Norwest
PRIVATE HOSPITAL

Admission Forms

In order to confirm your admission it is essential that the hospital receives these forms as soon as possible following your visit to the doctor.

Please take the time to read and fill out the relevant documents carefully.

Healthscope
Valuing Relationships

Norwest Private Hospital

Contact

Postal Address: Locked Mail Bag 5000, Baulkham Hills BC NSW 2153;
11 Norbrik Drive, Bella Vista NSW 2153

Telephone 02 8882 8882
Facsimile 02 8882 8883

Admission Office (Bookings) 02 8882 8804 (Monday to Friday) 8.30am - 5.00pm
Maternity (Bookings) 02 8882 8584 (Monday to Friday) 10.00am - 11.00am

Admission Information

On the week day prior to your admission (Monday to Friday),
please call our pre-admission office on 02 8882 8804 or 02 8882 8805
between 2.00pm and 4.30pm to obtain your admission and fasting details

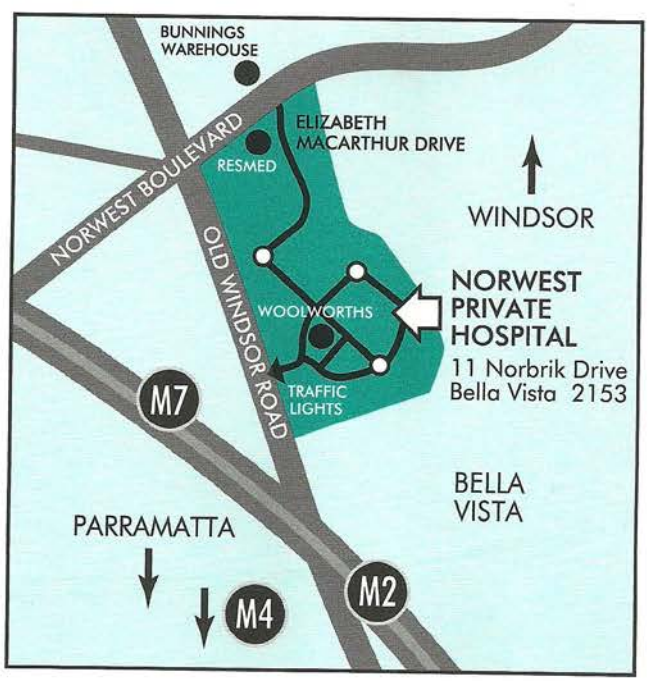
Visiting Hours

(Women's Health) 3.00pm - 4.30pm, 6.30pm - 8.00pm
(General Medical & Surgical) 10.00am - 12.30pm, 2.30pm - 8.00pm
(Day Surgery Unit) No visitor access

Discharge Information

Discharge time is 9.00am sharp (excluding Day Procedures)

Norwest Private Hospital: 11 Norbrik Drive, Bella Vista NSW 2153



Norwest Private Hospital

Patient Information

Welcome and thank you for choosing a Healthscope Hospital. We hope that your stay with us will be as comfortable and pleasant as possible.

Pre-Admission Information

Pre-admission is an important part of your hospital care. To ensure we can confirm your admission, financial and other arrangements, **we ask that you:**

- **Ask your Doctor to complete the Doctor's Referral / Consent form.**
- **Complete the Pre-Admission and Patient History forms**
- Remove the completed forms from the booklet and **forward immediately** to the hospital in one of the following ways.
  - ✔ **In person to Reception**

    11 Norbrik Drive, Bella Vista NSW 2153
    (Open 6.00am - 8.30pm Monday to Friday)
    (Open 8am - 8pm Saturday to Sunday)
  - ✔ **Fax (02) 8882 8883**

    Please remember to bring the original forms on the day of admission.
  - ✔ **Post**

    Locked Mail Bag 5000, Baulkham Hills NSW 2153
    11 Norbrik Drive, Bella Vista NSW 2153 at least 7 days before admission.
  - ✔ **Email**

    Download your admission forms from our website: www.healthscopehospitals.com.au Follow the links to Norwest Private Hospital, click on 'NSW', 'Norwest Private Hospital' then click on the 'Patients' tab at the top. Once printed, email your completed admission forms to AdmissionNorwest@healthscope.com.au Please remember to bring the original forms on the day of admission.
- Please ensure that you bring the following documentation either when you bring your forms to the Hospital or on the day of admission:
  - ✔ Health fund book and/or card
  - ✔ Medicare card
  - ✔ Pharmaceutical entitlements card
  - ✔ Pension card / Health Care card
  - ✔ Repatriation / Veterans' Affairs card
- If your account is subject to **Work Cover** or a **Third Party** claim, forward full details of the claim **including a letter from your insurance company accepting liability for this admission to our pre-admission office.**

Your doctor will notify the Hospital of the date of your procedure / operation and inform you of the day of admission. The doctor will also explain your procedure or operation and complete the consent form with you.

If you have any questions about hospital procedures, completion of forms, cost or health insurance status, our staff will be happy to assist you.

On the day of admission

What to do:

- Bring all medications you are currently taking (make sure that they are in their original containers or box).
- Bring all relevant x-rays.
- Do not eat or drink, chew or smoke anything (including water) from midnight the night before if you are having morning surgery, or from 7am if you are having afternoon surgery.
- Do not wear jewellery other than a wedding band.
- Do not wear make-up or nail polish.
- Shower with an antimicrobial soap (available from your chemist) the day before and the morning of your surgery, paying particular attention to groins and armpits and any skin folds.
- Take any regular medications used to control blood pressure with a sip of water when you regularly take them, regardless of fasting instructions.
- Do not take any tablets used for controlling diabetes. If you normally take insulin, please contact your doctor for specific advice.

If you are having your surgery on the day of your admission, and staying overnight or longer, you will be admitted via the Surgical Admission Centre (excluding obstetric patients). Our admission centre staff will get you ready for your operation and check your medications. We request that you leave all belongings, other than the clothes you are wearing and your medications, with a family member or friend and arrange for them to meet you later with them in the ward.

Day Only patients are also admitted via the surgical admission centre. Please do not bring additional belongings with you, only your relevant paperwork and health fund information, your medications (in the original containers) and x-rays, glasses, hearing aids or other aids, and wear loose fitting, comfortable clothing. There are patient locker facilities in the Day Only area for safe storage of these items. Relatives / friends are welcome to wait in the hospital while Day Only patients have their procedure and recover, however are not permitted into the unit **(with the exception of paediatric patients who may be accompanied by one parent / guardian).**

The admitting nurse will inform you and your relatives of an approximate time for discharge and collection. Please ensure that you have arranged for a responsible adult to collect you on discharge and to care for you for 24 hours after your surgery.

General information

- Norwest Private Hospital is a smoke-free environment
- Parking is available on-site. Charges are detailed at the entrance to the carpark. We have a drop off point at the front of the hospital
- The telephone beside each bed is for local calls only.

Norwest Private Hospital

Patient Information

Accounts / Fees

If you are a member of a health fund it is important prior to your admission to check with them regarding the following:

a) That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation outlined in the Pre-Admission Form. (eg: in the case of post natal patients, is your new born baby covered.)

b) If an excess is payable for this admission. This would need to be paid prior to your procedure.

c) 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 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.

(d) If you are having a surgical procedure, please be aware that you may incur a fee for a Doctor's assistant. If a Career Medical Officer (CMO) is consulted, this will also involve a fee.

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

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.
- Repatriation (DVA) patients - the hospital will lodge a claim on your behalf. Any additional costs incurred during your stay are payable prior to discharge.
- 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 - total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.
- Uninsured 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, bank cheque, most credit cards or eftpos. Check access to these funds prior to the admission date.

Meals

Norwest Private Hospital aims to provide a choice of meals and to supply special diets where it is in the interest of your medical care. Food or alcoholic drinks should not be brought to you by visitors without the permission of your Nurse.

Valuables

It is strongly recommended that you do not bring jewellery or large amounts of money to Hospital as provision for safe custody is limited. However, if it is unavoidable, please arrange with the Nurse to have it put into safe custody. Healthscope does not accept liability for any items brought into the Hospital.

Visiting

- General Wards, High dependency and Post natal: refer to Hospital Admission Information (page 1)
- ICU / CCU - Visiting hours are restricted and limited to immediate family only. Visitors with children should check with the Registered Nurse in charge
- Arrangements for visiting outside of usual visiting hours can be made in consultation with the Nursing staff
- Relatives may stay with critically ill patients for extended periods, as may parents with their children (please notify prior to admission so we can arrange stretcher bed for one parent)
- Day procedure patients - no visitor access
- If you have indicated that you would like a Religious or ESO/ RSL visit, we will make every attempt to facilitate this.

Medical Records and Privacy

Records will be kept of your illness and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law. You are entitled to view your medical record at any time in the company of a clinical staff member.

Healthscope complies with the Privacy Act 1988, and the NSW Health Records and Information Act 2002, including the way we collect, store, use and disclose health information. It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our Hospital (eg. to your health fund, DVA, the supplier / manufacturer of your prosthesis, to our insurer, to an external company contracted by Healthscope to evaluate customer satisfaction). Please indicate to front office staff if you do not wish to have your details provided for the purpose of evaluating customer satisfaction.

Consent to Procedure

As part of our policy, we would like to inform you that your consent may be sought to provide a blood sample should a staff member sustain a body fluid exposure through a needle stick / sharps injury or splash exposure. Please be assured that this is routine in the event that a member of staff sustain exposure to body fluids in the hospital. Consent to this will be sought prior to any tests should it arise. If you have any questions on this matter please ask any member of the nursing staff.

Discharge Information

- **DISCHARGE TIME IS 9am** (Excluding Day Procedure patients who will be informed of their approximate discharge time on admission).
- You must arrange for someone to escort you home
- **You must not drive a car until the day following your operation / procedure or anaesthesia (your motor vehicle insurance may not cover you)**
- Before you leave the hospital, make sure that you or your relatives / friends know how to care for you at 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 the Nursing Staff if you have any concerns, problems or suggestions during your stay.

Norwest PRIVATE HOSPITAL

DOCTOR'S REFERRAL FORM

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

To be completed by Doctor. Please PRINT clearly.

Please Admit

Mr, Ms, Mrs, Miss, Master: ..... Date of Admission: ...../...../.....
Surname Given Names

Address: .....

Telephone: ..... Date of Birth: ...../...../..... Sex: .....
Home Business

Clinical Details

Presenting symptoms: .....

.....

Principal diagnosis, i.e. the condition which best accounts for patient's stay in hospital: .....

.....

Other conditions present: .....

.....

Medications: .....

.....

ALLERGIES: .....

Operation

Proposed operation / treatment: .....

.....

.....

Date of Operation: ...../...../..... **Item Numbers:** .....

Type of anaesthetic: ..... **Expected length of procedure:** .....

Expected length of stay: ❑ Day Only ❑ Overnight or longer ..... day ICU bed required: ❑ Yes ❑ No

Specific pre-operative instructions (including tests required):

❑ Pre-Admission Nursing Assessment

❑ Anaesthetic Consultation

❑ Pathology: .....

❑ Investigations: .....

❑ Drug Orders on Admission (if possible please attach drug chart or detail below): .....

.....

❑ Special Instructions: .....

.....

Obstetric Details

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

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

GP / Other Referring Doctor's Details

Name: ..... Address: .....

DOCTOR'S REFERRAL FORM

Norwest PRIVATE HOSPITAL

CONSENT FORM

REQUEST / CONSENT FORM FOR SURGICAL OPERATION PROCEDURE AND/OR MEDICAL TREATMENT

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Part A: Provision of Information to Patient (To be completed by Medical Practitioner)

I, Doctor .....
(Insert name of medical practitioner)

have informed: .....
(insert name of patient / parent / guardian)

of the nature, likely results, and material risks of the recommended operation / procedure and/or treatment.
The agreed operation / procedure and treatment that the patient is to undergo is:

.....

.....

.....
(Insert name of operation / procedure and/or treatment)

Signature of Medical Practitioner: ..... Date: ...../...../.....

Part B: Patient Consent (To be completed by Patient)

The doctor whose name appears in Part A above and I have discussed my / my child's / my charge's present condition and the various alternative ways in which it might be treated. The doctor has told me that:

- The administration of an anaesthetic, medicines, and/or a blood transfusion may be needed in association with this operation / procedure and/or treatment and these carry some risks.
- Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional operations / procedures and/or treatment being carried out if required as long as they are related to the primary procedure set out in Part A.
- Even though the operation / procedure and/or treatment is carried out with all due professional care, the operation / procedure and/or treatment may not give the expected result.
- The operation / procedure and/or treatment carries some risks and that complications may occur.

I have been given the opportunity to ask questions of the doctor whose name appears above and understand the nature of the procedure / treatment and that undergoing the operation / procedure and/or treatment carries risk.

I have been advised of the material risks associated with this operation / procedure and/or treatment.

I have had the opportunity to ask questions about the operation / procedure and/or treatment and I am satisfied with the answers and information I have received.

I understand that I may withdraw my consent at any time prior to the operation / procedure and/or treatment.

I consent / do not consent to a blood transfusion if needed. (circle one)

I request, understand and consent to the operation / procedure and/or treatment as outlined above in Part A

.....	.....
Signature of patient / parent / guardian	Signature of witness to patient's signature
.....	.....
Print name of patient / parent / guardian	Print name of witness
Date: ...../...../.....	Date: ...../...../.....
Address:	Address: .....
.....	.....

Interpreter required

Interpreter required? ❑ Yes ❑ No

I, ..., an accredited interpreter, have accurately interpreted the advice given by the medical practitioner named above to .....

.....	.....
Signature of Medical Practitioner	Signature of Interpreter
Date: ...../...../.....	Date: ...../...../.....

CONSENT FORM

Norwest PRIVATE HOSPITAL

PRE-ADMISSION FORM

To be completed by Patient.
Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Admission Details

Date of Admission: ...../...../..... Date of Operation: ...../...../.....

Due Date (Maternity): ...../...../..... Admission Time: .....

Admitting Doctor: .....

Admission Type:

❑ **Inpatient** ❑ **Day Patient**

❑ **Maternity** ❑ **OutPatient**

Admission Diagnosis / Procedure: .....

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: .....

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 and TSI

Religion: ..... Would you like a religious visit? ❑ No ❑ Yes

Person Responsible For Account

Is the Patient responsible for this account? ❑ Yes (Go to next section) ❑ No (Complete this section)

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

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

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

Person To Contact (Next of Kin)

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

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

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

Second Contact / Power of Attorney: ..... Telephone: .....

GP / Local Doctor

Full name of GP: .....

GP Address: .....

GP Telephone: ..... GP Facsimile: ..... GP email: .....

Preferred Accommodation

Whilst every effort is made to accommodate your request, we cannot always guarantee availability on the day of admission. Overnight and Maternity Patients only - please indicate your preferred accommodation below. Note: Veterans' Affairs, Workcover and Third Party Patients are covered for shared Room Accommodation only - a separate charge may apply for a single room.

❑ Shared Room ❑ Single Room **Please check level of health insurance cover if requesting a single room**

PRE-ADMISSION REGISTRATION FORM

Surname: ..... Given Names: ..... DOB: .....

Previous Hospitalisation

Have you previously been treated at this Hospital or the Hills Private Hospital? ❑ No ❑ Yes Year: .....

Is this admission for a child? ❑ No ❑ Yes

Was the child born at this Hospital? ❑ No ❑ Yes Mother's Name: .....

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

Which Hospital? ..... Dates: .....

Entitlements

Medicare Card No: |_|_|_|_|_|_|_|_|_|_| Medicare Reference No: ..... Medicare Expiry Date: .....

Pension / Health Care Card No: |_|_|_|_|_|_|_|_|_| Expiry Date: .....

Safety Net No: |_|_|_|_|_|_|_|_|_|

Repatriation No: |_|_|_|_|_|_|_|_|_| Card colour: ❑ White ❑ Gold ❑ Other

Do you wish to be visited by a member of an Ex-Service Organisation? Please indicate:

❑ No ❑ Yes, I will organise it ❑ Yes, please organise it for me

How will this Admission be Claimed (please tick)

❑ Private Health Insurance - Please complete Sections A and C

❑ Repat / Veterans' Affairs - 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: ...../...../.....

Type of cover: ❑ Single ❑ Family ❑ Other Level of cover (if known) .....

Has this level of cover changed in the last 12 months? ❑ No ❑ Yes

Do you have an excess? ❑ No ❑ Yes Amount $ ..... Have you paid an excess this year? ❑ No ❑ Yes Amount $ .....

Section B: Workcover or Third Party

❑ Workcover or ❑ Third Party or ❑ TAC (Please tick one box)

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

Insurance Company Details: Name of Insurance Company: .....

Address Street: .....

.....

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

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

Has your insurance company accepted liability? ❑ Yes ❑ No Please specify reason (if no): .....

Workcover Patients Only - Employer Details: Name of Employer: .....

Address Street: .....

.....

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

Telephone: ..... Date of Accident: ...../...../.....

Has your employer completed a Report of Injury Form?: ❑ Yes ❑ No

Have you completed a Workcover Claim Form?: ❑ Yes ❑ No

Please go to Section C - "Payment of Account"

Section C: 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. Maternity patients pay all extra fees prior to admission. 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: ...../...../.....

Norwest PRIVATE HOSPITAL

PATIENT HISTORY FORM

Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Admission Details

Admission date:

Please specify the reason for your admission

What are the signs / symptoms that lead to this admission?

	No	Yes	Comments or Further Information
Do you require an interpreter?	☐	☐	Language spoken at home
Do you have someone to interpret for you?	☐	☐	Name of Person
Is this admission due to a past or present injury?	☐	☐	Cause of injury: Place (e.g. School, Home) Date / /
Have pathology / blood test / autologous blood been taken for this admission?	☐	☐	Pathologist: Results with:
Have x-rays been taken for this admission?	☐	☐	❑ With patient ❑ With doctor

What is your: Height ..... cms Weight ..... kgs Blood Group (If known) .....

Surname: .....Given Names: .....DOB: .....

Previous Operations / Procedures / Anaesthetic Details

Have you had previous operations? Please list dates and operation performed:

Date / / .....

Date / / .....

Medications

Do you take blood thinning / arthritis medication (Aspirin based / Warfarin)?			Name of Medication:
Have you been instructed to cease this medication?			Date last taken / / or still taking ❑ Yes
Have you taken any steroids or cortisone tablets / injections in the last 6 months?			Name of Medication Date last taken / / or still taking ❑ Yes
Are you taking any other prescription or non-prescription medication? List the medications you currently take (include name of medication). Please bring all medications you are currently taking with you on admission in the original packaging			

Medical History

			Specify Details
Diabetes			Type 1 Type 2 Unsure Managed by Diet Tablets Insulin
Cancer			Site:
Stroke			Date / / Residual problems
Infectious diseases / recent infections			
High blood pressure			
Heart attack / chest pain / angina			Date / /
Cardiac Surgery			
Palpitations / irregular heart beat / heart murmur			
Pacemaker			Make Model last checked / /
Prosthetic heart valve			Type
Rheumatic Fever			
Tendency to bleed / bloodclots / bruise easily			
Arthritis			
Asthma / bronchitis / pneumonia / hayfever			
Liver disease / hepatitis (Specify type A, B or C)			
Kidney/bladder problems			
Hiatus hernia / gastrointestinal ulcers / bowel disorder			
Thyroid problems			
Epilepsy / fits / febrile convulsions			
Depression / dementia / other mental illness			
Migraines			
Recent cold or flu			
Female patients could you be pregnant?			Number of weeks:
Impairment e.g. vision, hearing, mobility, confusion			
Other health problems			

PRE-ADMISSION REGISTRATION FORM

	No	Yes	Specify Details
Have you or anyone in your immediate family ever had a reaction to an anaesthetic?			Details of reaction
Have you ever had a blood transfusion?			Details of any reaction

Prosthesis / Aids / Others

Glasses / Contact Lenses / Eye Problems			
Hearing aid or other hearing appliance			
Body Piercing			
Dentures / Caps / Crowns / Loose Teeth			
Artificial joints or limbs			
Metal plates / pins			

Lifestyle

Have you ever smoked?			Daily amount or date ceased / /
Do you drink alcohol?			Daily amount
Do you use recreational drugs?			Type Daily amount
Do you require a special diet?			Type of diet
Have you a fear of falling or have fallen within the last 12 months?			
Have you experienced fainting or dizziness in the last 12 months?			

Allergies

Do you have any allergies to medications, food, sticky plaster, latex / rubber (e.g. balloons, gloves) or other substances?			Specify Details and Reaction

Creutzfeldt-Jakob Disease (CJD)

	Yes	No
Have you had a dura mater graft prior to 1990?		
Do you have a family history of two or more first degree relatives with classical Creutzfeldt-Jakob (cCJD) disease or other unspecified progressive neurological disorder?		
Have you (the patient) suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?		
Have you received human pituitary hormones prior to 1986?		
Have you been involved in a "Look Back" study for cCJD or are in the possession of a "Medical in Confidence Letter" regarding risk of cCJD?		

STOP Action Required - Hospital Staff

	Date/Time Contacted	Sign
If the patient answers yes to any of the above questions notify: 1. **Theatre Floor Manager (ONLY if surgical patient)** 2. **Infection Control** (ICC onsite or HICMR Ph: 016 301 701) 3. Document in patients notes 4. Enter on RISKMAN		
Infection Control Coordinator informed		
Theatre Floor Manager informed		

Discharge Planning (This information is necessary in order to help you plan a safe return to home after discharge. (ALL patients to complete)

	No	Yes	
Are you over 75 years of age?			
Do you live alone?			
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			
Do you require assistance with any aspect of day to day living?			Details
Do you have multiple health problems?			

Discharge Plan (Patients to complete)

Who will look after you after discharge from hospital?

Name of person ..... Relationship .....

Where do you plan to go after discharge?..... How will you get there? .....

How long do you expect to stay in hospital?.....

Preadmission Nurse.....

Signature Designation Print Initials Date Time (Hrs)

Admission Nurse.....

Signature Designation Print Initials Date Time (Hrs)

I have read and understand the information regarding patient rights & responsibilities including how to make a complaint on page 10 of this booklet.

Signature of Patient..... **Date**.....

Signature of Nurse ..... **Date**.....

Norwest Private Hospital

Understanding your rights and responsibilities

As a patient of Norwest Private Hospital, you have certain responsibilities as a patient and the right to expect a certain standard of healthcare.

Your Rights

You have the right to:

- Considerate and respectful care, regardless of your beliefs and ethnic, cultural and religious practices.
- Know the name of the doctor who has primary responsibility for coordinating your care, and the identity and functions of others who are involved in providing care
- 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
- 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
- Receive from your doctor a description of any 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
- Participate in decisions affecting your healthcare
- Be informed of the estimated costs charged by the hospital
- 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
- Confidentiality and privacy. Details concerning your medical care, including examinations, consultations and treatment are confidential. No information or records 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
- 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
- Not be restrained, except as authorised by your doctor or in an emergency when necessary to protect you or others from injury
- 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.
- Expect safety where practices and environment are concerned
- Privacy for visits during established patient visiting hours
- Make a comment or complaint about the treatment or the quality of the health services or care without fear that you will be discriminated against
- Have your dietary and other special needs considered

Your Responsibilities

You have the responsibility to:

- Provide accurate and complete information about present complaints, past illnesses, hospitalisations, medications and other matters relating to your health
- Report unexpected changes in your condition to the responsible practitioner
- Report if you do not comprehend a contemplated course of action or what is expected of you
- Follow 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 coordinated plan of care and implement the responsible practitioner's orders
- Keep appointments and, when unable to do so for any reason, to notify the responsible practitioner or the health care facility
- Provide information concerning your ability to pay for services
- Accept the consequences of your actions if you refuse treatment or do not follow the practitioner's instructions
- Be considerate of the rights of other patients and health care facility personnel and for assistance in the control of noise, smoking and numbers of visitors
- Be respectful of the property of other persons and of the health care facility
- Behave in a lawful manner and contribute to a safe and comfortable environment

Making a suggestion, compliment or a complaint about your healthcare at Norwest Private Hospital

At Norwest Private Hospital, we value your feedback; any compliments and suggestions that you may have that would assist us in improving our service is greatly appreciated. Please feel free to complete the patient satisfaction survey that is provided on each ward. This may be completed before leaving the hospital and given to reception or you may choose to return it by mail should you prefer.

Any concerns you or your family may have in relation to the care and services provided should be directed to the Nursing Unit Manager in the first instance or in writing to the Director of Nursing.

If you have an unresolved issue, you may wish to refer your concerns to the NSW Healthcare Complaints Commission which is available at:

Health Care Complaints Commission

Level 4, 28-36 Foveaux Street
Surry Hills NSW 2010

Tel:	02 9219 7444
Fax:	02 9219 4585
Toll Free in NSW:	02 9219 7555
Email:	hccc@hccc.nsw.gov.au