Continued) – To be completed by the Nurse on Admission

RISK SCREENING ASSESSMENT

Risk Factor	Pressure Injury (✓)	Falls (✓)	Manual Handling (✓)	Discharge Issues (✓)
History of falls in last 12 months				
Agitation / confusion				
Vision impairment which impedes everyday function				
Unsteady gait (test muscle strength) and / or impaired mobility				
Frequency / incontinence				
Withdrawn, aggressive, wandering				
Unintentional weight loss in last 6 months				
Excessive weight > 100 kgs				
Poor / fragile skin integrity				
Perfusion impairment				
Hearing impairment				
Language, communication barrier				
Pain				
Social Lives in residential care				
Not coping at home				
Age over 70 / frail				
Chronic complex needs				
Procedure - tick all boxes (non shaded) that relate to the patient's current condition under all four headings. If any box is ticked then the following assessments / actions must be attended	For inpatients complete the PIRA Score* and record actions on care plan or clinical pathway	Refer Falls Prevention Guidelines and document falls and injury prevention strategies on care plan or clinical pathway	Record preventative actions on care plan (risk management section) or clinical pathway	Notify Unit Manager if complex issues

COGNITIVE ASSESSMENT	Current	Prior to Current illness	Action
Orientated and alert	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Short term memory loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Known to wander	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Behavioural problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PRESSURE INJURY RISK ASSESSMENT*

Sensory Perception	1. Completely limited	2. Very limited	3. Slightly limited	4. No impairment	
Moisture	1. Constantly moist	2. Very moist	3. Occasionally moist	4. Rarely moist	
Activity	1. Bedfast	2. Chair fast	3. Walks occasionally	4. Walks frequently	
Mobility	1. Completely immobile	2. Very limited	3. Slightly limited	4. No limitations	
Nutrition	1. Very poor	2. Probably inadequate	3. Adequate	4. Excellent	
Friction and shear	1. Problem	2. Potential problem	3. No apparent problem		

TOTAL SCORE

Is the patient at risk of developing a pressure injury? No Yes
 If Yes, record action taken in progress notes / care plan / clinical pathway.

Admitting RN Signature: _____
 Print Name & Designation: _____
 Date: ____ / ____ / ____ Time: _____

DETACH ALONG PERFORATION

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