F1(CCH) **AO3**(HKH) **MR5**(MAN) **A20**(MVH) **A31**(RYD) **U2B7**(RNS)

Surname: .....

Given Names: .....

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

(Please hand write patient information)

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

RECOMMENDATION FOR ADMISSION BOOKLET

PAGES WITH MARGINS COLOURED AS BELOW MUST BE COMPLETED AS INDICATED

Surgeon/AMO

Patient/Parent/Guardian

Booklet received by hospital with incomplete data on pages 2 and 3 ***may be*** *returned for completion.*

Hospital Delivery Options – see back cover

Booklet must be completed and returned to appropriate hospital intact (see back cover).

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

RECOMMENDATION FOR ADMISSION

Surname: .....

Given Names: .....

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

(Please hand write patient information)

Facility for Procedure: ☐ Gosford ☐ Hornsby ☐ Manly ☐ Mona Vale ☐ RNS Day Surgery Unit
☐ RNS Main Theatres ☐ Ryde ☐ Wyong MRN *(If Known)*: .....

DOCTOR SECTION

PATIENT DETAILS

Title: Family Name: First Name:

Presenting Problems/Diagnosis:

Significant Medical History:

Spinal Injury or Other Disability?

Planned Procedure/Reason for Admission:

Suitable for Local Anaesthetic? CMBS Code(s) .....

Known Biohazard:
☐ Multi Resistant Organism
☐ Other.....

Allergies:

Current Anticoagulation:
☐ Warfarin ☐ Aspirin
☐ Clopidogrel (Iscover®) ☐ Clopidogrel (Plavix®)
☐ Other.....

Interpreter Required ☐
Language.....

Specific Pre-operative Requirements: *(eg Anticoagulant management – Pre-op Medications must be ordered on the appropriate Medication Chart)*

Operative Requirements/Equipment:

Estimated Procedure Time (minutes):

Admission Date: *(If Known)*	Procedure Date:	Number of Nights:

Urgency Status: ☐ 30 Days ☐ 90 Days ☐ 365 Days ☐ Staged Reason: .....

☐ Day Only ☐ Day of Surgery Admission (DOSA) Patient Available at Short Notice (48 Hours): Y / N

☐ Patient Not Suitable for DOSA Reason: ..... ☐ ICU ☐ HDU

Anticipated Election Status: ☐ Non-chargeable Medicare ☐ Private ☐ Vet Affairs ☐ Workers Comp

☐ Third Party ☐ Self Insured ☐ Eligible Overseas Visitor – Reciprocal (Immediate Care Only)

☐ Overseas – M/C Ineligible ☐ Other

Diagnostic Blood Tests Already Performed By: ..... Pathologists Date: ..... / ..... / 20.....

Other Diagnostic Tests/Consults Already Performed:

Patient to Bring X-Ray/Scans when admitted: Y / N

Referral to Pre-Admission Clinic Medicare Services: *(Mark all relevant boxes)*

☐ Pre-admission Clinic ☐ Anaesthetic Consult ☐ ECG ☐ Spirometry

☐ Pathology ..... Prof L Burnett ☐ Radiology ..... Blome, Hanson, Duffy

Admitting Specialist Name: .....

Signature: ..... Date: ..... / ..... / 20.....

Name (If not Admitting Specialist): .....

☐ Referred from Private Rooms

☐ OPD

☐ Other .....

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

RECOMMENDATION FOR ADMISSION

Surname: .....

Given Names: .....

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

(Please hand write patient information)

Medicare Number: | | | | | | | | | | | Patient Identifier Number: ☐ Valid To: ..... / .....

PATIENT DETAILS

Title: ..... Family Name: .....

First Name: ..... Middle Name: .....

Maiden Name: ..... Previous Surname/Names: .....

Preferred First Name: ..... Mother's Maiden Name: .....

Residential Address: .....

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

Mailing Address: .....

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

D.O.B.: ..... / ..... / ..... Sex: M / F Marital Status: ..... Religion: .....

Phone No: Home: ..... Mobile: ..... Work: .....

Country of Birth: ..... Language Spoken at Home: ..... Interpreter Required ☐

Are you: ☐ Aboriginal but not Torres Strait Islander Origin ☐ Torres Strait Islander but not Aboriginal origin
☐ Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal nor Torres Strait Islander origin

Health Fund Name: ..... Membership Number: ..... Level of Cover: .....

Contributor Name: ..... Do you have an Excess? Y / N How much? .....

Veterans Affairs Number: Card Colour: ☐ Gold ☐ White ☐ Orange

Next of Kin Details:

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

Address: .....

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

Phone No: Home: ..... Mobile: ..... Work: .....

Emergency Contact Person:

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

Address: .....

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

Phone No: Home: ..... Mobile: ..... Work: .....

GP Doctor Name: ..... Phone: .....

Address: .....

Consent For Information Release

I consent to my Local Doctor/Specialist/other healthcare provider being advised of my admission and details of my investigation and treatment and allow medical information to be sourced from them to assist in my care.

I understand that if I am discharged on the same day as anaesthetic/sedation and my surgery/procedure, I should not drive a motor vehicle or drink alcohol for 24 hours. I also understand that I must be accompanied home and cared for by a responsible adult for 24 hours.

Patient/Guardian's Signature: ..... Date: ..... / ..... / 20.....

NOTE: If you do not wish for us to collect certain information about you, you need to tell us and we will discuss with you any consequences this may have for your health care.

PATIENT SECTION

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

REQUEST/CONSENT FOR MEDICAL PROCEDURE OR TREATMENT

(For patients 14 years and above – not for Guardianship Act purposes)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr ..... have discussed with this patient the various ways of treating the patient's
(Insert name of medical practitioner)

present condition including the following proposed procedure/treatment .....
(Insert Name, Site, Reasons for procedure or treatment. Do not use abbreviations)

.....

.....

.....

I have informed this patient of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

..... *(Signature Of Medical Practitioner)*	...../...../ 20 ..... *(Date)*	..... *(Time)*
Interpreter present* ..... *(Signature Of Interpreter)*	...../...../ 20 ..... *(Date)*	..... *(Time)*

PATIENT CONSENT

To be completed by Patient

Dr _____ and I have discussed my condition and the various ways in which it
(Insert name of Medical Practitioner)
might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines or blood transfusions may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*I have been told that another doctor may perform the procedure/treatment.

I request and consent to the procedure/treatment described above for me.

***Delete where not applicable**

Continued

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

REQUEST/CONSENT FOR MEDICAL PROCEDURE OR TREATMENT

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor if retained*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure or treatment :

.....
(Insert Objection)

Medical Practitioner's Acknowledgement: .....
(Medical Practitioners Signature)

I also consent to anaesthetics, medicines or other treatments, which could be related to this treatment/procedure.

I have received and understood information given to me related to blood and blood products as management of my condition and **I consent/do not consent*** to a blood transfusion if needed.

..../...../ 20 ....
(Signature Of Patient) *(Date)* *(Time)*

.....
(Print Name of Patient)

.....
(Patient's Address)

.....

USE OF REMOVED TISSUE (SEE EXPLANATORY NOTE BELOW)

I understand that the above procedure may involve the removal of some bodily tissue which may be required for the diagnosis or management of my condition.

I consent/do not consent* to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

.....
(Insert terms, if any)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

..../...../ 20 .....
(Patient's Signature) *(Date)*

EXTRACT FROM SECTION 33 OF DOH CIRCULAR 2004/84

- The Human Tissue Act 1983 requires the written consent of a person if tissue removed from their body during medical, surgical or dental treatment is to be used for any medical, therapeutic or scientific purposes, other than the ongoing treatment of the patient. Tissue includes any organ, or part of a human body, and any substance, including blood, extracted from a part of the human body. If, for example, tissue is removed during medical treatment for diagnostic purposes, a separate consent for a pathological examination is not required. However, if a tumour removed from a person's body is to be retained, and used in the future for the education of students and other medical professionals, or for research or for quality assurance purposes, then the consent of the person from whom the tumour was removed is required before the tumour can be used for these other purposes.
- It is noted that this applies only to tissue which must necessarily be removed as part of the procedure, It does not authorise the removal of any additional tissue from the person's body. For this to occur lawfully, the person must specifically consent to the removal of that tissue under different provisions of the Human Tissue Act 1983.

***Delete where not applicable**

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

REQUEST/CONSENT FOR MEDICAL PROCEDURE OR TREATMENT FOR A MINOR

(For parents/guardians of patients less than 16 years of age)

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr ..... have discussed with this parent/guardian the various ways of treating the
(Insert name of Medical Practitioner)

patient's present condition including the following proposed procedure/treatment .....
(Insert Name, Site, Reasons for procedure or treatment. Do not use abbreviations)

.....

.....

.....

I have informed this **parent/guardian*** of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

.....	...../...../ 20	.....
(Signature Of Medical Practitioner)	*(Date)*	*(Time)*
Interpreter present*	...../...../ 20	.....
(Signature Of Interpreter)	*(Date)*	*(Time)*

PATIENT CONSENT — To be completed by Parent/Guardian

Dr ..... and I have discussed the present condititon of
(Insert name of Medical Practitioner)

.....
(Insert name of Minor)
and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines or blood transfusions may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*I have been told that another doctor may perform the procedure/treatment.

I request and consent to the procedure/treatment described above for .....
(Insert name of Minor)

***Delete where not applicable**

Continued

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

REQUEST/CONSENT FOR MEDICAL PROCEDURE OR TREATMENT FOR A MINOR

Surname: .....

Given Names: .....

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

(Please hand write patient information)

DELETE IF NOT REQUIRED *This part must be countersigned by the treating doctor if retained*

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure or treatment:

.....
(Insert Objection)

Medical Practitioner's Acknowledgement: .....
(Medical Practitioners Signature)

I note that the *Children and Young Person's (Care and Protection) Act 1998* provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

I also consent to anaesthetics, medicines or other treatments, which could be related to this treatment/procedure.

I have received and understood information given to me related to blood and blood products as management of

..... 's condition and **I consent/do not consent*** to a blood transfusion if needed.
(Insert name of Minor)

..../...../ 20..... .....
(Signature Of Patient/Guardian) *(Date)* *(Print name of Parent/Guardian)*

.....
(Address of Parent/Guardian)

.....

USE OF REMOVED TISSUE (SEE EXPLANATORY NOTE BELOW)

I understand that the above procedure may involve the removal of some bodily tissue which may be required for the diagnosis or management of ..... 's condition
(Insert name of Minor)

I consent/do not consent* to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of ..... 's condition
(Insert name of Minor)

My consent is conditional on the following terms:

.....
(Insert terms, if any)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

..../...../ 20 .....
(Signature of Parent/Guardian) *(Date)*

EXTRACT FROM SECTION 33 OF DOH CIRCULAR 2004/84

- The Human Tissue Act 1983 requires the written consent of a person if tissue removed from their body during medical, surgical or dental treatment is to be used for any medical, therapeutic or scientific purposes, other than the ongoing treatment of the patient. Tissue includes any organ, or part of a human body, and any substance, including blood, extracted from a part of the human body. If, for example, tissue is removed during medical treatment for diagnostic purposes, a separate consent for a pathological examination is not required. However, if a tumour removed from a person's body is to be retained, and used in the future for the education of students and other medical professionals, or for research or for quality assurance purposes, then the consent of the person from whom the tumour was removed is required before the tumour can be used for these other purposes.
- If the person is a child, the senior available next of kin may consent to the use of the child's tissue. The senior available next of kin are the child's parents, or if there are no parents available, the child's guardian. However, tissue removed from children who are in the care of the State may not be used for any other medical, therapeutic or scientific purposes.
- It is noted that this applies only to tissue which must necessarily be removed as part of the procedure, It does not authorise the removal of any additional tissue from the person's body. For this to occur lawfully, the person must specifically consent to the removal of that tissue under different provisions of the Human Tissue Act 1983.

***Delete where not applicable**

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

PATIENT HEALTH QUESTIONNAIRE

PATIENT SECTION

How tall are you?		**How much do you weigh?**
Do you have any Allergies? (Especially to food, medications, sticking plaster, iodine or latex?)	No ☐ Yes ☐	What are you allergic to? Reaction?
Have you or any of your blood relatives had any problems with an anaesthetic? (Including at the dentist)	No ☐ Yes ☐	
Do you have any difficulty with neck movement?	No ☐ Yes ☐	Specify
Do you take any Warfarin, Aspirin, Iscover, Plavix or other blood thinning drugs?	No ☐ Yes ☐	
Do you use any regular medications such as tablets, pills, injections, puffers, eye drops, and creams?	No ☐ Yes ☐	

Name of Medications	How Much?	How Often?	Name of Medications	How Much?	How Often?

Do you take any non prescribed oral or alternative medicines? Eg vitamins/herbal medicine?	Specify

Do you have or have you ever had any of the following		
High Blood Pressure?	No ☐ Yes ☐	How long?
Chest pain or "angina"?	No ☐ Yes ☐	How often?
Heart Attack?	No ☐ Yes ☐	When?
Pacemaker, irregular heart beat or any other heart condition?	No ☐ Yes ☐	What type?
Are you being treated or have you been investigated for sleep apnoea?	No ☐ Yes ☐	Give details (eg CPAP)
Shortness of breath when climbing hills or stairs?	No ☐ Yes ☐	
Shortness of breath when lying flat?	No ☐ Yes ☐	
Chronic bronchitis/emphysema?	No ☐ Yes ☐	Give details
Asthma?	No ☐ Yes ☐	Requiring hospital admission?
Have you had tuberculosis?	No ☐ Yes ☐	
Hayfever	No ☐ Yes ☐	How often?
Diabetes	No ☐ Yes ☐	Do you take insulin/tablets?
Epilepsy or fits?	No ☐ Yes ☐	When was the last one?
Stroke?	No ☐ Yes ☐	When?
Blackouts or fainting?	No ☐ Yes ☐	When?

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

PATIENT HEALTH QUESTIONNAIRE

Surname: .....

Given Names: .....

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

(Please hand write patient information)

Blood clots or bleeding – self or relatives?	No ☐ Yes ☐	What type?
Anaemia?	No ☐ Yes ☐	What year?
Previous Blood Transfusion?	No ☐ Yes ☐	When?
Stomach ulcers/Hiatus Hernia/reflux?	No ☐ Yes ☐	Specify
Kidney condition?	No ☐ Yes ☐	What type?
Hepatitis or liver condition?	No ☐ Yes ☐	What type?
Arthritis?	No ☐ Yes ☐	What type
Is there a condition that runs in the family? (eg Thalassemia, Muscular Dystrophy)	No ☐ Yes ☐	What type
Have you ever had previous surgery?	No ☐ Yes ☐	Please list operation, hospital and year.
Have you been isolated in hospital because of infection?	No ☐ Yes ☐	Details
Have you seen any other Specialist in the past 2 years?	No ☐ Yes ☐	Please list names and phone numbers
Could you be pregnant?	No ☐ Yes ☐	
Do you have any speech, hearing, vision or swallowing problems?	No ☐ Yes ☐	Please specify?
Are you on a special diet? (eg low fat, diabetic, allergy)	No ☐ Yes ☐	Please specify?
Do you smoke?	No ☐ Yes ☐	How many per day?
Are you an ex smoker?	No ☐ Yes ☐	How many per day? For how many years?
Do you drink alcohol?	No ☐ Yes ☐	How much per week?
Do you take recreational drugs?	No ☐ Yes ☐	Please specify?
Do you receive Community Service? Eg Home Care, Meals on Wheels, other?	No ☐ Yes ☐	
Do you expect any difficulties looking after yourself at home following discharge from hospital?	No ☐ Yes ☐	
Do you have someone who can help you at home when you are discharged from hospital?	No ☐ Yes ☐	
Do you have a carer?	No ☐ Yes ☐	
Are you the main carer for another person? *A carer is anyone who gives regular unpaid assistance to ie husband, wife, child, and friend, neighbour to enable them to stay at home.*	No ☐ Yes ☐	Will you have difficulty arranging alternative care for this person while you are in hospital or during recovery?
Do you require an aid for walking?	No ☐ Yes ☐	
Do you have someone to collect you from the hospital? *The hospital can not provide transport home.* ***Morning discharges should be by 10am***	No ☐ Yes ☐	
Are you available at short notice for admission to hospital (48 hours)?	No ☐ Yes ☐	
Any other health issues you wish to mention?	No ☐ Yes ☐	Please list

Who has filled out this questionnaire? ☐ Patient ☐ Other..... (Relationship).....

PATIENT SECTION

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

SCREENER FORM

(To be completed by Hospital Staff Only)

PRE-OPERATIVE ASSESSMENT

SCREENER

Patient needs Anaesthetic Assessment

☐ No Assessment Required

☐ Assessment Req'd (due to) ☐ Procedure Type

☐ Other .....

☐ Referred to Anaesthetist *(see comments section)*

Category 'A' ☐ No ☐ Yes

Category 'B' ☐ No ☐ Yes

BMI

Coding – CCH: ☐ PAC ☐ NNTA ☐ GP ☐ Anaesthetic Clinic

Patient Referred to *(Please document the Reason/Action and Outcome)*

☐ Dietitian	☐ Diabetes Educator
Special Diet Required: ☐ No ☐ Yes If Yes, what type:	
☐ Physiotherapist	☐ Orthopaedic Education Session
☐ Occupational Therapist	☐ Pathology
☐ Community Nurse	☐ Radiology
☐ Infection Control	☐ ECG
☐ Social Worker	☐ Spirometry
☐ Speech Pathologist	☐ Breast CNC
☐ Stomal Therapist	☐ Transport
☐ Discharge Planner	☐ CNC Cancer Services
☐ Acute/Post Acute Care (APAC)	☐ Pharmacist
☐ Other (Please State)	

Medications ☐ No ☐ Yes

Do these medications require pre-operative intervention?

☐ No

☐ Yes *(Please State)*: .....

Comment Section:

.....

.....

.....

.....

.....

.....

Patient Deferred *(Reason)*: .....

Medication Information Given: .....

Reason for further PAC: .....

.....

.....

Screener's Signature ..... Date: ..... / ..... / 20.....

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Surname: .....

Given Names: .....

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

(Please hand write patient information)

BOOKING CLERK FORM

(To be completed by Hospital Staff Only)

Date Received: ..... / ..... / 20..... Clerk's Name: ..... RFA Complete: ☐ Yes ☐ No

Complete: .....

.....

.....

Incomplete RFA returned to Specialist/Registrar	Date:	Clerk:
Completed RFA received:	Date:	Clerk:
Booking entered on Patient Administration system	Date:	Clerk:
Patient contacted/instructions given	Date:	Clerk:

This section is to be utilised to document all contact with the Patient, AMO, Rooms, Clinic, Ward etc after the booking has been entered into the Patient Administration System. EG delays, cancellations, date of patient contact/instructions, patient requests etc.

Date	Clerk	Comments

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

RFA Package Hospital Delivery Options

POST OR HAND DELIVER TO:

The Royal North Shore Hospital:
Office Fax: (02) 9906 5142

Integrated Booking Unit
Level 3
Royal North Shore Hospital
Pacific Highway
St Leonards NSW

Hornsby Hospital:
Office Fax (02) 9477 9808
Phone: (02) 9477 9346

Admissions Office
Hornsby Hospital
Palmerston Rd
Hornsby NSW 2077

Gosford Hospital:
Office Fax (02) 4320 2783
Phone (02) 4320 5674

Integrated Booking Unit
Gosford Hospital
PO Box 361
Gosford NSW 2250

Manly Hospital:
Office Fax: (02)9976 9594
Phone: (02) 9976 9538

Admissions Office
Manly Hospital
150 Darley Rd
Manly NSW 1655

Mona Vale Hospital:
Office Fax: (02) 9998 0511
Phone: (02) 9998 0467

Admissions Office
Mona Vale Hospital
Coronation St
Mona Vale NSW 2103

Ryde Hospital:
Office Fax: (02) 9858 7718
Phone: (02) 9858 7888

Admissions Office
Ryde Hospital
Denistone Road
Eastwood NSW 2122

Wyong Hospital:
Office Fax: (02) 4394 4805
Phone: (02) 4394 4953

Integrated Booking Unit
Wyong Hospital
PO Box 4200
Lake Haven NSW 2263