



Please read this booklet and return the completed forms to the Hospital as soon as possible after your appointment with your specialist.

For your convenience, you can also fill these forms in online. Visit the hospital website and click on the **online admission forms** link or visit **[www.yourhealthportal.com.au](http://www.yourhealthportal.com.au)**

# Ramsay Health Care Admission Information Booklet



Patient information

WARRINGAL  
PRIVATE HOSPITAL



## Thank you for choosing our hospital.

### Please ensure all forms are forwarded to the hospital promptly in order to confirm your admission.

In order to ensure your admission is streamlined, we request that you complete this hospital admission form prior to your admission date.

You will need approximately 30 minutes to fill in this form. It may be faster and easier for you to fill in the form online. Visit the hospital website and click on the online admission form or visit **[www.yourhealthportal.com.au](http://www.yourhealthportal.com.au)**. By completing your admission form online, some of this information will be retained for future admissions and will only require updating.

**We apologise for the length of these forms but much of the information required is dictated by Commonwealth or State legislation or is required by your health fund.**

### To assist you with this process, it is advisable that you have the following information at hand:

- Personal/Next of Kin details
- Medicare Card
- Funding details (eg DVA, Private health insurance, workcover or self funding)
- Benefit details (eg pharmacy benefit card or pension card)
- Item numbers if these were quoted by doctors' rooms
- Information your doctor supplied to you re implantable medical devices (eg prosthetic and disposables) – if applicable
- Medication information

*If you have private health cover, we recommend you contact your health fund prior to admission to check for any excess or waiting periods. We know that health and billing charges can be difficult to understand and we are happy to assist in any way we can, however we also advise that you seek clarification from your doctor and health fund.*

When you have completed filling in this admission form (and unless you have completed the forms online), please return it to the hospital in one of the following ways:

**a. Complete the forms online ([www.warringalprivate.com.au](http://www.warringalprivate.com.au))**

**b. Hand Deliver to Hospital Reception**

**c. Fax to 03 9457 5873 or**

**d. Post to**

Warringal Private Hospital  
216 Burgundy Street  
HEIDELBERG, VIC, 3084

**If you have questions regarding your admission costs or health insurance status please phone the Pre-Admission Office on;**

03 9274 1378 [Monday to Friday 8.00am to 5.00pm] or email: [OnlinePread.WRP@ramsayhealth.com.au](mailto:OnlinePread.WRP@ramsayhealth.com.au)

**If you have any queries regarding the patient health history form, you will need to call the hospital and ask to speak to a Case Manager.**

03 9274 1300 [Monday to Friday 8.00am to 5.00pm]

**Please have the following information available when phoning.**

- Health History and a list of current medications

Warringal Private Hospital

216 Burgundy Street, Heidelberg, VIC, 3084

Tel: (03) 9274 1300 Fax: (03) 9457 5873

Web: [www.warringalprivate.com.au](http://www.warringalprivate.com.au)

# Preparing for your Admission

We are committed to providing patients with the highest standards of care. Throughout your stay, from pre-admission to discharge, you will be treated with the utmost respect and dignity.

After you have completed and returned the attached forms (or completed the online forms) you may be contacted by telephone prior to your day of admission by a preadmission nurse to get further details.

Your doctor will also explain your procedure or operation and complete the enclosed consent form with you.

## Preadmission

You may be asked to attend a preadmission clinic or contacted by the hospital preadmission nurse prior to your admission so we can speak with you about your hospital stay, your operation, previous surgical and medical history, what to bring to hospital, as well as allay any concerns you may have.

Discharge planning will also be addressed at this time (eg who will care for you at home on discharge, who will take you home etc). You are welcome to bring a relative or friend to this clinic.

## Day of Admission

### On the day of admission

You will be informed of the scheduled time for your surgery and subsequent 'nil by mouth' time by your doctor or the hospital.

#### Fasting Time

This is a period of time, prior to your operation, when you will have a restricted diet or not be allowed to eat or drink (including water). This time is determined by your Anaesthetist or Surgeon and is related to factors such as your age and the type of operation. It is imperative that fasting times be observed for your safety during your anaesthetic.

If you have any questions about your fasting times please check with your doctor or contact the hospital.

Please shower before your admission to hospital.

**Please bring with you into hospital anything applicable to your admission including:**

- doctor's admission letter
- consent form (if not already returned to the hospital)
- health fund number / details (if applicable)
- medicare card
- regular medications in original packaging
- pension health benefits card (if applicable)
- pharmaceutical benefits card (if applicable)
- relevant x-rays and / or test results
- for a child - favourite toy, formula, bottle and any special dietary needs (if applicable)
- Children may go to the procedure/theatre in their own pyjamas. These pyjamas must be cotton or cotton interlock with button through/loose fitting tops
- comfortable closed in shoes/slippers with non-slip soles
- night attire (if staying overnight)
- toiletries
- aides such as walking sticks, hearing aides or glasses
- personal articles i.e. sanitary pads (if applicable)
- method for settling your account
- certified copy of Advanced Health Directive or Enduring Power of Attorney (if available)
- please do not bring valuables as the hospital will not be liable for any loss

#### DO NOT:

- Smoke cigarettes or **chew gum**
- Wear jewellery. A wedding ring and watch are permitted
- Bring valuables ie. mobile phones and large amounts of cash. Mobile phones can interfere with some medical devices and may not be able to be used whilst in hospital.
- Wear make-up or nail polish

If you are feeling unwell (eg cold/flu) and are unsure if you are well enough for your procedure, please contact your treating doctor or GP for advice before admission.

## Day procedure patients (additional information)

- Please shower with soap on the day of admission before coming to the Day Procedure Unit and put on clean clothes
- 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

## Day Patients

If you are coming into hospital as a day only patient (no overnight stay) then there are a couple of important things to note.

The major effects of your anaesthetic or sedation wear off quickly, however minor effects on memory, balance and muscle function may persist for some hours. These effects vary from person to person and are not individually predictable. Because of this please note the following:

### Important information

- **You are not permitted to drive for at least 24 hours after a general anaesthetic or sedation.**
- **A responsible person must be available to transport you home in a suitable vehicle. A train or bus is usually not suitable**
- **A responsible person must be available to stay at least overnight following discharge from the Day Surgery Unit. This person must be physically and mentally able to make decisions for you if necessary.**
- **You must have ready access to a telephone in the post operative dwelling**
- **You must remain within 1 hour of appropriate medical attention until the morning after discharge**
- **You should not operate machinery or make any important decisions for at least 24 hours after your anaesthetic.**

## Overnight patients

For patients staying overnight at hospital, please check your hospital website for information regarding the services and facilities that are available to you during your stay such as internet access, telephones, televisions, visiting hours and other relevant information.

There is some important information that we would like to share with you here about keeping safe and well during your stay in our hospital:

### Infection Control

This hospital is committed to providing all patients with the highest quality of care by preventing the spread of infection.

Hand washing, high standards of housekeeping, and the use of sterile techniques and equipment are all part of our service to ensure your speedy recovery and to reduce the risk of infection.

Patients and visitors also have a role to play in reducing the risk of infection to themselves and other patients. Here are a few very simple guidelines:

- Hand hygiene is the most effective way to prevent the spread of infection. Alcohol based handrubs are a very effective form of hand hygiene and are located at strategic locations in the hospital. We encourage all patients and visitors to use these.
- We ask that people do not visit the hospital if they have gastroenteritis or other contagious diseases.



## Falls Prevention

The unfamiliar environment of a hospital combined with the fact that you may be on medication or fatigued can increase the likelihood of falls in hospital. Below are a few ways that you can reduce the risk of falling whilst in hospital:

- Take special care when walking or taking to your feet particularly if you are on pain-relieving drugs or other medications.
- Ensure you know the layout of your room and take care when moving around at night. Please use your call bell if you need assistance.
- Check the floors in your area to ensure they are not wet before walking. Avoid using talcum powder which makes floors slippery.
- Ask your nurses for assistance if you need to use the toilet and feel unsteady on your feet
- Loose or full-length clothing can cause you to trip. Ensure your clothing is the right length for you
- Check that your slippers or other footwear fit securely. If your doctor has requested you to wear pressure stockings then it is a good idea to also wear slippers over the top to reduce the risk that you may slip. Rubber soled slippers are ideal footwear whilst in hospital.

## Medication Safety

Please provide your nurse with any tablets or medicines (or prescriptions for these) that you have been taking before admission. These will be secured in a personal drug cabinet. Any additional medication you require while in hospital will be ordered by your doctor and supplied to you. When you are discharged, medications that you are required to take will be provided to you to take home.

## Pressure Injury Prevention

A pressure injury is an area that has been damaged due to unrelieved pressure. They may look minor, such as redness on the skin, but can hide more damage under the skin surface.

It is important that you relieve pressure by keeping active and changing your position frequently when you are lying in bed or sitting in a chair. If you are unable to move by yourself, the staff will help you change your position regularly. Special equipment such as air mattresses and booties may be used to reduce the pressure in particular places.

Tell staff if you have any tenderness, or soreness over a bony area or if you notice any reddened, blistered or broken skin.

## Blood Clot Prevention

Blood clotting is the body's natural way of stopping itself from bleeding. Clotting only becomes an issue when it is in the wrong place and blocks blood flow. Being immobile is a big risk in developing a clot and so blood clotting can increase when you are staying in hospital and spending a long time immobile.

In addition, there are a number of risk factors to blood clotting including previous strokes, inherited blood clotting abnormalities, lung disease, being overweight having had major surgery in the past or heart failure, smoking or contraception medications. If you have any of these risk factors, please alert your doctor or the staff.

While in hospital, staff will assess your risk of developing a clot and may ask you to wear compression stockings or sleeves, or they will provide you with blood thinning medication.

Staying mobile, taking any prescribed medications to reduce your risk of blood clotting, drinking plenty of fluid and avoid crossing your legs can reduce your risk of clotting.

If you have sudden increased pain or swelling in your legs; pain in your lungs or chest; difficulty in breathing, please alert your nurse as soon as possible. If these symptoms occur after discharge, seek emergency treatment.

## When You Leave

Before you leave hospital, please make sure you have the following:

- a discharge letter
- all personal belongings
- all personal x-rays
- all current medications
- follow-up appointment requirements

On your way out, please see staff at the Reception, to complete any discharge information.

If you have any excessive pain or are generally concerned about your condition after you leave hospital please contact your specialist, your GP or ring the hospital directly.

## Payment Information

It is very important that you approach your admission to hospital well informed of the financial consequences. Please read the following information and contact your hospital if you have any concerns or queries.

**Privately Insured Patients** - should confirm with your health fund prior to admission the following:

- Does my policy cover me for this procedure?
- Do I have an "excess" payment on my insurance policy?
- Are there any co-payments required for each night I will be in hospital?
- Does my policy exclude some treatments, for example cardiac, orthopaedic or rehabilitation?
- Are any prosthetic or disposable items used in the surgery not covered by my insurance?

Please note that if you have been a member of your health fund for less than 12 months your fund may not accept liability for the costs of this admission, eg if your condition or any symptoms of your condition existed prior to you joining your health fund. Any excess will be required to be paid on admission.

**Repatriation (DVA) Patients** – Gold card holders are covered for all care. White card holders are covered subject to approval by DVA.

**WorkCover Patients** – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed by your insurance company.

**Third Party Patients** – total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed by your insurance company. Please bring full details of claim, including letter from insurance company with you.

**Uninsured Patients** – total payment (aside from any ancillary charges) must be made on admission. Please contact the hospital prior to admission for an estimate of fees and charges. As it is an estimate only, in the event of unforeseen complications or variations from the proposed treatment the cost may vary.

**Overseas Patients** – If you are insured with an overseas company, you will be asked to pay the estimated cost on admission. Please contact the hospital prior to admission for an estimate of fees and charges. As it is an estimate only, in the event of unforeseen complications or variations from the proposed treatment the cost may vary.

**What costs could I incur that will not be covered by my health fund?**

- Pharmacy (medicines required during your admission and discharge medications)
- Pathology (eg blood tests)
- Imaging or x-ray
- Medical and allied health practitioner's fees may be billed separately by the practitioner. Please discuss these with your doctor before your admission. You may receive separate accounts for:
  - Surgeon
  - Anaesthetist
  - Assisting Surgeon
  - Other consultants

- Emergency Centre attendance (if the hospital has an emergency centre and you received treatment in the centre prior to your admission a separate account will be rendered for these services)
- The following incidental items may not be covered by your health fund and will be payable on admission or discharge from the hospital\*:
  - STD telephone calls;
  - Standard **Fee for Incidentals** may apply during your admission.

This relates to Foxtel/Austar and wifi services or business centre access. Please check the hospital website before you are admitted for further information.

*\* Not all hospitals offer these services. Please check at time of admission.*

#### How do I pay?

For your convenience, payment may be made by cash, EFTPOS, Bank cheques, MasterCard or Visa. If you are wanting to pay by Amex or Diners, please check with your hospital if these cards are accepted.

If you have any further questions, please call the hospital's patient accounts department.

## Privacy Policy

**Ramsay Health Care is bound by the National Privacy Principles under the Privacy Act 1988 (Cth) and other laws about how private health service providers handle personal information. Ramsay Health Care complies with privacy laws in the way we collect, use, disclose and store your personal information.**

**The Privacy Statement below is a short version of how Ramsay Health Care 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](http://www.ramsayhealth.com)) or telephone the Hospital and ask to speak with our Privacy Officer. You can also write to our Privacy Officer to ask for more information.**

Ramsay Health Care collects your personal information so that it can provide 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
- when working 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 risk management, quality assurance and accreditation processes
- to teach health care workers
- to keep 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. Some of our services are provided by outside organisations. This may mean that we share your personal information with third parties. For example, the contractor who conducts our patient satisfaction surveys may write to you for feedback about your experience with Ramsay Health Care. Your medical records may also be archived with an outside organisation. When we outsource our services, we make sure that their contracts with Ramsay Health Care comply with all laws about the privacy and confidentiality of your personal information.

Ramsay Health Care usually collects 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.

You have the right to access your personal information in your health record. You can also ask for us to change your health record if you think that it is inaccurate.

# 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](http://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.

## CONTACTS

It is always best to try to resolve your complaint with your local health service provider. If you have tried this and are still unsatisfied, you can make a complaint to the Health Care Complaints Commissioner in your state or territory. Some useful contact information is listed below:

- ACT Human Rights Commission, Health Services Commissioner - [www.hrc.act.gov.au](http://www.hrc.act.gov.au) - (02) 6205 2222
- NSW Health Care Complaints Commission - [www.hccc.nsw.gov.au](http://www.hccc.nsw.gov.au) - 1800 043 159
- NT Health and Community Services Complaints Commission - [www.hcsc.nt.gov.au](http://www.hcsc.nt.gov.au) - 1800 004 474
- QLD Health Quality and Complaints Commission - [www.hqcc.qld.gov.au](http://www.hqcc.qld.gov.au) - 1800 077 308
- SA Health & Community Services Complaints Commissioner - [www.hcsc.sa.gov.au](http://www.hcsc.sa.gov.au) - 1800 232 007
- TAS Health Complaints Commissioner - [www.healthcomplaints.tas.gov.au](http://www.healthcomplaints.tas.gov.au) - 1800 001 170
- VIC Office of the Health Services Commissioner - [www.health.vic.gov.au/hsc](http://www.health.vic.gov.au/hsc) - 1800 136 066
- WA Office of Health Review - [www.healthreview.wa.gov.au](http://www.healthreview.wa.gov.au) - 1800 813 583

# Important Information

**DOCTOR OR PATIENT TO RETURN THE FOLLOWING TWO PAGES [RHC003] TO THE HOSPITAL AS SOON AS POSSIBLE FOLLOWING CONSULTATION CONFIRMING ADMISSION. FORMS CAN BE RETURNED VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.**

**RAMSAY HEALTH CARE**  
**ADMISSION REFERRAL FORM**  
 TO BE COMPLETED BY DOCTOR  
 Please PRINT clearly in block letters.

**Please Admit**  
 Mr, Ms, Mrs, Dr, Miss, Master: \_\_\_\_\_ Surname \_\_\_\_\_ Given Names \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Home \_\_\_\_\_ Business \_\_\_\_\_ Mobile \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

**Admission Details** Facility to be admitted to: \_\_\_\_\_  
 Proposed operation/treatment: \_\_\_\_\_

**Date of Admission:** \_\_\_\_\_ **Expected length of stay:** ☐ Day Only ☐ Overnight or longer ☐ nights  
**Date of Operation:** \_\_\_\_\_ **ICU request:** ☐ Yes ☐ No **Intubated:** ☐ Yes ☐ No **Image intensifier:** ☐ Yes ☐ No  
**Indication for ICU:** \_\_\_\_\_

**Estimated duration of operation:** \_\_\_\_\_ mins **Type of Anaesthetic:** ☐ General ☐ Local

**Clinical Details**  
 Presenting Symptoms: \_\_\_\_\_  
 Provisional Diagnosis: \_\_\_\_\_  
 Other conditions present: \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

History of Diabetes: ☐ Yes ☐ No If yes, what type?: ☐ Type 1 ☐ Type 2 Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

**ALLERGIES**  
**Expected Item Number(s):** \_\_\_\_\_

**Equipment Details:**  
 Immobile device: ☐ Endotracheal Device ☐ Breathing Device  
 Will the prosthesis used attract a gap payment? ☐ No ☐ Yes If so, gap estimate \$ \_\_\_\_\_  
 Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature: \_\_\_\_\_

**Pre-operative instructions (including tests required):**  
☐ Pre-admission clinic attendance required.  
☐ Pathology tests ☐ X-ray/ultrasound ☐ ECG ☐ Other \_\_\_\_\_  
☐ Anaesthetic Consult \_\_\_\_\_  
☐ Drug Orders on Admission (drug order valid 24 hours only) \_\_\_\_\_  
☐ Special Instructions \_\_\_\_\_

**Obstetric Details:**  
 Parity: \_\_\_\_\_ EDC: \_\_\_\_\_ Blood Group: \_\_\_\_\_ Rh: \_\_\_\_\_ Hb: \_\_\_\_\_  
 AetC & B type screen: \_\_\_\_\_ Rubella: \_\_\_\_\_ HbA1c: \_\_\_\_\_  
 \*Consent (over page) to be completed and signed

**Admitting Doctor**  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DO NOT WRITE IN THIS BINDING MARGIN

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ADMISSION REFERRAL FORM

RHC003

**RAMSAY HEALTH CARE**  
**CONSENT FOR TREATMENT**

**Part A To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER**

I have informed \_\_\_\_\_ and/or \_\_\_\_\_ 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).  
 (Print name of patient / child) (Guardian / person responsible if applicable) (Relationship - Higher membership no)  
 Procedure/Reason for Admission: \_\_\_\_\_ (Please print)

• Procedure site \_\_\_\_\_  
 • Procedure side of body: Right ☐ Left ☐ Both ☐ Not Applicable ☐  
☐ Patient does NOT consent to having a blood or blood products transfusion.  
☐ Interpreter used: Name of RHC accredited Interpreter: \_\_\_\_\_ Language: \_\_\_\_\_  
 Sight Translated ☐ (NSW) Verbally Interpreted ☐ (NSW)  
 Treating RHC Accredited Practitioner / Doctor \_\_\_\_\_  
 Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Contact No. (Mob): \_\_\_\_\_ Date: \_\_\_\_\_

**Part B To be completed by the PATIENT / Person Responsible**

I acknowledge that:  
 Doctor \_\_\_\_\_ and I have discussed the treatment of my / patients condition, \_\_\_\_\_  
 (Print name of Treating RHC Accredited Practitioner / Doctor)  
 • I have consented to the Operation / Procedure as described above.  
 • Ramsay employees will administer care / treatment under my treating Doctors direction, or in an emergency, medical and nursing care will also be delivered as required.  
 • I understand the explanation the Doctor gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) as discussed by my Doctor above.  
 • I have had the opportunity to ask questions and these have been answered in a way I understand by my Doctor above.  
 • I have read / seen / heard and understand the following where applicable.  
☐ Information sheet(s) \_\_\_\_\_ (Name of information sheet(s))  
☐ Multimedia presentation(s) \_\_\_\_\_ (Name of multimedia presentation(s))  
 Where applicable which explains the operation / procedure(s) and the risks involved.  
 • I am able to withdraw this consent in writing at anytime prior to the commencement of treatment / procedures.

\_\_\_\_\_  
 (Print name of patient / person responsible) (If person responsible sign, state relationship to patient eg. mother / father / husband)

DO NOT WRITE IN THIS BINDING MARGIN

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CONSENT FOR TREATMENT

RHC003

**YOU CAN COMPLETE THE SUBSEQUENT 8 PAGES OF FORMS [RHC001 - PATIENT ADMISSION DETAILS & RHC002 - PATIENT HEALTH HISTORY - GENERAL] ONLINE. GO TO HOSPITAL WEBSITE LISTED ON PAGE 2 OF THIS BOOKLET AND FIND THE ONLINE ADMISSION FORM LINK. THESE DETAILS WILL BE SAVED FOR FUTURE ADMISSIONS.**

**ALTERNATIVELY, PLEASE RETURN THESE FORMS AT YOUR EARLIEST CONVENIENCE VIA THE MAIL, FAX, OR EMAIL DETAILS LOCATED ALSO ON PAGE 2 OF THIS BOOKLET OR IN PERSON TO THE HOSPITAL MAIN RECEPTION.**

**IF YOU HAVE ANY CONCERNS OR QUERIES THROUGH THE PROCESS PLEASE EMAIL OR PHONE THE DETAILS IN RED ON PAGE 2 OF THIS BOOKLET.**

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**TO BE COMPLETED BY DOCTOR**  
Please **PRINT** clearly in block letters.

Mr, Ms, Mrs, Dr, Miss, Master: ..... Surname ..... Given Names .....

Address: .....

Telephone: ..... Home ..... Business ..... Mobile .....

Date of Birth: ..... / ..... / ..... Sex: .....

**Admission Details** Facility to be admitted to: .....

Proposed operation/treatment: .....

**Date of Admission:**..... / ..... / ..... **Expected length of stay:** ☐ Day Only ☐ Overnight or longer ..... nights

**Date of Operation:** ..... / ..... / ..... **ICU request:** ☐ Yes ☐ No **Intubated:** ☐ Yes ☐ No **Image intensifier:** ☐ Yes ☐ No

**Indication for ICU:** .....

**Estimated duration of operation:** ..... mins      **Type of Anaesthetic:** ☐ General   ☐ Local

## Presenting Symptoms: .....

Provisional Diagnosis: .....

Other conditions present: .....

Infection Risk: ☐ Yes ☐ No      History of MRSA ☐    VRE ☐    Other: .....      VTE Risk: ☐ High ☐ Low

**CURRENT MEDICATIONS:** .....

**Is the patient taking any oral anticoagulants or antiplatelet medications?** ☐ Yes ☐ No **If Yes, date when ceasing:** .....

History of Diabetes: ☐ Yes ☐ No      If yes, what type?: ☐ Type 1 ☐ Type 2      Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

**ALLERGIES:** .....

**Expected Item Number(s):**

[illegible]

Implantable device: ☐ Implanting Device  
☐ Removing Device

Type:

Company: ☐ Contacted

Type: ☐ Contacted

Will the prosthesis used attract a gap payment? ☐ No ☐ Yes If so, gap estimate \$

Has informed financial consent been provided? ☐ Yes ☐ No

Patient Signature.....

### Pre-operative instructions (including tests required):

- ☐ Pre-admission clinic attendance required.
- ☐ Pathology tests: .....
- ☐ Investigations:      ☐ xray/ultrasound      ☐ ECG      ☐ Other .....
- ☐ Anaesthetic Consult
- ☐ Drug Orders on Admission (drug order valid 24 hours only) .....
- 
- ☐ Special Instructions: .....

## Parity: ..... EDC: ...../...../..... Blood Group: ..... Rh: ..... Hb: .....

Anti-D & agglut screen: ..... Rubella HIA titre: ..... HBs Ag: .....

\*Consent (over page) to be completed and signed

### Admitting Doctor

Name: ..... Signature: ..... Date: ..... / ..... / .....

UR: .....

Surname: .....

Given Names: .....

Date of Birth:..... Sex:.....

RHC100.20

Referral/Consent

DO NOT WRITE IN THIS BINDING MARGIN

Ver 1.4- 04/13



**RAMSAY**  
HEALTH CARE

## CONSENT FOR TREATMENT

UR: .....  
Surname: .....  
Given Names: .....  
Date of Birth: ..... Sex: .....

### Part A To be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed ..... and/or ..... / .....  
Print name of patient / child 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: .....  
(Please print)

- Procedure site .....
- Procedure side of body: Right ☐ Left ☐ Both ☐ Not Applicable ☐
- ☐ 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 / Doctor

Signature

Print Name

Contact Ph. No.

Date

### Part B To be completed by the PATIENT / Person Responsible

I acknowledge that:

Doctor ..... and I have discussed the treatment of my / patients condition.  
Print name of Treating RHC Accredited Practitioner / Doctor

- I have consented to the Operation / Procedure as described above.
- Ramsay employees will administer care / treatment under my treating Doctors direction, or in an emergency, medical and nursing care will also be delivered as required.
- I understand the explanation the Doctor gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) as discussed by my Doctor above.
- I have had the opportunity to ask questions and these have been answered in a way I understand by my Doctor above.
- I have read / seen / heard and understand the following where applicable.

☐ Information sheet(s) .....  
Name of information sheet(s)

☐ Multimedia presentation(s) .....  
Name of multimedia presentation(s)

Where applicable which explains the *operation / procedure(s)* and the risks involved.

- 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

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

Ver 3.1 - 10/12

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CONSENT FOR TREATMENT

RHC003



Preadmission Patient RHC100.16

## PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.  
Please PRINT clearly in block letters and return  
immediately to confirm your booking.

UR: .....  
Surname: .....  
Given Names: .....  
Date of Birth: ..... Sex: .....

### ADMISSION DETAILS

Specialist Surname: ..... Specialist First Name: .....  
Overnight: ☐ Yes ☐ No Do you know your admission date: ☐ Yes ☐ No Date of Admission: ..... / ..... / .....  
Procedure / Reason for Admission: .....  
Item Numbers (if known): .....

Is the person completing the form the patient: ☐ Yes ☐ No

If No, Your Name: ..... Your Phone No. ....

### PATIENT DETAILS

Title: ..... Surname: ..... Maiden Name: .....  
Given Names: ..... Preferred Name: .....

Residential Address: .....

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

Postal Address: ☐ As above ☐ Different Details: .....

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

Telephone (Wk/Day).....(Home/AH).....(Mobile/Other) .....

If there is a voice message service, may we leave a message? ☐ Yes ☐ No Allow SMS alert: ☐ Yes ☐ No

Email: .....

(Your email address is important as it is used to confirm to you that your admission form has been received and is NOT used for marketing purposes)

Date of Birth ..... / ..... / ..... Gender: ☐ Male ☐ Female ☐ Indeterminant

Contact Preferences: (indicate your preferred contact option) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

Marital Status: ☐ Single/Child ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Home Duties ☐ Other ☐ Retired ☐ Student ☐ Unemployed

Are you an Australian Resident? ☐ Yes ☐ No

Country / State of Birth: .....

Are you of Aboriginal / Torres Strait Islander (TSI) descent?

☐ No ☐ Aboriginal ☐ TSI ☐ both Aboriginal & TSI ☐ Not Stated/Unknown

Are you of Australian South Sea Islander (SSI) descent? ☐ No ☐ SSI ☐ Not Stated/Unknown

Religion: .....

Do you consent to the Hospital disclosing your name to the following visiting officials (if they are available)?

Chaplain Visit: ☐ Yes ☐ No Veteran Organisation Representative: ☐ Yes ☐ No

Language spoken at home: ..... Interpreter Required: ☐ Yes ☐ No

Referring Doctor Surname: ..... First Name: .....  
(Specialist or GP who referred you to the admitting specialist)

Address: .....

Suburb: ..... Postcode: ..... Phone No: .....

General Practitioner (GP) Surname: ..... First Name: .....  
(If same as above write: "AS ABOVE")

Address: .....

Suburb: ..... Postcode: ..... Phone No: .....

NEXT OF KIN Relationship to patient: .....

Title: ..... Surname: ..... Given Names: .....

Address: ☐ Same as patient ☐ Different from patient .....

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

Telephone (Wk/Day).....(Home/AH).....(Mobile/Other) .....

PERSON TO NOTIFY Relationship to patient: .....

Title: ..... Surname: ..... Given Names: .....

Address: ☐ Same as patient ☐ Different from patient .....

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

Telephone (Wk/Day).....(Home/AH).....(Mobile/Other) .....

## PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

Please PRINT clearly in block letters and return immediately to confirm your booking.

### ENDURING POWER OF ATTORNEY

Do you have a current Advance Health Directive? ☐ Yes ☐ No

Do you have enduring power of attorney – health and medical guardian? ☐ Yes ☐ No

Name: ..... Relationship: ..... Phone: .....

### PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

☐ Self ☐ Next of Kin ☐ Workers Compensation ☐ DVA ☐ Third Party ☐ Other: .....

Title: ..... Surname: ..... Given Names: .....

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

Telephone (Wk/Day) ..... (Home/AH) ..... (Mobile/Other) .....

### MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ Yes ☐ No Medicare Number: 

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Medicare Reference No: ..... (number in front of your name) Medicare Expiry date (MM/YYYY): .....

### PENSIONS / CONCESSIONS / HEALTH CARE CARD / SENIORS CARD / CONCESSIONAL PHARMACY BENEFITS

Do you have any type of pension/concessional benefits card?

☐ No ☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: ..... Benefit Card No: .....

Have you reached the Safety Net for Pharmaceuticals? ☐ Yes ☐ No Safety Net No: .....

### HEALTH INSURANCE DETAILS

Insurance Type: ☐ Private health fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ Self Funded ☐ Public

Name of health fund: ..... Type of Cover: .....

Membership No: ..... Do you have an excess? ☐ Yes ☐ No Amount: \$ .....

Have you changed your level of insurance cover in the last 12 months? ☐ Yes ☐ No

Public: Hospital Name: .....

Workers' Comp Fund Name: .....

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

Claim No: ..... Date of Accident: ..... / ..... / .....

Employer Name: ..... Phone: .....

HR Manager: ..... Fax No: .....

Third Party Name: ..... Details: ..... Policy No.: .....

Serving Member of: ..... DVA No: ..... DVA Card Colour: .....

Details of cover (white card only) .....

### ACCOMMODATION PREFERENCE (whilst every effort will be made to meet your preference, we cannot guarantee availability)

Room preference: ☐ Private room ☐ Shared room

### HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

☐ Hospital Booklet ☐ Private Patient's Hospital Charter ☐ Your right to privacy under the Privacy Act

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent ☐ Payment Information

Person responsible for payment of accounts - Please provide your name, signature and today's date.

Name: ..... Signature: ..... Date: .....

Patient's Signature

Signature: ..... Date: ..... / ..... / .....

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION



Patient Completed C RHC100.11

# PATIENT HEALTH HISTORY

## – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
**Please PRINT clearly in block letters and return immediately to confirm your booking.**

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

ADMISSION INFORMATION				NURSING NOTES	
Is your admission to hospital for treatment of an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, please provide the date of injury: ____ / ____ / ____					
How did the injury occur?: <input type="checkbox"/> Car accident <input type="checkbox"/> Work <input type="checkbox"/> Sport <input type="checkbox"/> Other					
Please specify: .....					
Where did the injury occur?: <input type="checkbox"/> Roadway <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Sports area <input type="checkbox"/> Other					
Please specify: .....					
Could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient under the age of 18 years: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, name of legal guardian of the child? Details: .....					
Was the child born prematurely? <input type="checkbox"/> Yes <input type="checkbox"/> No Details: .....					
Are the child's immunisations up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No					
	YES	NO	COMMENTS	NURSING NOTES	
Have you had Xrays taken for this admission?			Where:		
Have you had blood tests for this admission?			When: Where:		
Have you donated your own blood for the purposes of this operation?			Where:		
Have any other doctors been consulted recently eg. cardiologist, physician			If yes, please write details below		
Doctor consulted: .....			Specialty: .....		
Doctor consulted: .....			Specialty: .....		
Doctor consulted: .....			Specialty: .....		
Doctor consulted: .....			Specialty: .....		
	YES	NO	COMMENTS	NURSING NOTES	
Have you been admitted to this hospital before					
Have you been admitted to any hospital within the last 7 days					
Have you been admitted to any hospital within the last 28 days					
Have you been admitted to a hospital outside WA in last 12 months (For WA residents only)				WA hospitals only	
Reason for Admission:			Hospital Name:		
<b>PREVIOUS SURGERY / PROCEDURES eg joint replacement, transplants, implants, colonoscopy</b>					
OPERATION	APPROX YR	SURGEON		NURSING NOTES	
MEDICATIONS (including puffers, eye drops etc)		YES	NO	COMMENTS	NURSING NOTES
Do you take anti-coagulant or blood thinning therapy (Warfarin, Coumadin, Plavix, Iscover, Aspirin)				Still take? <input type="checkbox"/> Yes <input type="checkbox"/> No Date to be ceased:	
Do you take steroids, anti-inflammatory drugs, cortisone tablets/injections					
Do you take herbal supplements or complementary therapies e.g. fish oil					
Have you received advice from your specialist rooms regarding taking/ceasing your medications prior to admission?					
<b>NOTE: Please list all medications including those above in the following section</b>					





# PATIENT HEALTH HISTORY – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
Please **PRINT** clearly in block letters and return  
immediately to confirm your booking.

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?**

CARDIOVASCULAR	YES	NO	COMMENTS	<input type="checkbox"/> Cardiac risk
Elevated cholesterol, triglycerides				
Blood pressure problems eg. low, hypertension				
Cardiac conditions eg. heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina				
Cardiac irregularities eg. palpitations, irregular heart beat, heart murmur, Atrial Fibrillation				
Cardiac surgery eg. pacemaker, implants/devices, prosthetic heart valve, grafts, stents, angioplasty, bypass or any other heart condition.				Year: Model:
Vascular disease eg. carotid disease, aortic aneurysm, peripheral vascular disease.				
Family history of cardiac disease				
ENDOCRINOLOGY	YES	NO	COMMENTS	NURSING NOTES
Diabetes			Type: Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets	
Blood glucose levels normally greater than 10 mmol/L				
Thyroid problems, hypothyroidism, goitre				
GASTROINTESTINAL	YES	NO	COMMENTS	NURSING NOTES
Hiatus hernia, gastrointestinal ulcers, reflux				
Liver disease, hepatitis (eg A, B, C), jaundice				
Bowel problems/habits, stoma or bowel disease eg Crohns, IBS				
GENITOURINARY	YES	NO	COMMENTS	NURSING NOTES
Kidney disease, dialysis, renal impairment				
Bladder problems or habits, stoma, incontinence, urinary retention				<input type="checkbox"/> Falls risk screen
HAEMATOLOGY & ONCOLOGY	YES	NO	COMMENTS	NURSING NOTES
Ever had a blood transfusion			Any reaction: Year Transfused:	
Blood Type:				
Diagnosed with cancer			Type: Body Site: Treatment: Date of Diagnosis:	
Blood clot in lung / legs (DVT / PE)				
Blood disorders eg anaemia				
Bleeding disorders or problems				
MUSCULOSKELETAL	YES	NO	COMMENTS	NURSING NOTES
Arthritis eg rheumatoid arthritis, osteoarthritis				
Back or neck injury or problems				

RHC100.11  
Patient Completed C

DO NOT WRITE IN THIS BINDING MARGIN

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# PATIENT HEALTH HISTORY

## – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**

**Please PRINT clearly in block letters and return immediately to confirm your booking.**

NEUROLOGY	YES	NO	COMMENTS	NURSING NOTES
Neuromuscular diseases eg MS, myasthenia , dystrophies, parkinsons.				
Stroke, mini stroke, TIA			Date: Impairment:	
Speech problems or swallowing problems eg coughing when eating or drinking				
Limb paralysis or weakness			Left / right side or both	
Difficulties with attention span, understanding and/or problem solving				<input type="checkbox"/> Falls risk screen
Epilepsy, fits, blackouts, funny turns				
Other neurological problems eg migraine, polio, meningitis				
Short term memory loss or dementia				
Previous confusion in hospital				<input type="checkbox"/> Falls risk screen
PROSTHETICS / AIDS / OTHER	YES	NO	COMMENTS	<input type="checkbox"/> Brought by Patient
Visual aids - glasses, contact lenses, visual impairment				
Hearing aids, hearing appliance or hearing impairment, cochlear implant				
Dentures, caps, crowns, loose teeth, implants, veneers				
Other aids for daily living - e.g. artificial limbs				
RESPIRATORY	YES	NO	COMMENTS	NURSING NOTES
Asthma, Pneumonia, Hay Fever, Asbestosis, Chronic Obstructive Pulmonary disease (COPD) e.g. bronchitis, Emphysema.				
Shortness of breath eg walking more than 50m, climbing stairs/inclines				
Sleep Apnoea, disturbed sleep, snoring			Treatment	
Do you use a CPAP machine?			Please bring your CPAP	<input type="checkbox"/> Brought by patient
Other lung problems eg tuberculosis				
OTHER	YES	NO	COMMENTS	NURSING NOTES
Depression, other mental illness				
Lymphoedema				
Any other medical conditions				
FALLS RISK	YES	NO	COMMENTS	<input type="checkbox"/> Falls risk screen
Do you have a fear of falling, are unsteady on feet or have fallen in last 6 months				
Do you use mobility aids eg walking stick, frame etc			Distance without aids	
Have you experienced fainting, dizziness in last 6 months				

DO NOT WRITE IN THIS BINDING MARGIN

DETACH ALONG PERFORATION

# PATIENT HEALTH HISTORY – GENERAL

**TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.**  
**Please PRINT clearly in block letters and return immediately to confirm your booking.**

PATIENT TO COMPLETE

Patient Surname: .....

Given Names: .....

Date of Birth: .....



RHC100.11  
Patient Completed C

INFECTION RISK	YES	NO	COMMENTS	<input type="checkbox"/> Infection risk
Have you travelled to a country with a health alert in last 7 days				
Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose				
Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms				
Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. SARs/H5N1 Influenza 09, either overseas or in Australia, within 7 days of onset of symptoms				
Have you ever had MRSA, VRE or ESBL				
Do you have any wounds or breaks on your skin				
Do you have any other conditions or infections				
Have you had vomiting & diarrhoea in the past 48 hours?				
Are you having an operation on your: brain, pituitary gland, spinal cord, nerve root ganglia, retina, optic nerve or having facial maxillary surgery. If you are unsure please tick YES.			If yes, please answer the following 6 questions otherwise continue on to the next section	
To find out more about cCJD please go to the following URL - <a href="http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf">http://www.ramsayhealth.com.au/information/CJD-Info-Sheet.pdf</a>				
1. Do you think you may have cCJD				
2. Do you have a first degree relative with cCJD				
3. Have you an unexplained progressive neurological illness of less than 12 mths				
4. Have you a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)				
5. Have you previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)				
6. Have you been involved in a look back for cCJD or have a "medical-in-confidence" letter regarding your risk for cCJD				
DISCHARGE PLANNING	YES	NO	COMMENTS	<input type="checkbox"/> Discharge Planner
Do you live alone				
Do you have someone to look after you after discharge or concerns after discharge			Name of person: Contact Number: Relationship:	
Are you solely responsible for the care of another person at home				
Do you currently receive community support and/or nursing services				
Do you require assistance or have concerns with any aspects of day to day living				
Where do you plan to go after discharge				
Do you have escorted transport from hospital				

I confirm that the information completed in this Patient Health History form is correct.

Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

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# Additional Information

## Pharmacy - APHS

Prescription medicines are supplied to inpatients by the hospital pharmacy. If you are a member of a health fund that has an agreement with the hospital, you will not be billed for prescriptions related to your admission. You will be responsible, however, for the cost of any medication you were using prior to your admission and any discharge medications to take home. Please ensure all concession cards or safety net benefits have been documented during pre admission, in order to charge your medicines appropriately. Non health fund members are responsible for the cost of all prescriptions filled on their behalf. Pharmacy items are invoiced and any balance payable at reception on discharge.

## Coffee Shop

There is a coffee shop located on the ground floor of the medical centre. Snacks, sandwiches, pies, light refreshments, along with magazines and newspapers, are available.

### The cafe is open:

Monday to Friday 8.30am - 6.30pm

Saturday 8.30 - 12.30pm

## Confidentiality

As a patient you can feel safe in the knowledge that we safeguard your personal health information ensuring that confidentiality is respected and maintained and information is stored securely. The medical, nursing and allied health staff will only use or disclose your health information for the purpose that it was collected. Beyond this, we must have your consent to use or disclose information, unless authorized by law.

## Newspapers

Newspapers and magazines are available for purchase from the coffee shop.

Reception also have the daily newspapers available for purchase.

## Postal facilities

Incoming mail is delivered to the wards daily and outgoing mail may be given to the ward receptionist for posting. Any letters received after your departure will be forwarded to you at home.

## Flowers

The hospital will provide vases for your flowers. However, in order to prevent the introduction of possible infections, we do not allow potted flowers or plants inside the hospital.

We would remind you that we do not permit flowers for patients who are in our Intensive Care Unit because of the electrical and medical equipment in constant use in this area and the infection control risk.

## Internet Access

The hospital has been wired to provide wireless internet access. If your personal electronic device is wireless compatible then all you require to use the service is an access card which is available from reception.

## Smoking Policy

Warringal Private Hospital adheres to Victorian Government legislation and maintains a smoke free environment. During your stay in hospital, please refrain from smoking in the interests of other patients, staff and visitors.

## Discharge Information

**Discharge time is 9.30am**

## Visiting Hours

The support of family and friends is an important part of the recovery process and we endeavour to provide quiet times for our patients to rest and recover. Long visits may tire some patients, so please support your loved one's recovery by staying for short periods only.

We also ask that visitors are considerate of other patients by keeping noise levels low and supervising children at all times.

Unwell visitors or children should refrain from visiting.

**The visiting hours are requested to be followed wherever possible.**

### General Wards

10.00am to 1.00pm

3.00pm to 8.00 pm

### McCubbin Cardiac Unit

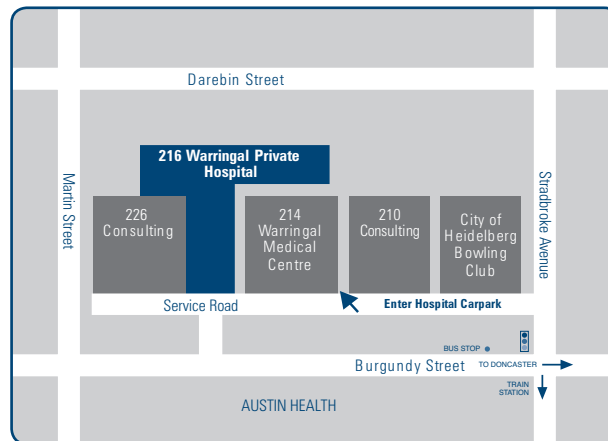
11.00 am to 1.00 pm

3.00 pm to 8.00 pm

### Intensive Care Unit

Immediate family please make arrangements with ICU Nursing team.

**We appreciate there are valid reasons to visit outside visiting hours. Please check with ward staff in your area what is best for your family or friend in hospital. Parents of children are welcome at anytime.**



Melway reference Map 31 K4

## Parking & Transport

### Patient drop off/pick up zones

There are 5 minute pick up and drop off zones at the main entrance.

Please utilise these to make sure the patient arrives on time for admission and is easily transported back to the vehicle on discharge.

## Car Parking & Public Transport

### Parking

Limited parking is available on the hospital grounds at cost. The parking attendants will assist you when possible. Street parking is available at the front of the hospital for drop-off and pick-up, and disabled parking. If you are being discharged in a wheelchair, the person collecting you can pick you up via the Ambulance Bay, which is accessed via the hospital car park. Please ask your nurse or ward clerk for advice in regard to accessing this.

### Public transport

#### Train Routes

The hospital is within walking distance of Heidelberg Station on the Hurstbridge line.

#### Taxis

A direct dial facility for taxi service is available at Reception.



People caring for people

### Warringal Private Hospital

216 Burgundy Street, Heidelberg VIC 3084

Ph: 03 9274 1300 - Fax: 03 9459 7606

[www.warringalprivate.com.au](http://www.warringalprivate.com.au)