

Person completing this form: ..... ADMISSION TYPE:  LA DAY CASE  DAY CASE  OVERNIGHT

Surgeon Name: .....		Admission Date: .....		Admission Time: .....	
Operation/Procedure: .....					
CMBS Item Number: .....				Address: .....	
GP (General Practitioner): Name: .....			Phone: .....		
<b>PERSONAL DETAILS</b>					
Have you been a patient at Bethesda before?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what was your surname then: .....	
Have you been a patient in any hospital in the past 28 days?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, the hospital was: .....	
Title: .....		Patient Surname: .....		Given Name(s): .....	
Preferred Name: .....		Date of Birth: .....		Age: ..... Gender: .....	
Address (Residential): .....			Suburb: .....		Post Code: .....
Address (Postal): Same as Residential: <input type="checkbox"/> Yes <input type="checkbox"/> No			Suburb: .....		Post Code: .....
Phone: Home: .....		Work: .....		Mobile: .....	
Email: .....			Preferred Contact: .....		
Marital Status: <input type="checkbox"/> Married/Defacto <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced					
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Home Duties <input type="checkbox"/> Retired <input type="checkbox"/> Pensioner <input type="checkbox"/> Student					
Country/State of Birth: .....		Ethnicity: .....		Religion: .....	
Language Spoken at Home: .....			Interpreter Services Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>NEXT OF KIN</b>			<b>PERSON TO CONTACT IN AN EMERGENCY</b>		
Relationship to Patient: .....			Next of Kin <input type="checkbox"/> Yes <input type="checkbox"/> No. If not Next of Kin complete below		
Full Name: .....			Full Name: .....		
Same address as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No, if no complete below			Same address as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No, if no complete below		
Address: .....			Address: .....		
After Hours: .....		Mobile: .....		After Hours: .....	
Business Hours: .....		Business Hours: .....			
<b>OVERNIGHT PATIENT'S ROOM PREFERENCE</b>			<input type="checkbox"/> Private Room <input type="checkbox"/> Shared Room		
<b>PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT</b>					
Patient <input type="checkbox"/> Yes <input type="checkbox"/> No. If not Patient, Title: .....		Full Name: .....		Address: .....	
Phone: Home: .....		Work: .....		Mobile: .....	
<b>HEALTH INSURANCE DETAILS</b>					
Medicare No: .....		Patient Position on Card: .....		Expiry Date: .....	
Payment Option: .....		Fund Name: .....		Membership Number: .....	
Table: .....		Do you have an excess? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, \$ .....			
Have you changed your fund/level of cover in the past 12 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Pharmaceutical/Pension Entitlement Number: .....			DVA: File Number: .....		Card Colour: .....
Defence Force (ADF): Service No: .....			Base: .....		
Contact Name: .....			Contact No: .....		
Insurer: <input type="checkbox"/> WC <input type="checkbox"/> MVA		Date of Accident: .....		State Where Accident Occurred: .....	
Claim No: .....		Employer: .....		Employer Address: .....	
Case Manager: .....		Phone: .....		Fax: .....	
Branch: .....					
Procedure approval is required prior to admission. If not received, you may choose to use your private health insurance or to self-fund.					

FOLD & TEAR HERE

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ADMISSION DETAILS MR 4A



**PATIENT ADMISSION  
GENERAL HEALTH HISTORY**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

Do you have an Enduring Power of Attorney/Substitute Decision Maker?  Yes Name: \_\_\_\_\_ Phone: \_\_\_\_\_  No

Do you have an Advanced Health Directive?  Yes (please bring a copy to the hospital with you)  No Nursing Use Only  
Complete MRO Form

**MEDICATION** Please include all medications (patches, ointments, tablets etc.) that you use including over the counter and alternate therapies. Please bring your medication to hospital in its original labeled packaging. We are unable to accept Dosette boxes.

Medication	Frequency	Dose	Medication	Frequency	Dose	Nursing Use Only Patient own stock? <input type="checkbox"/> Pt med drawer <input type="checkbox"/> Schedule 8 + S4R secured <input type="checkbox"/> Sent home	

PRE-PROCEDURE MEDICATION MANAGEMENT	NO	YES	If YES, please complete below:	Nursing Use Only
Have you received advice from your doctor regarding taking/ceasing any medications prior to admission?	<input type="checkbox"/>	<input type="checkbox"/>	Medication to be ceased: _____ Date to be ceased or last taken: _____	
Do you take any anti-coagulant or blood thinning medication? eg: Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaben, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor	<input type="checkbox"/>	<input type="checkbox"/>	If yes has your doctor advised you to cease this medication prior to your surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Which medication: _____ Date to be ceased or last taken: _____	

PROCEDURE/ADMISSION	NO	YES	If YES, please complete below:	Nursing Use Only
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last menstrual period: _____	
Have you had any tests or x-rays taken for this admission?	<input type="checkbox"/>	<input type="checkbox"/>	When: _____ Where: _____ <input type="checkbox"/> With me <input type="checkbox"/> With my doctor	
Blood Test	<input type="checkbox"/>	<input type="checkbox"/>		
MRI, Xray, Scan, Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>		
Have you consulted with a cardiologist or physician recently?	<input type="checkbox"/>	<input type="checkbox"/>	Dr Name: _____ Dr Name: _____	
Cardiologist	<input type="checkbox"/>	<input type="checkbox"/>		
Physician	<input type="checkbox"/>	<input type="checkbox"/>		

PREVIOUS SURGERY/PROCEDURES	NO	YES	If YES, please complete table below:		
Operation	Approx. Year	Operation	Approx. Year	Nursing Use Only	

DO NOT WRITE IN THIS BINDING MARGIN

MR 4B



**PATIENT ADMISSION  
GENERAL HEALTH HISTORY**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

LIFESTYLE	NO	YES	Please complete below:	Nursing Use Only
Do you have a medically required or a preferred diet? e.g. diabetic, coeliac, vegan, vegetarian, lactose intolerant, kosher	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	Daily amt: _____ Ceased: _____	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How many days per week? _____ How many standard drinks per day? _____	
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>		
What is your weight?		kg	<b>For your safety, we are unable to admit patients who weigh &gt;150kg and/or have BMI &gt;45. Please call the hospital on (08) 9340 6300</b>	Check BMI <18 >40
What is your height?		cm		
Have you lost >5kg in weight unintentionally?	<input type="checkbox"/>	<input type="checkbox"/>		MST Screen
<b>PROSTHETICS/AIDS</b> <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section	NO	YES	Please complete below:	Nursing Use Only
Do you use any aids/prosthetics? e.g. aids for vision, hearing, walking, other aids for daily living	<input type="checkbox"/>	<input type="checkbox"/>		If yes to either, complete FRAMP
Have you had a fall in the last 12 months or do you fear falling or feel unsteady on your feet?	<input type="checkbox"/>	<input type="checkbox"/>		

MEDICAL CONDITIONS					
Allergies or adverse reactions	NO	YES	Please complete below:		Nursing Use Only
complete section below, if yes please provide details and dates			Allergy substance:	Reaction:	Alert sticker ePAS entry
Do you have any allergies or sensitivities? e.g. medications, latex, sticking plaster, iodine, x-ray dyes, food (seafood, nuts, fruit, eggs, gluten, food additives such as salicylates, amines) insects such as bees and dust mites	<input type="checkbox"/>	<input type="checkbox"/>			
Have you or a family member:			You	Family Member	
Reacted to anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Had/been tested for malignant hyperthermia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Had post operative nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Cardiovascular</b> Have you ever had any problems with your heart or circulation? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section	NO	YES			Nursing Use Only
High cholesterol, triglycerides	<input type="checkbox"/>	<input type="checkbox"/>			
Blood pressure problems (low or high), requiring treatment or medication	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac conditions eg: heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac irregularities eg: palpitations, irregular heartbeat, heart murmur, atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac surgery eg: pacemaker, implants or devices, prosthetic heart valve, grafts, stents	<input type="checkbox"/>	<input type="checkbox"/>	Year: _____ Model: _____		
Vascular disease eg: carotid disease, aortic aneurysm, peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			

DO NOT WRITE IN THIS BINDING MARGIN

MR 4C



**PATIENT ADMISSION  
GENERAL HEALTH HISTORY**

Surname:		MRN:
Given Names:		
DOB:		Gender:
Address:		

**Please use I.D. or block print**

<b>Diabetes</b> Do you have or have you previously had diabetes? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section			<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>	Controlled by:	
Type 1 diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diet <input type="checkbox"/> Insulin	
Type 2 diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tablets <input type="checkbox"/> Pump	
Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Gastroenterology /Urology</b> Have you ever had any problems with your stomach, bladder or bowel? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section			<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>		
Hiatus hernia, gastrointestinal ulcers, reflux	<input type="checkbox"/>	<input type="checkbox"/>		
Liver disease, hepatitis (eg: A, B, C), jaundice, cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>		
Bowel problems/habits, stoma or bowel disease eg: Crohns, IBS	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney disease, dialysis, renal impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder problems/habits, stoma, incontinence, urinary retention (including post operative)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Falls Risk Screen
Other:	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Blood</b> Have you ever had a blood transfusion or blood condition? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section			<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>		
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Year transfused: _____ Any reaction: _____	
Blood clots in lung or leg (PE/DVT)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> VTE Screen
Blood or bleeding disorders e.g. anaemia	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Cancer</b>			<b>IF YES, Please describe below:</b>	Nursing Use Only
Do you have a history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Body site: _____ Treatment: _____ Date of diagnosis: _____	<input type="checkbox"/> VTE Screen
<b>Musculoskeletal</b> Have you ever had any musculoskeletal conditions? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section			<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>		
Arthritis eg: rheumatoid or osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Back or neck injury/ problems	<input type="checkbox"/>	<input type="checkbox"/>		
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Neurological</b> Have you ever had any neurological conditions? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> NO, go to next section			<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>		
Neuromuscular disease eg: MS, MND, Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Falls Risk Screen
Stroke, mini-stroke, TIA	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Impairment: _____	<input type="checkbox"/> Falls Risk Screen
Limb paralysis or weakness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Falls Risk Screen
Epilepsy/ fits, faints, blackouts, dizziness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Falls Risk Screen
Difficulties with problem solving, attention span, understanding, confusion post surgery, short term memory loss, dementia, Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Cognitive Risk Screen
Other neurological problems eg: migraine, meningitis, polio	<input type="checkbox"/>	<input type="checkbox"/>		

**DO NOT WRITE IN THIS BINDING MARGIN**

**MR 4D**



**PATIENT ADMISSION  
GENERAL HEALTH HISTORY**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

DO NOT WRITE IN THIS BINDING MARGIN

<b>Breathing</b>	Have you ever had any problems with your breathing or lungs? <input type="checkbox"/> Yes, complete details below <input type="checkbox"/> No, go to next section		<b>Please describe below:</b>	Nursing Use Only
	<b>NO</b>	<b>YES</b>		
Asthma, pneumonia, hayfever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary disease (COPD), home oxygen	<input type="checkbox"/>	<input type="checkbox"/>		
Shortness of breath eg: walking more than 50m, climbing stairs or inclines	<input type="checkbox"/>	<input type="checkbox"/>		
Sleep apnoea, disturbed sleep, snoring	<input type="checkbox"/>	<input type="checkbox"/>		Stop Bang Score:
Use of a CPAP machine	<input type="checkbox"/>	<input type="checkbox"/>	Please bring CPAP to hospital	
Other lung problems eg: tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Mental Health</b>	<b>NO</b>	<b>YES</b>	<b>Please describe below:</b>	Nursing Use Only
Do you have a mental health condition such as depression, anxiety, bipolar or PTSD?	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Other Conditions</b>	Please complete section below, if yes please provide details and dates		<b>Please describe below:</b>	Nursing Use Only
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>		
Lymphoedema	<input type="checkbox"/>	<input type="checkbox"/>	Limb:	
Thyroid problems, hypothyroidism, goitre	<input type="checkbox"/>	<input type="checkbox"/>		
Any other medical conditions	<input type="checkbox"/>	<input type="checkbox"/>		
<b>INFECTION RISK</b>	Please complete section below, if yes please provide details and dates		<b>Please describe below:</b>	Nursing Use Only
Have you had an antibiotic resistant infection? Such as MRSA, VRE, CRE, ESBL or C <i>Auris</i>	<input type="checkbox"/>	<input type="checkbox"/>		
In the last 12 months have you been admitted overnight, worked or volunteered in a hospital or residential care facility outside WA?	<input type="checkbox"/>	<input type="checkbox"/>	Where:	
Are you a resident of a residential care facility or have you been admitted overnight to a hospital in WA in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Name of facility/hospital:	
Do you have flu like symptoms and a history of travel outside Australia in the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	Countries visited:	
Do you have two or more first or second-degree relatives with CJD?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have an unexplained progressive neurological illness of less than 12 months duration?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you previously had surgery on the brain or spinal cord that included a dura mater graft (prior to 1990)?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you been involved in a 'look-back' for CJD or do you have a 'medical in confidence' letter regarding your risk for CJD?	<input type="checkbox"/>	<input type="checkbox"/>		

**Please notify your doctor and the hospital if you become unwell with a cold, respiratory symptoms, diarrhoea or vomiting in the week prior to your admission.**

<b>DISCHARGE PLANNING</b>				Nursing Use Only
Where do you plan to go after discharge? (Please note you will be unable to drive or take public transport or a taxi alone and will need a responsible carer to escort you home and remain with you for 24 hours after your anaesthetic/sedation if a day patient)				
Do you have someone to look after you after discharge?	<b>NO</b>	<b>YES</b>	Name:	
	<input type="checkbox"/>	<input type="checkbox"/>		
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you solely responsible for the care of another person at home?	<input type="checkbox"/>	<input type="checkbox"/>	Details:	
Do you <b>currently</b> require assistance with daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	Details:	
Do you have concerns about how you will manage after discharge?	<input type="checkbox"/>	<input type="checkbox"/>		
Would you like to discuss your admission or discharge needs before your admission?	<input type="checkbox"/>	<input type="checkbox"/>		
Is there any other information that you think would help us while you are in hospital?	<input type="checkbox"/>	<input type="checkbox"/>		

MR 4E



**PATIENT HEALTH HISTORY**  
**Additional Clinical Information**

Surname:

Given Names:

DOB:

Address:

MRN:

Gender:

Please use I.D. or block print

**ADDITIONAL CURRENT MEDICATIONS**

Medication	Dose	Frequency

**ADDITIONAL SURGICAL HISTORY / OPERATIONS**

Operation	Date Performed

**ADDITIONAL ALLERGIES**

Allergies	Reaction	Nursing Staff
		Document on Anaesthetic and Medical Record - Alert sheet and NIMC.  If latex allergy, follow latex policy.

**ADDITIONAL NOTES**


DO NOT WRITE IN THIS BINDING MARGIN



**STAFF USE ONLY**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

**NURSE USE ONLY**

RISK SCREENING REQUIRED	Required	Not Required	Date Completed	Signature
Fall Risk Screen	Yes			
• Falls Risk Assessment Management Plan (FRAMP)				
Infection Risk Screen	Yes			
• Infection Risk Plan				
Pressure Injury Screen	Yes			
• Pressure Injury Management Plan				
Cognitive Impairment Screen (aged 65 years of age and over)				
VTE Risk Screen				
STOPBang Screen	Yes			
• Obstructive Sleep Apnoea (OSA) Risk Interventions				
Malnutrition Risk Screen				

**PRE-ADMISSION / ADDITIONAL NOTES**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

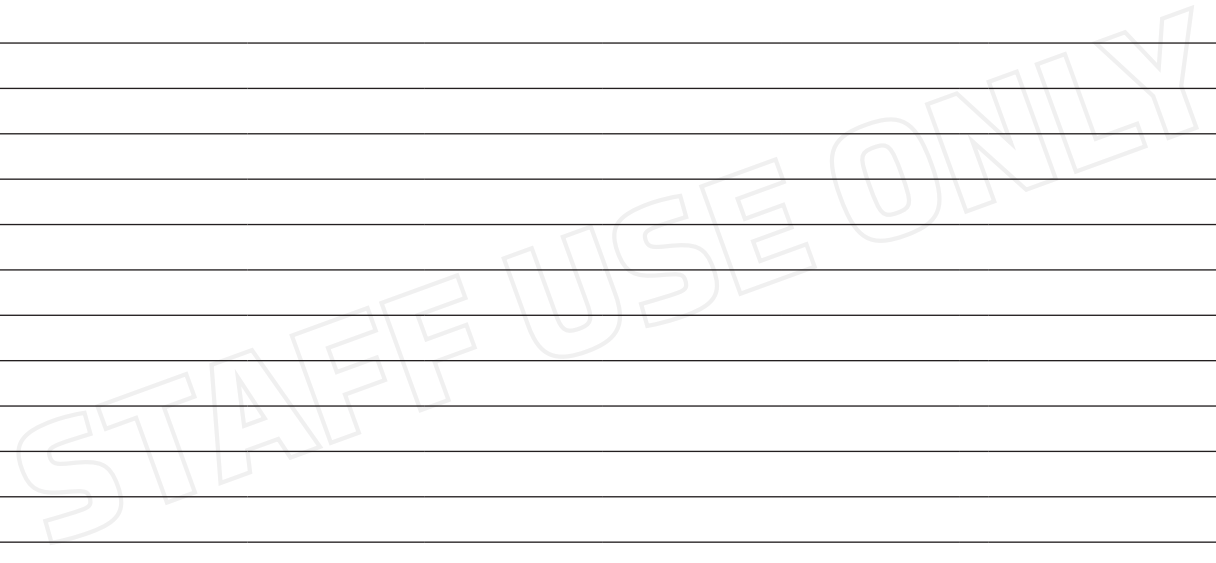
---

---

**CONFIRMATION - Patient history form has been reviewed**

<b>ADMISSION CLERK</b>	Name: .....	Date: .....
	Signature: .....	Time: .....
<b>PRE-ADMISSION NURSE</b>	Name: .....	Date: .....
	Designation: .....	Time: .....
	Signature: .....	
<b>ADMITTING NURSE</b>	Name: .....	Date: .....
	Designation: .....	Time: .....
	Signature: .....	
<b>WARD NURSE</b>	Name: .....	Date: .....
	Designation: .....	Time: .....
	Signature: .....	

DO NOT WRITE IN THIS BINDING MARGIN



This page left blank intentionally





**CONSENT TO USE AND DISCLOSE  
PERSONAL INFORMATION**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

**PATIENT OR PERSON RESPONSIBLE FOR PATIENT TO READ AND SIGN**

Bethesda Health Care is committed to managing your personal health information according to the current Australian Privacy Act. More information is available on our website [www.bethesda.org.au](http://www.bethesda.org.au) or by contacting our Privacy Officer on (08) 9340 6300



**COLLECTION**

Bethesda Health Care staff will collect your personal information:

- that is necessary for your safety, optimal care and treatment;
- that is required by law;
- that is necessary for billing and the business management of our service; and
- that enables us to monitor our service quality and customer satisfaction.

We may also need to obtain and share information from other sources such as your GP, other healthcare providers and hospitals, including pathology laboratories and the My Health Portal System. In emergency situations we may need to collect personal information from your next of kin, your relatives or other sources.

**USE AND DISCLOSURE**

Your information will be used as listed above and also:

- to inform manufacturers of any prosthetic or medical devices you may receive as part of your treatment, for safety and regulatory purposes. These manufacturers may be located overseas;
- to inform the person you have nominated of your health status;
- for account keeping and billing, including sharing information with health insurer's, Medicare and, if required, outside collection agencies;
- for the management of patient safety, training and education, quality assurance and accreditation purposes; and
- where legally required, such as producing records to court and mandatory reporting of information to State and Federal authorities, including the notification of certain communicable diseases.

**ACCESS TO YOUR MEDICAL RECORD**

You are entitled to access your own medical record at any time convenient to both yourself and the hospital. Requests or queries must be directed to our Privacy Officer. The request will be actioned within 30 days of receipt and a charge for photocopying, staff time and processing your request may be made.

Access may be denied where:

- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another person;
- your request is frivolous;
- the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings;
- it is in the interests of National Security; or
- it would create a serious threat to life or health if access was granted.

**SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION**

We have policies, processes and storage systems that comply with relevant legislation to ensure your information is protected from misuse, interference, loss, unauthorised access, modification or disclosure. Information will be retained for the period of time determined by current Australian legislation and will be disposed of confidentially in line with legislated document disposal schedules.

**MAKING AMENDMENTS TO YOUR MEDICAL RECORD**

You are entitled to amend the information on your medical record. We will take steps to record, all of your amendments, and place them with your medical record but will not erase the original record. Please contact our Privacy Officer.

**WITHHOLDING SENSITIVE INFORMATION**

You may request certain information be withheld for personal reasons. Bethesda may not be able to admit or treat you where it considers the information is not comprehensive enough to provide quality health care.

**USE OF A PSEUDONYM**

You may choose to be known by a pseudonym (alias) while in hospital, however your accurate identifying details may be required for our billing purposes but will be kept confidential.

**WITHDRAWING CONSENT**

If you provide your consent to release information to other parties or for other purposes and would like to withdraw this consent, please contact our Privacy Officer

**FEEDBACK AND COMPLAINTS PROCESS**

Please lodge any feedback via our Patient Feedback Surveys, via our website [www.bethesda.org.au](http://www.bethesda.org.au) or contact our Privacy Officer.

**CONSENT:**

**Bethesda Health Care is an independent private hospital that has been providing outstanding medical and health services to the WA community for close to 80 years.**

We would like to update you on our latest activities and keep you informed about new services, fundraising campaigns and Volunteer activities. To do this we would need to utilise your personal information provided to us. To comply with privacy laws we are asking your permission to do so. If you would like to opt out of receiving updates about Bethesda Health Care, please tick here:

**I consent to Bethesda Health Care managing my personal information as detailed above.**

Patient's name: .....

Signature: .....

If consenting on behalf of the patient as a person responsible / other please print and sign:

Guardian's name: .....

Signature: .....

Relationship to patient: .....

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

DO NOT WRITE IN THIS BINDING MARGIN



**CONSENT TO PROCEDURE**

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

**Please use I.D. or block print**

ADMITTING DOCTOR: \_\_\_\_\_ ADMISSION TYPE  LA DAY CASE  DAY CASE  OVERNIGHT

ADMISSION DATE: \_\_\_\_\_ ADMISSION TIME: \_\_\_\_\_

PROVISIONAL DIAGNOSIS: \_\_\_\_\_

**ADMISSION CRITERIA      HEIGHT:                      WEIGHT:                      BMI:**  
*For safety reasons patients whose weight exceeds 150 kgs and/or BMI >45 will not be admitted to Bethesda*

I, \_\_\_\_\_ (full name of person giving consent)  
of \_\_\_\_\_ (address)  
hereby consent to the following procedure (s) \_\_\_\_\_

\_\_\_\_\_ (no abbreviations, please print)  
being performed upon \_\_\_\_\_ (full name of patient if different from self)  
the nature and effect of which has been explained to me by Doctor \_\_\_\_\_

I also consent to:

- further procedure(s) as may be found necessary to be performed during the course of the procedure(s), stated above and to the required post-operative treatment;
- digital images being made during my procedure and, if made, copies being retained as part of my medical record;
- the administration of such anaesthetics and medicines as may be considered by the anaesthetist to be necessary or advisable;

• **to the transfusion of blood products if needed  Yes  No (please tick). The risks have been explained to me. (if no, a Refusal of Blood Product form must be completed);**

- blood being collected and tested for infectious agents (including Hepatitis and HIV antibody) in the event of an occupational exposure to a staff member. I understand I will be informed that blood has been taken for testing, that there will be no additional cost to myself and the results of the test will be made available to me, the staff member and the infection control officer of the hospital. **All health care workers are bound to maintain confidentiality of the test results.**

Patient/Guardian signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_  
(if not self)

I (Doctor's name) \_\_\_\_\_ confirm that I have explained to the patient (or person legally responsible for the patient) the nature, purpose, benefits and risks of the proposed procedure(s) and in my opinion he/she understands my explanation.

Medical practitioner's signature: \_\_\_\_\_

**Interpreter's declaration: Specific language requirements (if any).** I declare that I have interpreted the dialogue between the patients and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

Interpreter's full name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_ Time \_\_\_\_\_

Agency name: \_\_\_\_\_ Interpreter's signature: \_\_\_\_\_

**MEDICAL USE ONLY  
CRUETZFELDT-JAKOB DISEASE RISK**

Will the intended procedure involve dura mater, cranial or dorsal root ganglia, spinal cord or olfactory epithelium?

Do you think the patient may have CJD?  NO  YES  
If yes please contact Bethesda Infection Control Manager.

Medical Practitioner's Signature: \_\_\_\_\_

**MEDICAL PRACTITIONER  
PREOPERATIVE INSTRUCTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Practitioner's Signature: \_\_\_\_\_

DO NOT WRITE IN THIS BINDING MARGIN

MR 4.1

This page left blank intentionally



25 Queenslea Drive, Claremont WA 6010  
admissions@bethesda.org.au  
[www.bethesda.org.au](http://www.bethesda.org.au)