Pre Admission Booklet

Thank you for choosing The San Day Surgery Hornsby for your care.

Please carefully read this booklet and retain for your information.

PATIENT TO COMPLETE THESE FORMS
- Admission Form (1 page double sided)
- Patient History Form (1 page double sided)

DOCTOR TO COMPLETE THESE FORMS
- Hospital Booking Letter (1 page double sided)
- Consent to Medical/Surgical Treatment (1 page single sided)

PLEASE PRINT CLEARLY ON ALL FORMS.

PLEASE RETURN THESE FORMS AS SOON AS POSSIBLE

It is important that the completed forms are received by the Day Surgery (SDSH)

- At least 3 working days prior to admission

If faxed or emailed:

- Bring originals on the day of your admission

Completed forms may be forwarded to SDSH by mail, fax, email or hand delivered.

THE SAN DAY SURGERY HORNSBY
1a Northcote Road
Hornsby, NSW 2077

General enquiries: (02) 9476 2900
Patient Admission Fax: (02) 9476 2921
Email: info@sandaysurgery.com.au
Website: www.sandaysurgery.com.au
WELCOME TO SAN DAY SURGERY HORNSBY

Welcome to the San Day Surgery Hornsby, a division of Sydney Adventist Hospital Limited. Thank you for choosing us for your surgical needs. We are committed to providing the highest standard of health care in an environment designed to help you feel at ease. The information contained in this booklet will ensure that your stay with us proceeds as smoothly as possible.

The San Day Surgery Hornsby opened in 1986 and was the first private, freestanding and licensed Day Surgery in New South Wales. We believe that day surgery is the most cost effective and efficient way of performing many investigative and surgical procedures. The advent of less invasive surgery, as well as advances in anaesthetics and modern technology, has contributed to the increase in procedures performed on a day-only basis.

OUR GOAL

At the San Day Surgery Hornsby we are committed to helping promote your health and recovery by the best available means. Our philosophy seeks to affirm the uniqueness of the individual by looking at the integrated physical, mental, spiritual and social dimensions of each person.

CENTRE OF EXCELLENCE

The San Day Surgery Hornsby boasts a team of skilled medical professionals dedicated to providing the highest standard of care and a positive outcome for patients. Our facility has two fully equipped theatres with the latest technology, as well as a procedure room for minor surgical procedures.

Our facility offers surgical services for both children and adults and we were the first day surgery in Australia to be granted an Extended Recovery Care License by the NSW Department of Health (DOH). This means that patients who have undergone more advanced surgery can stay overnight for post-operative care.

OUR QUALITY STATEMENT

Our Mission is:

CHRISTIANITY IN ACTION

Caring for the body, mind and spirit of our patients, colleagues, community and ourselves.

We will remain our community’s favourite private hospital.
BEFORE COMING TO HOSPITAL

We ask that you read the following information carefully and comply with all requests:

- Please ensure the Consent/Referral and Patient History forms are completed and forwarded to us by hand, post or fax at least 3 working days prior to admission. If faxed, please bring the originals with you on the day.
- If your admission has been arranged at short notice, contact us to provide admission details. Bring the completed forms with you on the day of surgery.
- Our staff will contact you between 3pm and 6pm on the working day prior to surgery to provide your admission details.

MORE ABOUT YOUR FORMS

To assist with the completion of your forms, please find below a list of definitions of terms.

DEFINITIONS

- An Enduring Guardian can make personal decisions on your behalf, such as where you should live, medical treatment and services you should receive.

- A Power of Attorney can make financial decisions on your behalf, for example disposing of assets or operating your bank account.

- An Advance Care Directive refers to written instructions that relate to the provision of health care when a person is unable to make their wishes known. It is sometimes called a ‘living will’.

Please send a copy of your Advance Care Directive with your forms if you have one.

PREPARING FOR YOUR PROCEDURE

FASTING

- You should not eat for at least 6 hours prior to your admission, unless your doctor has indicated otherwise. Sips of water are permitted up to 2 hours before your admission.
- You may clean your teeth.
- If you are having assisted local anaesthetic e.g. Cataract Surgery, you will also need to fast as outlined above.
- Fasting requirements do not apply if you are having local anaesthetic. You may have an early, light meal.

MEDICATION

You should continue to take regular medication with a minimal amount of water unless otherwise instructed by your doctor.

ADDITIONAL INFORMATION

- If you have acquired any illness [including colds or chest infections] since consulting with your surgeon, please notify your surgeon prior to your admission.
- You should cease smoking as soon as possible and at least 24 hours prior to your surgery. Smoking can adversely affect your anaesthetic and increases the likelihood of complications.
- Please shower before coming to the San Day Surgery Hornsby and wear loose, simple clothing, which can be changed easily. You should not wear makeup, nail polish, contact lenses or jewellery, although wedding rings are permitted.
- If you require the service of an interpreter, please inform us at least 48 hours prior to surgery.
THE DAY OF YOUR SURGERY

Please arrive on time for your appointment so that we can prepare for your surgery. If you are delayed it is important that you contact us as soon as possible.

Wear loose, comfortable clothing and low-heeled shoes.

WHAT TO BRING

- Your original, signed Consent form (if faxed)
- Your completed Admission/Patient History form (if faxed)
- X-Rays or results of tests relevant to your condition
- Medications you would normally take during the day
- Reading material
- Medicare and Health Fund details (book or card)

OPERATION TIMES

Although we make every effort to keep to scheduled times, please be aware that occasionally unforeseen circumstances can cause changes in surgery times.

PROCEDURE

On arrival, please present at the reception desk where our helpful clerical staff will finalise your details. You will then be taken to the admission area according to the order of the theatre list for the day. A nurse will provide you with a gown to change into and prepare you for surgery. An anaesthetist will also visit you if this is applicable to your procedure.

Your anaesthetist may require you to have some pre-operative medication before you are taken to theatre. This will help you feel more relaxed.

AFTER YOUR PROCEDURE

Operative procedures often involve the use of intravenous fluids and other equipment to monitor your progress. These may still be in place following surgery.

Your progress will be checked regularly by staff who will assist you in making your recovery as comfortable as possible. If you are uncomfortable, in pain or have any problems, don’t hesitate to inform the nursing staff.

Light refreshments will be provided as appropriate to your surgery.

VALUABLES

Please do not bring excessive cash and/or valuables with you. While all care of valuables is taken, the San Day Surgery Hornsby does not accept liability for lost or damaged personal items or valuables.

ALCOHOL & SMOKING

Alcohol should not be consumed prior to surgery as it may interact with some medications. Patients are not permitted to bring alcoholic beverages to the Day Surgery.

The San Day Surgery Hornsby is a non-smoking environment. We ask that you and your visitors respect the health of others and refrain from smoking within our grounds.

AFTER DISCHARGE

GOING HOME

If you are undergoing a procedure that requires general anaesthetic or sedation, you will need someone to drive you home from the San Day Surgery Hornsby and stay with you for 24 hours following the procedure.

POST OPERATIVE CARE

For the first 24 hours following a general anaesthetic or sedation it is important that you:

- Do not drive a car
- Do not drink alcohol
- Do not remain on your own (unless approved by your specialist)
- Do not make complex or legal decisions

Your surgeon may request a follow-up appointment with you. Please contact their rooms 24 to 48 hours after your procedure to arrange this.

If you have concerns and are unable to contact your doctor, telephone our facility on 02 9476 2900. After hours, contact Sydney Adventist Hospital’s Emergency Care on 02 9487 9000 OR Hornsby Ku-Ring-Gai Hospital Emergency Department on 02 9477 9123.
PAEDIATRICS

The San Day Surgery Hornsby is experienced at undertaking Paediatric surgery. We understand that having surgery can be stressful for both parents and children and our aim is to make you feel at ease as much as possible.

CONSENT

- Your consent is required before any treatment for your child can commence. Your written consent needs to be specific and consent forms should only be signed if you feel suitably informed.
  By having your child admitted to our facility you have implied general consent for treatment.
- You may withdraw your consent and refuse further treatment for your child at any time.

A special paediatric orientation is available for children undergoing surgery, to help them prepare for theatre. An appointment can be made on the day of booking.

PRE-OPERATIVELY

- Fasting - children must not eat for 6 hours before their scheduled time of surgery, or as specifically ordered by the surgeon. Sips of water are allowed up to 2 hours before surgery.
- Wherever practical and with the anaesthetist’s approval, parents or guardians are permitted to remain with their child until induction of anaesthesia in the operating room. Post operatively, you can be present as soon as your child’s conscious condition permits.
- If desired, the child may come in their own pyjamas, dressing gown or comfortable clothes on surgery day. It is advisable to bring a spare set of clothes, including underwear.
- Please also bring any additional items for your child - eg. bottle, dummy, nappies, favourite toy or book.

POST-OPERATIVELY

Refreshments will be offered, as appropriate, following your child’s surgery.

LOCAL ANAESTHETIC

Please refer to page 3 regarding completion of the necessary paperwork prior to your admission.

Fasting requirements do not apply if you are having a local anaesthetic. If you are on medication, you should continue to take it with minimal water unless otherwise instructed by your doctor.

You should not wear makeup if you are having surgery to the facial area. Jewellery other than wedding rings should not be worn.

If you require the services of an interpreter, please inform us at least 2 working days prior to admission.

For information on Payments and Health Insurance Funds: See page 6

On the day of surgery, please bring with you:

- Any relevant letters from your doctor
- Original & completed Consent/Referral form, if not already forwarded by your surgeon
- Any original paperwork that has not already been forwarded to us
- Payment if required

OVERNIGHT PATIENTS

If your surgeon deems it necessary for you to stay overnight following your procedure, you are required to bring night attire including dressing gown, slippers, toiletries and any medication usually taken, along with a written schedule from your GP of when it should be taken.

You may have visitors at any time during the afternoon or evening, at the discretion of staff.

Meals are provided for those staying overnight. If you have any special dietary needs, please contact us prior to your admission.
FINANCIAL INFORMATION

SETTLING YOUR ACCOUNT

Your San Day Surgery Hornsby account will include charges for accommodation, theatre fees, surgical supplies and prosthesis, if applicable.

Payment is due at the time of admission. Cash, credit card, cheque or Eftpos are accepted. All cheques should be made payable to:

The San Day Surgery Hornsby
1A Northcote Road
Hornsby 2077

Accounts for your Surgeon and Anaesthetist should be settled with the respective doctor, not the Day Surgery.

If you have Private Health Insurance we will submit a benefits claim form on your behalf using the health fund details on your admission form. The gap between the hospital costs and the fund’s cover is to be paid at the time of admission. The benefits available under private health insurance vary considerably from one fund to another.

Please check with your health fund prior to surgery, the level of cover you can expect and if you are excluded from receiving any benefits.

Provided your admission forms have been received by the Day Surgery prior to your admission you will be advised of any excess payable.

This estimate is a guide only and may vary depending on the treatment you actually receive.

Uninsured patients are required to pay an estimate of the total account at the time of admission and any balance on discharge.

Workers Compensation patients, whose claims have been accepted by the Insurance Company, should contact their surgeon to confirm that their account will be covered on the day. If approval has not been received by the day of surgery the patient will be required to pay the full amount on the day.

Gold Card Veterans Affairs patients do not require approval prior to admission. Prior approval for patients with a white card should be organised through your surgeon.

OUR ASSOCIATION WITH SYDNEY ADVENTIST HOSPITAL

The San Day Surgery Hornsby is a division of Sydney Adventist Hospital Limited known as ‘the San,’ at Wahroonga. We are proud of our association with the San - the largest single campus private Hospital in New South Wales. Sydney Adventist Hospital is a modern, acute care facility with all diagnostic, surgical and therapeutic services conveniently located on-site.

Since its establishment in 1903, Sydney Adventist Hospital has been a not-for-profit institution. This means all profits made by the Hospital go back into the Hospital, ensuring we can continue to provide the best equipment and care.

WELLNESS AND COMMUNITY SERVICES

Today there is a growing awareness of the importance of health. The underlying philosophy of Sydney Adventist Hospital has always been based on the importance of disease prevention and promoting wellness through a balanced approach to health and lifestyle. The San is dedicated to your care during times of illness and good health. We offer a wide range of services aimed at helping members of our community stay healthy and fit, and return to health following illness or surgery. Services include San Nutrition, San Physiotherapy and Hydrotherapy, Fox Valley Medical and Dental Centre, Cardiac Rehabilitation, Cancer Support Centre, Jacaranda Lodge Accommodation, and regular free public forums. For further information see www.sah.org.au or contact Sydney Adventist Hospital’s Marketing & PR department on 02 9487 9871 or comrel@sah.org.au.
### Patient Details

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<tr>
<th>Title</th>
<th>Surname</th>
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<tr>
<th>Date of birth</th>
<th>Unit / Street No. / Street Address</th>
<th>Home Ph</th>
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<th>Mobile Ph</th>
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</table>

### Clinical Details

**Provisional Diagnosis**

**Diabetes**
- [ ] Type 1
- [ ] Type 2
- [ ] Type 2 on insulin

**Diabetic instructions (if applicable)**

**VTE Prophylaxis**
- [ ] Chemical
- [ ] Mechanical
- [ ] Yes
- [ ] No
- [ ] Stockings
- [ ] SCD
- [ ] Yes
- [ ] No

**Co-morbidites (leave blank if 'No')**

**Confirmed MRO**
- [ ] MRSA
- [ ] VRE
- [ ] ESBL
- [ ] MRAb
- [ ] Yes
- [ ] No

**Latex allergy**
- [ ] Yes
- [ ] No

**Weight**
- NB patients > 140kg cannot be admitted:
  - [ ] < 110 kg
  - [ ] 110-140 kg
  - [ ] Weight > 140kg

**Other allergies**

**Other known infectious risk**

### Admission Details

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<tr>
<th>Admission date</th>
<th>Overnight expected #</th>
<th>Overnight booking confirmed</th>
<th>GA</th>
<th>LA</th>
<th>ALA</th>
<th>Topical</th>
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<tr>
<td>2</td>
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<td>2</td>
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**Pre-admission by:**
- [ ] SDSH PAC
- [ ] AMO
- diagnostic results following

### Procedure Details

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<th>Operation / Procedure Date</th>
<th>CMBS Item No.(s)</th>
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**Planned Procedure(s)**

### Equipment Details

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<tr>
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<th>Type</th>
<th>Implanting Device</th>
<th>Company</th>
<th>Contacted</th>
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</table>

**Removing device**
- [ ] Type
- [ ] Company
- [ ] 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 consultation

**Anaesthetist**

**Other instruction notes**

**Pre-operative tests**

<table>
<thead>
<tr>
<th>Please organise the following tests</th>
<th>ECG</th>
<th>Other</th>
</tr>
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</table>

**Required test(s)**

**Could this patient be pregnant?**
- [ ] Yes
- [ ] No

**Consent to Medical / Surgical Treatment completed**

**Specific medication orders at admission (see over)**

**AMO Signature**

**Date**

[MR 1ABS]

### VTE Prophylaxis (Chemical)

<table>
<thead>
<tr>
<th>Date of order</th>
<th>Medication</th>
<th>Strength</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Doctor's Signature</th>
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<tbody>
<tr>
<td>On admission</td>
<td>VTE Prophylaxis</td>
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**Administration**

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<tr>
<th>Medication time</th>
<th>Date</th>
<th>Time</th>
<th>Initial</th>
<th>Date</th>
<th>Time</th>
<th>Initial</th>
</tr>
</thead>
</table>

Attach an additional Hospital Booking Letter if extra space is required for medication.
CONSENT TO MEDICAL OR SURGICAL TREATMENT

I, Dr ................................................................................................................................ have discussed with
........................................................................................................................................... D.O.B ....../......./........
the need for him / her to have the following medical treatment and/or procedure ..........................................
.........................................................................................................................................................................
.........................................................................................................................................................................
.........................................................................................................................................................................
We have discussed what alternatives are available; the nature and risks of this medical treatment and/or procedure; the risk that it may not give the expected result, and the possibility of altered or additional procedures being required. We have also discussed the fact that the medical treatment and/or procedure may involve anaesthetics, medications and/or blood transfusions, blood products and that these also carry risks. On the basis of this understanding, we agree that I perform, and he/she consent to, this medical treatment and/or procedure.

Doctor ............................................................. (Name) ................................................Date......./......./........
(Signature)

Patient ........................................................... (Name) ................................................Date......./......./........
(Signature)

OR

CONSENT BY PERSON RESPONSIBLE TO MEDICAL OR SURGICAL TREATMENT

I, Dr ................................................................................................................................ have discussed with
........................................................................................................................................... the person responsible for
........................................................................................................................................... D.O.B ....../......./........
the need for the latter to have the following medical treatment and/or procedure ..........................................
.........................................................................................................................................................................
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We have discussed what alternatives are available; the nature and risks of this medical treatment and/or procedure; the risk that it may not give the expected result, and the possibility of altered or additional procedures being required. We have also discussed the fact that the medical treatment and/or procedure may involve anaesthetics, medications and/or blood transfusions, blood products and that these also carry risks. On the basis of this understanding, we agree that I perform, and he/she consent to, this medical treatment and/or procedure.

Doctor ............................................................. (Name) ................................................Date......./......./........
(Signature)

Person Responsible ........................................ (Name) ................................................Date......./......./........
(Signature)

Revised SDSH form May10 V1
# ADMISSION FORM

**PATIENT TO COMPLETE BOTH SIDES of this form**

## This Hospital Visit

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Admitting Dr’s Name</th>
<th>Initials</th>
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<tbody>
<tr>
<td>2020</td>
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<table>
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## Personal Details

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<thead>
<tr>
<th>Have you attended this Hospital as a patient before?</th>
<th>No</th>
<th>Yes (under what name)</th>
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<table>
<thead>
<tr>
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<th>Surname</th>
<th>Given Name(s)</th>
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<table>
<thead>
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<th>Preferred Name</th>
<th>Previous Surname (if applicable)</th>
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<th>Gender</th>
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<table>
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<th>Marital Status</th>
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<tr>
<td>Married (including defacto)</td>
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<tr>
<td>Single</td>
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<tr>
<td>Widowed</td>
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<td>Separated</td>
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<td>Divorced</td>
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<table>
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<tr>
<th>Preferred pre-operative contact no.</th>
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<table>
<thead>
<tr>
<th>Postal address same as above</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>If No, postal address</td>
<td>Suburb</td>
<td>P/code</td>
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<tr>
<td>Sydney Contact No.(s) if not from Sydney</td>
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<table>
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<tr>
<th>Country of Birth</th>
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<th>Language spoken at home?</th>
<th>Interpreter Required</th>
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<td></td>
<td></td>
<td>English</td>
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<table>
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<tr>
<th>Indigenous status (please tick at least one box)</th>
<th>Occupation</th>
<th>Religion</th>
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<tbody>
<tr>
<td>Aboriginal</td>
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<tr>
<td>Torres Strait Islander</td>
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<tr>
<td>Neither</td>
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<table>
<thead>
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<th>Usual GP’s name</th>
<th>Address</th>
<th>Phone No.</th>
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<td>Suburb</td>
<td>P/code</td>
<td>Fax No. (if known)</td>
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## Persons to Contact

<table>
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<thead>
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<th>Work Ph</th>
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<table>
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<th>Name of other Emergency contact</th>
<th>Contact Phone No.(s)</th>
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</table>

If you are claiming through the Department of Veteran’s Affairs or Workers’ Compensation please go to next page

Do you have private health insurance? | No | Yes |
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>If yes, please provide details below</td>
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## Private Health Fund

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<th>Client / membership No.</th>
<th>Table / type of cover</th>
<th>Relationship of patient to contributor</th>
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<th>Contributor’s address if different from patient’s personal street address?</th>
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<table>
<thead>
<tr>
<th>Have you been in this fund / table for over 12 months?</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>If No, have you transferred from another fund?</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If Yes, which fund?</td>
<td></td>
</tr>
</tbody>
</table>

---

**Return address:**
San Day Surgery Hornsby
1a Northcote Road
Hornsby 2077

**PATIENT ID label**
MRN .............................................. ACN ..............................................
Surname ............................................................
Given Names ..........................................................
DOB ..............................................................
**ENTITLEMENTS**

<table>
<thead>
<tr>
<th>Medicare Card</th>
<th>Card No</th>
<th>Medicare ID No</th>
<th>Left of name</th>
<th>Expiry ___ <em><strong>/</strong></em> ___</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Card Type</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pensioner Card</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Card</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C’wealth Senior Card</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety Net Card</th>
<th>Safety Net Entitlement</th>
<th>Safety Net Concession</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

*If you have a current Prescription Record Form, please bring this with you to the hospital as you may be eligible for benefits under the Medicare Safety Net Scheme.*

*If you do not intend to claim your hospitalisation costs through the DVA please complete Medicare Entitlement Section above*

<table>
<thead>
<tr>
<th>Veterans’Affairs</th>
<th>Gold</th>
<th>Orange*</th>
<th>DVA No</th>
<th>* (Pharmaceutical benefits only)</th>
<th>Expiry ___ <em><strong>/</strong></em> ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*White cardholders only: Your doctor must obtain approval from the Department of Veterans’ Affairs prior to day of admission*

**WORKERS’ COMPENSATION / PUBLIC LIABILITY / THIRD PARTY PATIENTS ONLY**

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>Workers’ Compensation</th>
<th>Third Party motor vehicle</th>
<th>Public Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/</td>
<td>Name of Insurer at time of accident</td>
<td>Insurer’s Claim No.</td>
<td></td>
</tr>
<tr>
<td>Insurer’s address</td>
<td>P/code</td>
<td>Insurer’s fax no.</td>
<td>Phone No.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WCC Cases only</th>
<th>Name of employer</th>
<th>Contact person</th>
<th>Phone no.</th>
</tr>
</thead>
</table>

**PERSON RESPONSIBLE FOR PAYMENT**

(if other than patient)

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Ph</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Postal address for account (if different to above)</td>
<td>P/Code</td>
<td>Work Ph</td>
</tr>
</tbody>
</table>

**POWER OF ATTORNEY / ENDURING GUARDIAN / ADVANCE CARE DIRECTIVE**

(a copy of these is required if applicable)

<table>
<thead>
<tr>
<th>Do you have an Advance Care Directive?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Enduring Guardian (if one appointed)</td>
<td>Phone No.</td>
<td></td>
</tr>
<tr>
<td>Name of Power of Attorney (if one appointed)</td>
<td>Phone No.</td>
<td></td>
</tr>
</tbody>
</table>

**CONSENT TO USE PERSONAL INFORMATION**

I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the section on the San Day Surgery Hornsby Personal Information & Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital. I understand that my contact details may be given to the Sydney Adventist Hospital Foundation.

I give consent to the use of my personal information as described in this Pre-Admission booklet. I understand that I may withdraw my consent at any time.

**ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES**

I have read and understand the section entitled Patients’ Rights and Responsibilities in this Pre-Admission booklet and will discuss any queries with staff.

**CONFIRMATION OF COMPLETENESS OF FORM**

I certify the information on this form to be true & complete to the best of my knowledge.

**Recent hospital admission**

<table>
<thead>
<tr>
<th>Hospital admission in the last 6 months (including SDSH)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From ............/.........../...............</td>
<td>If SDSH, planned admission</td>
<td></td>
</tr>
<tr>
<td>to ............/.........../................</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Signature**

........................................................................................................... Print Name ........................................................ Date ........./............/...........
# PATIENT HISTORY FORM

**PATIENT TO COMPLETE BOTH SIDES of this form**

<table>
<thead>
<tr>
<th>Planned procedure</th>
<th>Is this admission the result of a past injury?</th>
<th>Specify cause &amp; place</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Y N</td>
</tr>
</tbody>
</table>

- Diabetes
  - Controlled by: □ diet □ tablet □ injection
  - Y N Low blood sugar
  - Thyroid problems

- Bronchitis / asthma / emphysema etc
  - Specify
  - Do you use: □ nebulisers □ puffers □ home oxygen
  - Y N Recent cold
  - Other lung problems
    - Specify

- High blood pressure
  - Y N Chest pain / angina

- Previous deep vein thrombosis / pulmonary embolism / varicose veins
  - Specify

- Artificial implants / devices / grafts
  - Coronary artery bypass
    - Specify
  - Coronary / vascular stent
    - Y N
  - Artificial heart valve
    - Y N
  - Pacemaker
    - Y N

- Gastric ulcer / reflux / hiatus hernia
  - Y N Hepatitis
  - Jaundice
    - Y N Stoma

- Arthritis
  - Y N Hip / knee replacements
    - Specify
  - Back / neck injury or problems
    - Specify

- Fits / fainty / funny turns / epilepsy
  - Y N Speech / swallowing problems

- Stroke / mini stroke / TIA
  - If yes, any residual weakness, please specify
  - Y N Limb paralysis □ right arm □ left arm □ right leg □ left leg

- Previous falls / unsteady on feet
  - Y N Polio / meningitis
    - Specify

- Short term memory loss / dementia
  - Specify

- Kidney trouble / dialysis / renal impairment
  - Y N Bladder problems
    - □ urinary incontinence □ frequency □ urgency □ pain

- Have you ever smoked?
  - Y N If yes, daily amount
    - Date ceased

- Do you presently smoke?
  - Y N If yes, □ per day

- Do you drink alcohol?
  - Y N □ standard drinks per day

- Past history of drug dependency
  - Y N Specify

- Disturbed sleep pattern / sleep apnoea
  - Y N □ CPAP used

- Could you be pregnant?
  - Y N

- Do you have chronic pain?
  - Y N Specify

- Do you have a history of a multi resistant organism? eg. MRSA, VRE other
  - Y N Specify

- eg. Coronary artery bypass, brain, liver or pancreatic surgery, hip replacements
  - Y N Specify

- Problems with anaesthetic eg. nausea, vomiting, malignant hyperthermia
  - Y N If Yes, □ self □ family
    - Specify

- Cancer
  - Date: / / Site:
    - Y N Treatment
      - □ surgery □ chemotherapy □ radiotherapy

- Transplants
  - Y N Specify

- Other
  - Do you have Creutzfeldt-Jakob Disease (CJD)?
    - Y N Specify

  - Have you had Human Pituitary Growth Hormone prior to 1985?
    - Y N Specify

  - Have you had neurosurgery prior to 1985?
    - Y N Specify
### PATIENT HISTORY FORM (continued)

<table>
<thead>
<tr>
<th>Height &amp; weight details</th>
<th>Height [cm]</th>
<th>Weight [kg]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dietary Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a special diet?</td>
<td>☐ No ☐ Yes (specify)</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics / Aids / Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual aids</td>
<td>Y N</td>
<td>☐ Glasses ☐ Contact lenses ☐ Eye prosthesis</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Y N</td>
<td>☐ Left ☐ Right</td>
</tr>
<tr>
<td>Walking aids</td>
<td>Y N</td>
<td>Specify</td>
</tr>
<tr>
<td><strong>Allergies &amp; Sensitivities</strong></td>
<td>Please document any known allergies or sensitivities eg. medications, latex plants, tape</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>Sensitivities</td>
<td>Reaction</td>
</tr>
<tr>
<td>Food allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your current Medications</strong></td>
<td>Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. Consult your GP or surgeon if you are unsure of any details about your medications or which medications should be ceased prior to your surgery. Bring to the hospital all current medication you are taking, in their original individual packaging (ie. not in Webster or Doset packs)</td>
<td></td>
</tr>
<tr>
<td>Prescription Medicine</td>
<td>Strength</td>
<td>Dose &amp; Frequency</td>
</tr>
<tr>
<td>Geranin (example)</td>
<td>100mgs</td>
<td>one tablet twice a day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Prescription Medication</strong></td>
<td>Strength</td>
<td>Dose &amp; Frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discharge Planning &amp; community support</strong></td>
<td>Do you live alone? ☐ Yes ☐ No If not, with whom?</td>
<td></td>
</tr>
<tr>
<td>Who is your main carer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you receive community services? ☐ Yes ☐ No If Yes,</td>
<td>☐ Nurses ☐ Home Care ☐ Meal on Wheels</td>
<td></td>
</tr>
<tr>
<td><strong>Going home</strong></td>
<td>Who will be taking you home and be with you for 24 hours?</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Best contact phone no</td>
<td>Or mobile no.</td>
<td></td>
</tr>
<tr>
<td><strong>SIGNATURE PATIENT / CARER</strong></td>
<td>I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Form completed by:</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Patient ........................................../Sign.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carer ............................................./Sign.</td>
<td></td>
</tr>
</tbody>
</table>

---

**PATIENT HISTORY FORM**

MRN ..............................................................
Surname ...........................................................
Given Names ....................................................
DOB ...............................................................
## PATIENT RIGHTS

<table>
<thead>
<tr>
<th>PATIENT RIGHTS</th>
<th>WHAT THIS MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Care</strong></td>
<td>I will receive treatment appropriate to my health needs. I can request a doctor of my choice, and request a second opinion.</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>I will receive safe and high quality health services provided by professional, caring and competent staff.</td>
</tr>
<tr>
<td><strong>Respect</strong></td>
<td>I will be provided with care that shows respect to me and my culture, beliefs, values and personal characteristics.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>I will receive open, timely and appropriate communication about my health care in a way I can understand. I will be asked to consent to treatment except when circumstances prevent this. I have the right to refuse recommended treatments, refuse experimental treatment, choose which treatments I wish to take, and withdraw consent to treatment at any time.</td>
</tr>
<tr>
<td><strong>Participation</strong></td>
<td>I may join in making decisions and choices about my care and treatment plan.</td>
</tr>
<tr>
<td><strong>Privacy</strong></td>
<td>My personal privacy will be maintained and proper handling of my personal health and other information is assured. I have the right to access information contained in my medical record. While in the centre – contact the Nursing Unit Manager. After discharge – contact the San Day Surgery Director of Clinical Services.</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>I can make positive and negative comments about my care, and have my concerns dealt with properly and promptly.</td>
</tr>
<tr>
<td><strong>Parental Rights</strong></td>
<td>I can choose to stay with my child at all times except when the provision of health care precludes this. I can make decisions regarding consent to treatment of my child if they are under 14 years of age. From the age of 14, children may seek treatment and provide consent or make decisions jointly with their parents or guardian.</td>
</tr>
</tbody>
</table>
# Patient Responsibilities

<table>
<thead>
<tr>
<th>Patient Responsibilities</th>
<th>What This Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety</strong>&lt;br&gt;Tell us of your safety concerns.</td>
<td>You should let staff know if you think something has been missed in your care or that an error might have occurred. You should explain any circumstances that may make your health care riskier or any other safety concerns that you have.</td>
</tr>
<tr>
<td><strong>Respect</strong>&lt;br&gt;Consider the well-being and rights of others.</td>
<td>You should always respect the well-being and rights of other patients, consumers and staff by conducting yourself in an appropriate way. This includes respecting the privacy and confidentiality of others. Patients and their visitors are requested to be respectful to all health care professionals who care for them. Verbal and physical abuse will not be tolerated. You should respect hospital property, policies, regulations and the property of other persons.</td>
</tr>
<tr>
<td><strong>Communication</strong>&lt;br&gt;Provide information regarding your medical history and ask questions.</td>
<td>Be as open and honest with staff as you can, including giving comprehensive &amp; accurate details of your medical history, past surgeries and all medications you may be taking. Ask questions of staff if you would like more information about any aspect of your care.</td>
</tr>
<tr>
<td><strong>Participation</strong>&lt;br&gt;Follow your treatment, cooperate and participate where able.</td>
<td>Where possible you should take an active role in your health care and participate as fully as you wish in the decisions about your care and treatment. Your family can also be actively involved. You should endeavour to follow your treatment, and inform your health provider when you are not complying with your treatment. You should cooperate fully with the doctor and clinical team in all aspects of your treatment. You must let staff know if there are changes to your condition or new symptoms. You should keep appointments or let the health provider know when you are not able to attend.</td>
</tr>
<tr>
<td><strong>Advanced Care Directive / Power of Attorney / Guardianship</strong></td>
<td>Please inform your health professional if you have a current Advance Care Directive or Power of Attorney for any health or personal matters, or if you are subject to a guardianship order.</td>
</tr>
<tr>
<td><strong>Pay Fees</strong></td>
<td>You should promptly pay the fees of the hospital &amp; your attending doctor.</td>
</tr>
<tr>
<td><strong>Complaint / Feedback</strong></td>
<td>You should direct any complaint to a staff member or the Manager so that immediate and appropriate action can be taken to remedy your concern.</td>
</tr>
</tbody>
</table>
**HOW TO MAKE COMPLAINTS OR COMPLIMENTS ABOUT YOUR CARE**

**Compliments**

We welcome your feedback. Feedback forms are available in reception or Discharge Lounge in the Day Surgery. The form can be mailed or faxed (See contact details below).

** Complaints**

You have a right to make comments or complain about your care. The centre welcomes feedback and will appoint an appropriate person to address your concerns.

Your care will not be adversely affected by making a complaint.

**Who to contact regarding concerns**

You should contact the San Day Surgery Director of Clinical Services or person in charge for problems experienced while you are at the centre.

Should you want to speak with someone outside the centre you can also contact the Sydney Adventist Hospital Quality Management Department. (See contact details below).

**Our contact details**

| Address | 1. The San Day Surgery Hornsby  
1A Northcote Road  
Hornsby NSW 2077  
**Phone** (02) 9476 2900  
**Fax** (02) 9476 2921  
**Email** info@sandaysurgery.com.au  
  2. Quality Management Department  
Sydney Adventist Hospital  
185 Fox Valley Road Wahroonga  
NSW 2076  
**Phone** (02) 9487 9744  
**Fax** (02) 9473 8344  
**Email** customerfeedback@sah.org.au |

It is always best to try and resolve your complaint with your health service provider. If you have tried this and are still unsatisfied, you can make a complaint to the Health Care Complaints Commission.


If you would like further information on the Australian Charter of Healthcare Rights (including information provided in different languages), please visit: [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)

If you would like to request access to support services (such as interpreters and support groups), please contact the San Day Surgery Director of Clinical Services or person in charge.
PERSONAL INFORMATION AND PRIVACY FOR PATIENTS

The San Day Surgery Hornsby (SDSH) recognises and respects every patient’s right to privacy. We will collect and use the minimum amount of personal information needed for us to ensure that you receive a high level of health care. SDSH will always endeavour to manage your information to protect your privacy.

Personal information we usually hold:

- Your name, address, telephone and email contact details
- Health fund details
- Date and country of birth
- Next of kin
- Occupation
- Health information
- The name and contact details of your General Practitioner and your referring doctor
- Returned Service information
- Religious beliefs or affiliations (if provided)
- Marital status
- Transaction details associated with our services
- Indigenous status and language spoken at home (for the Department of Health)

What we do with personal information:

1. We will collect it discreetly.
2. We will store it securely.
3. Subject to what we say in this section, we will only provide your personal information to people involved in your care.
4. We will provide relevant information to your health fund, or the Department of Veterans’ Affairs, Medicare Australia, Cancer Council, NSW Department of Health or to other entities when we are required by law to do so.
5. After removing details that could identify you, we may use the remaining information to assist with research and service improvement projects. We are also required to provide this kind of information to government agencies.
6. As SDSH is a division of Sydney Adventist Hospital Limited which is a teaching hospital, we may use personal information in the training and education of medical, nursing and other allied health students.
7. We will destroy our record of your information when it has become too old to be useful or when we are no longer required by law to retain it.
8. We may use the information to contact you. By providing your email address, we assume permission to use this address for administrative communications (for example, receipts) regarding your hospital visit.
9. We may share your contact details with the Sydney Adventist Hospital (SAH) Foundation. The SAH Foundation provides patients with information, newsletters and details about fundraising appeals. The SAH Foundation may use this information to contact you.

SAH NEWSLETTERS AND OTHER MAILED INFORMATION

In the future, SDSH, SAH and/or the SAH Foundation may send you information about our programs, services and activities in the form of newsletters and details about fundraising activities. If you do not wish to receive this information please advise the SDSH Director of Clinical Services in person or by calling (02) 9476 2900. Alternatively you may notify the SAH Privacy Officer on (02) 9487 9220 or via privacy@sah.org.au. The relevant mail outs will cease as soon as possible after your notification.

Your rights

1. You may give consent for us to use your personal information to provide you with health care services, or you may withdraw your consent at any time. If you withdraw consent for SDSH to use your personal information, this may reduce our ability to provide you with services.
2. You may ask us to limit access to your information. You may separately:
   a) Refuse to be seen by a chaplain or representative of your faith while in hospital
   b) Refuse to have your Discharge Summary sent to your General Practitioner or
c) Refuse to receive information about future SDSH or SAH events, services and fundraising appeals by signing the ‘Use of Personal Information’ form available from SDSH reception.

If you have a specific requirement for restricting access by someone to your information, please inform us of this as soon as possible.

3. You may ask us to give you (or another individual) access to your personal information. In most cases we will allow you to have access to your personal information. We may also provide a person to assist you and we may charge a fee for providing printed copies of reports. We may not provide you (or your responsible person) with access to your personal information if a doctor feels that it may be harmful to do so.

4. You may ask us to correct any error in your personal information.

5. You may make a privacy-related complaint if you feel that the Hospital has not kept your information confidential or has not maintained your privacy, by telephoning the SDSH Director of Clinical Services on (02) 9476 2900 or the SAH Privacy Officer on (02) 9487 9220. While you are in the Hospital, please speak with the Director of Clinical Services who will address your concerns. Should you wish to write, please address correspondence to:

   a) The Director of Clinical Services
   The San Day Surgery Hornsby
   1a Northcote Rd
   Hornsby NSW 2077

   or

   b) The Privacy Officer
   Sydney Adventist Hospital
   185 Fox Valley Rd
   Wahroonga NSW 2076

Alternatively you may send an email to:

   privacy@sah.org.au

You may contact the Privacy Commissioner if you are not satisfied that the Hospital has resolved your complaint.

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**TEACHING HOSPITAL**

An important component of Sydney Adventist Hospital’s role in meeting community healthcare needs is the provision of clinical education and placements for medical, nursing and other allied health trainees – which may involve education and placement at SDSH. Participation of trainees may include observation and involvement in your care while under appropriate supervision. You are free to refuse to allow a trainee to participate in your care at any time. Your refusal will not adversely affect the treatment you receive.
GETTING TO SAN DAY SURGERY HORNSBY

• Trains – The San Day Surgery Hornsby is located 2km from Hornsby Railway Station at 1a Northcote Road.

• Bus – A bus service runs regularly from Hornsby Railway Station to Palmerston Road, Hornsby.

• Car – Parking is available on site or on Northcote Road.

OFFICE HOURS
MONDAY TO FRIDAY 8AM – 5PM