Waikiki
Private Hospital

Hospital Address: 221 Willmott Drive, Waikiki WA 6169

Postal Address: PO Box 810, Rockingham WA 6968

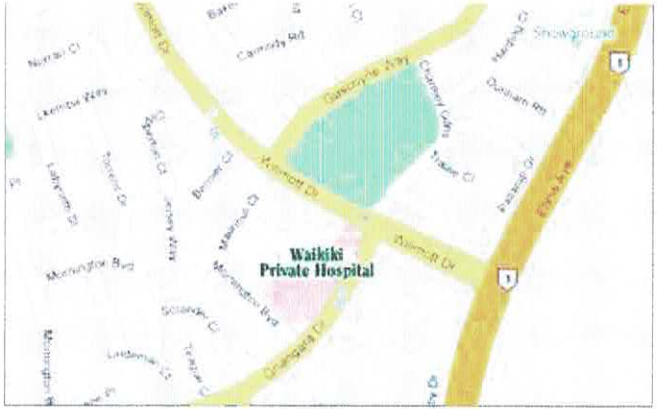
Ph: (08) 9550 0222

Fax: (08) 9592 4187

www.waikikiprivatehospital.com

PATIENT ADMISSION INFORMATION BOOKLET

Please detach and retain the front two sheets for your information.
Complete the remaining two sheets and return to the hospital at least
5 - 7 days prior to your admission date so that we can prepare for your arrival
and provide you with the best treatment.



Last reviewed Sept 2017

ADMISSION INFORMATION – Detach and retain for reference

Please complete the Patient Admission Form, Patient Health Questionnaire and Consent Form and post or fax to the hospital 5-7 days prior to admission.

ADMISSION DATE: **(Admission time to be confirmed the day prior to admission)**

FASTING

Your Anaesthetist may give you specific instructions otherwise **do not eat or drink anything if you are having a general anaesthetic or sedative, for at least 6 hours prior to you procedure.**

Do not eat sweets, chew gum or take sips of water. You may resume eating and drinking post operatively as soon as you are able.

SMOKING

We strongly advise against smoking for at least 24 hours prior to your procedure. In accordance with WA Health Department requirements, smoking is not permitted within the hospital grounds.

ADMISSION

Your doctor will give an arrival time when booking your procedure. The hospital will contact you to confirm your hospital arrival time the day prior to admission. NB: If you develop a cold or an illness prior to admission, please contact your doctor for advice.

On the day of admission:

- **Shower or bathe prior to arrival**
- **Wear comfortable, loose clothing, cotton underwear and socks**
- **Remove any nail polish, make up and jewelery**

What to bring:

- **Health fund membership details**
- **Medicare, pension card, DVA card**
- **Workers' Compensation/Third party claim details**
- **All current medication**
- **Letters or referrals from your doctors**
- **Advanced Healthcare Directive if applicable**
- **Relevant X-Rays**
- **Glasses / contact lenses / hearing aid if applicable**
- **If staying overnight, please bring sleeping attire and personal toiletries**
- **Reading material**

Do not bring any valuables with you as Waikiki Private Hospital does not accept responsibility for lost or stolen items.

PARKING

Free parking is available at the front of the hospital, with disabled parking bays adjacent to the main entrance. An undercover pickup and set down area is located at the main entrance for your convenience.

LENGTH OF STAY

Your doctor will give an indication of your expected length of stay in hospital. If you are staying overnight please bring your night attire and toiletries.

HEALTH FUND COVER

We strongly advise you to contact your health fund prior to admission and provide them with details of your proposed procedure(s) to determine if you will be required to contribute any payment on the day of admission.

HOSPITAL CHARGES

- Includes accommodation and theatre fees (if applicable) and may also include fees for anti-embolism compression stockings (TEDS), dressings, discharge medications, other consumables, surgical implanted prostheses and personal expenses such as visitors meals, mobile STD and International phone calls.
- For privately insured patients, Defence Personnel and DVA Gold card holders the hospital account is sent directly to the health fund or DVA by the hospital on your behalf. Depending on your level of private health insurance cover, you may be required to pay a health fund excess or a fee for other services that are restricted/excluded from your cover.
- Workers' Compensation claims, Defence Personnel and DVA White card holders require approval from the insurer prior to admission. The hospital account will be sent directly to the insurer, Department of Defence or DVA on your behalf.
- Uninsured patients are required to pay the total estimated hospital fee on admission.
- The hospital accepts cash and Eftpos payments, bank cheque and major credit cards. Amex, Diners cards and personal cheques are not accepted.

OTHER CHARGES

In addition to the hospital charge, you mare receive accounts from the following service providers.

- Doctor
- Laboratory
- Allied Health Professional
- Anaesthetist
- Medical Imaging
- Pharmacy

Please note that Medicare benefits are not payable for Private Hospital charges, you may however be able to claim for charges you receive from other service providers (such as those listed above). For further information please contact the relevant provider.

DISCHARGE / DRIVING

Discharge instructions will be provided to assist you with care of your condition at home. Patients are advised to not drive a vehicle for at least 24 hours following a general anaesthetic or intravenous sedation. For patients having a day only procedure performed under:

(1) Local Anaesthetic (LA)

- There may be occasion where a small resting period is required prior to discharge, otherwise discharge may be directly from theatre or the procedure room.
- If appropriate, you may drive to and from the hospital and be discharge unaccompanied. Your doctor will advise you if your procedure will be performed under LA.

(2) General Anaesthetic (GA) or Intravenous Sedation (IVS)

- Discharge on the day of surgery may occur once discharge criteria has been met.
- You must be accompanied by a responsible adult on discharge.
- Please arrange for a responsible adult to collect you from hospital. Nursing staff are required to discharge you directly into their care.
- Hospital policy does not permit patients to be discharged unaccompanied.
- Do not drive a vehicle for 24 hours.

Patients who have had an overnight admission:

- If your doctor has cleared you for discharge we require you to vacate the room by 10am in order to prepare for incoming patient admissions. A patient lounge area is available for patients who are waiting to be collected.
- Driving is not permitted if you have had a GA within the previous 24 hours or in accordance with doctors' instructions and management of your condition.
- Please arrange for a responsible adult to collect you from hospital. Nursing staff are required to discharge you directly into their care.

Waikiki
Private Hospital

YOUR PRIVACY AS A PATIENT AT WAIKIKI PRIVATE HOSPITAL

The Privacy Act
Waikiki Private Hospital respects and upholds your rights to privacy protection according to the Australian Privacy Principles contained in the Privacy Amendment (Enhancing Privacy Protection) Act 2012. The Australian Privacy Principles apply from their introduction on 12th March 2014. Further details regarding Waikiki Private Hospital's personal information management practices are available on request.

Collection of Personal Information
Waikiki Private Hospital collects your personal information and in particular your health information to provide you with a quality health service. The information will normally be collected directly from you, but in an emergency situation, when we are unable to obtain your prior consent, we may need to collect personal information from relatives or other sources.

Use of Personal Information
Your health information is used by the hospital to provide you with treatment and care, to recover costs from Health Funds and other Insurance Agencies as applicable and may be used in quality improvement and clinical audit and evaluation activities, for management, service monitoring, training and education, complaint handling and accreditation activities.

Disclosure of Personal Information
Waikiki Private Hospital is required by law to provide the Government of WA, Department of Health and your Health Fund with identified data for each in-patient episode of care and the Australian Government, Department of Health and Ageing with de-identified in-patient episode data. Waikiki Private Hospital may disclose personal information when it is required or authorised by or under an Australian law or a court/tribunal order or if the information is reasonably necessary for enforcement related activities conducted by, or on behalf of, an enforcement body. Waikiki Private Hospital will not disclose personal information without patient consent except on a confidential basis to agents that are used in the ordinary operation of its business.

Access to your Records
You may obtain access to your own medical records by completing a 'Request to Access Personal Information' form. We will provide you with a suitable range of choices as to how you may access your record. We may impose a charge for processing your request. Your request will be dealt with within 30 days of receipt.

Correcting your Records
If you believe that the personal information we hold about you is incorrect, incomplete or inaccurate, then you may request amendment of it by completing a 'Request to Amend Personal Information' form and this will be added to your medical record.

Withholding Sensitive Information
Under the Act you may withhold sensitive information. Depending of the circumstance and the extent to which sensitive information is withheld, Waikiki Private Hospital may decide not to admit or treat you, where it considers the information provided is not comprehensive enough to provide a quality health service.

Privacy Questions/Complaints
Any questions about our personal information handling practices or any complaint regarding treatment of your privacy by Waikiki Private Hospital can be made in writing addressed to:
Health Information Manager, Waikiki Private Hospital, 221 Willmott Drive, Waikiki WA 6169
Ph: (08) 9550 0222
F: (08) 9592 4187

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

AUSTRALIANCOMMISSIONON
SAFETYANDQUALITYINHEALTHCARE

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.

Return completed form to the hospital 5-7 days prior to admission

Waikiki
Private Hospital

PATIENT ADMISSION FORM

To facilitate an efficient admission process it is important that you complete this form and return it to the hospital prior to admission - 221 Willmott Drive, Waikiki WA 6169 - Fax: 9592 4187 Email: admin1@waikikiprivatehospital.com

SECTION A THIS SECTION TO BE COMPLETED BY DOCTOR

DOCTOR'S NAME: TELEPHONE NO:

ADMISSION DATE: / / TIME: Admission Type: (please tick) ☐ LA Day Case ☐ DAY CASE ☐ OVERNIGHT PATIENT

ADMISSION DIAGNOSIS:

PROCEDURE: PROCEDURE DATE: / /

CMBS ITEM No's.:

ANAESTHETIC: ☐ GENERAL/REGIONAL ☐ SEDATION ☐ LOCAL

SECTION B THIS SECTION TO BE COMPLETED BY PATIENT

PATIENT DETAILS:

Mr
Mrs (Patient's Surname)
Miss
Ms (Given Name(s))

Date of Birth: Age: Gender:

Marital Status: Married ☐ Defacto ☐ Widow ☐ Single ☐ Separated ☐ Divorced ☐

Postal/Residential Address:

Postcode:

Phone: (H) (W)

(Mobile)

Employment Status: Employed ☐ Unemployed ☐ Student ☐ Home Duties ☐ Retired ☐ Child not at school ☐ Pensioner ☐ Other: ☐

Country/State of Birth:

Prefered Language: English ☐ Other

Are you of Torres Strait Islander descent? Yes ☐ No ☐

Are you of Aboriginal descent? Yes ☐ No ☐

NEXT OF KIN, FRIEND OR GUARDIAN:

Relationship to patient:

Name:

Address:

Postcode:

Phone: (H) (W)

(Mobile)

IMPORTANT:

Have you previously been admitted to Waikiki Private, Coastal Private or Rockingham Family Hospital? Yes ☐ No ☐

If yes, during which year?

Please state surname at previous admission if different from above.

REGULAR GP:

ADDRESS:

TELEPHONE NO:

MEDICARE NUMBER:

Medicare Card Position No: **Expiry Date:**
(Please bring all relevant cards to hospital)

HEALTH INSURANCE DETAILS:

Fund Name:

Membership No:

Have you joined your private health fund within the last 12 months? Yes ☐ No ☐

Name of Person Responsible for Account (where different from patient):

Relationship to Patient:

Address:

Phone No:

DEPARTMENT OF VETERANS' AFFAIRS DETAILS:

DVA File No:

DVA Card Colour: Gold ☐ White ☐

DEPARTMENT OF DEFENCE DETAILS:

Defence Service No:

Barracks:

ADMISSION FOR: ☐ Workers Compensation ☐ MVIT
(please tick)

Date of Accident:

State where accident occurred (e.g. WA, QLD):

Claim Number:

Employers Name:

Address:

Phone No:

Insurance Co:

Phone No: **Fax No:**

ACCOMMODATION PREFERENCE:

Private Room ☐ Shared Room ☐

Whilst every effort will be made to provide the accommodation requested, room allocation will depend upon room availability on the day of admission.

Have you been a patient or worked in a health care facility OUTSIDE WA in the past twelve months?

Yes ☐ If yes, which hospital?

No ☐

PATIENT PRE-ADMISSION FORM

MR05

PAF:0917

Waikiki Private Hospital

SURNAME	UMRN
GIVEN NAMES	
D.O.B	GENDER
DOCTORS NAME	
ATTACH PATIENT ID LABEL	

PATIENT HEALTH QUESTIONNAIRE

PATIENT / GUARDIAN TO COMPLETE ALL SECTIONS BELOW

MEDICAL CONDITIONS - (Have you ever had or do you currently have any of the following conditions, please tick all relevant boxes)

☐ Nil Medical Conditions

☐ Diabetes: ☐ Diet Controlled ☐ Tablets ☐ Insulin Normal BSL Range.....mmols

☐ High Blood Pressure
☐ Heart Attack / Angina
☐ Pacemaker
☐ Congestive Heart Failure
☐ Rheumatic Fever
☐ Respiratory Disease
☐ Asthma

☐ Emphysema / Airway disease
☐ History of smoking
☐ Current smoker: ..... a day
☐ Currently pregnant

☐ Stroke
☐ Blood disorder / clots
Specify: .....
☐ Von Willebrands Disease
☐ Warfarin Therapy
☐ Kidney Disease
☐ Urinary / bowel problems

Specify: .....
☐ Thyroid problems
☐ Arthritis
☐ Epilepsy

☐ Human Growth Hormone Supplement
☐ Depression / anxiety
☐ History of confusion/dementia
☐ Sleep Apnoea
☐ Malignant Hyperthermia
☐ Alcohol intake: ..... a day
☐ History of multi-drug resistant organisms (MRSA, VRE, CRE)
☐ Skin Abnormalities
Specify: .....
☐ History of Fall in last 12 months
☐ Require Glasses / Hearing Aid

Current weight: ..... Height: ..... If your weight is greater than 150kg and/or your Body Mass Index (BMI) is greater than 45, admission not accepted at Waikiki Private Hospital.

Other relevant problems.....

.....

Special dietary requirements.....

Mobility difficulties: ☐ Immobile ☐ Wheelchair ☐ Require aids

.....

Have you ever suffered with complications relating to an Anaesthetic: ☐ No ☐ Yes

If yes, please specify:.....

CURRENT MEDICATIONS

(please list and bring with you on the day of admission) ☐ Nil

.....

.....

.....

.....

.....

ALLERGIES

Please tick and specify allergic reaction: ☐ Nil

☐ Medications .....

☐ Latex .....

☐ Sticking Plaster / Tapes .....

☐ Dyes / Lotions .....

☐ Foods .....

DECLARATION

I hereby: (Please tick)

☐ acknowledge having read and understood Waikiki Private Hospital's patient information handling practices as detailed in this Patient Admission Information booklet and consent to the collection, use and disclosure of my personal information in accordance with the Privacy Act.

☐ agree to other health professionals involved in my care, outside the vicinity of this hospital accessing information from my medical record.

☐ acknowledge having read and understood the admission information as detailed in this booklet including fees and rights and responsibilities.

☐ authorise Waikiki Private Hospital to act as my agent for the purposes of claiming pharmaceutical benefits for the period of my hospitalisation.

☐ acknowledge that my Doctor has advised me about any prostheses or medical devices planned to be used in my procedure and whether I will have to pay the gap, the likely amount of the gap and the availability of gap free alternatives and understand that the hospital will charge me for any protheses gap payment required and that I will be liable to pay the charge.

☐ authorise a follow-up phone call to be made by Nursing staff to myself post discharge.

☐ accept full responsibility for accounts rendered by Waikiki Private Hospital, including any shortfall in reimbursement by my Health Fund or other insurer following settlement.

☐ acknowledge having the financial cost of my hospitalisation explained to me and understand that total costs quoted in advance are an estimate only.

☐ declare the information provided by me in this form to be true and correct.

Patient /Guardian Signature: _____ Date: _____

Waikiki Private Hospital

PATIENT CONSENT TO TREATMENT OR INVESTIGATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	GENDER
DOCTORS NAME	
ATTACH PATIENT ID LABEL	

Please read the information below carefully and tick each item to indicate you have understood and agree with the information provided to you by your doctor. Any specific concerns should be discussed with your doctor or proceduralist prior to signing at the end of the page and overleaf. Please note, a 'No' response may prevent you from being admitted to hospital.

a) ☐ Yes ☐ No	The doctor has explained my medical condition and prognosis to me. The doctor has also explained the relevant diagnostic treatment options that are available to me and their associated risks, including the risk of not having the procedure.
b) ☐ Yes ☐ No	The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
c) ☐ Yes ☐ No	I understand that the result/outcome of the treatment/procedure cannot be guaranteed.
d) ☐ Yes ☐ No	I agree that tissue samples and blood removed as part of the procedure or treatment can be used for diagnosis and audit, stored or disposed of sensitively by the hospital.
e) ☐ Yes ☐ No	I consent to undergo the procedure/s or treatment/s as documented on this form.
f) ☐ Yes ☐ No	I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
g) ☐ Yes ☐ No	I agree for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit. When reporting all information will be de-identified.
h) ☐ Yes ☐ No	I understand that if immediate life-threatening events happen during the procedure, I will be treated according to established medical procedure.
i) ☐ Yes ☐ No	I acknowledge that visitors such as students and representatives of manufacturers of medical equipment and surveyors from accrediting bodies may be in the theatre during my procedure and I consent to their being present.
j) ☐ Yes ☐ No	If a staff member is exposed to my blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested.
k) ☐ Yes ☐ No	I consent to a blood transfusion, if needed.
Patient's Full Name:	_____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PCT:0917

PATIENT CONSENT TO TREATMENT OR INVESTIGATION MR01B

Waikiki Private Hospital

SURNAME	UMRN
GIVEN NAMES	
D.O.B	GENDER
DOCTORS NAME	
ATTACH PATIENT ID LABEL	

PATIENT CONSENT TO TREATMENT OR INVESTIGATION

I,_____ Date of birth: _____
(Name)

Consent to the procedure of _____
(No abbreviations, please print)

_____

Being performed on _____
(If not self state patient's name and relationship)

_____

The nature and purpose of which has been explained to me by _____

_____
(Medical Practitioner)

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure:

- ☐ I have informed the patient of the treatment options available, and likely outcomes of each treatment option, including known benefits and possible complications.
- ☐ I have recommended the treatment/procedures/investigations noted above on this form.
- ☐ I have explained the treatment/procedures/investigations, identified above, and what it entails to the patient.

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are documented below.

Special instructions on admission

Signature of doctor/proceduralist obtaining consent

Full Name (please print): _____

Signature: _____ **Date:** _____

Consent checked and correct on day of procedure

Signature: _____ **Date:** _____