# Healthe Care Australia

Unit Record Number ☐☐☐☐☐☐☐☐

Family Name _____

Given Names _____

Date of Birth ☐☐☐☐☐☐☐☐ Age ☐☐

Sex ☐ Room No. ☐☐☐

OR USE LABEL

## PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, ideally within 7 days prior to admission.

TO BE COMPLETED BY PATIENT

Have you been admitted to this Hospital previously? ☐ No ☐ Yes Year: .....

Preferred accommodation? ☐ Private room ☐ Shared room

Method of payment for this admission: ☐ Private Health Insurance
☐ Self Funded ☐ Workcover ☐ TAC/MVIT(WA) ☐ DVA ☐ Other: .....

How did you find out about this hospital?
☐ Specialist ☐ G.P. ☐ Newspaper ☐ Internet ☐ Other: .....

Have you been / will you be admitted to ANY Hospital within the past:
7 days? ☐ No ☐ Yes 28 days? ☐ No ☐ Yes
90 days? ☐ No ☐ Yes (TAS ONLY) *Previous to this admission
- If yes, please state previous hospital: .....
Is this admission related? ☐ Yes ☐ No
Dates of hospitalisation: From ...../...../..... to ...../...../.....
Any related admissions prior to that? ☐ No ☐ Yes
- If yes, please specify: .....

National Health Identifier Record Number (NHIRN):

Procedure or reason for this admission: ..... Admitting Doctor: .....

**Date to be admitted:** ...../...../..... Operating date *(if different from admission date:)* ...../...../.....

☐ Day Stay or ☐ Overnight Stay *(please tick)* Referring Doctor: .....

Title: ☐ Mr ☐ Master ☐ Miss ☐ Ms ☐ Mrs ☐ Dr ☐ Other

Surname:

Previous surname:

First given name:

Second given name:

Sex: ☐ Male ☐ Female

Date of birth: ☐☐☐☐☐☐☐☐ Estimated D.O.B. ☐

**Marital Status:** ☐ Single ☐ Married ☐ Defacto ☐ Widowed ☐ Divorced ☐ Separated

Occupation:

Religion: Religious visit ☐ Yes ☐ No

Country of birth:

(If Australia, please specify state):

☐ Resident ☐ Non-Resident

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ N/A ☐ ASSI *(QLD ONLY)*
*(Required by Dept. of Health)*

Interpreter required? ☐ Yes ☐ No

Preferred language:

Address:

Suburb: State: Postcode:

Medicare Card Number ☐☐☐☐☐☐☐☐☐☐ Number before patient name: ☐

Expiry date:

Home phone:

Work phone: Mobile phone:

Email:

**CONCESSION CARD DETAILS**

***These cards entitle patients to medicines at the concession rate and may be requested as proof of eligibility for subsidised medicine.***

Safety Net Number:

DVA Card No.:

DVA Card Colour: ☐ Gold ☐ White ☐ Orange Expiry: /

Would you like a visit from a member of an Ex Service organisation / DVA Liaison Officer? ☐ Yes ☐ No

Transport required: ☐ Yes ☐ No *(DVA patients only)*

Pension No.: Expiry: /

Healthcare Card No.: Expiry: /

Senior Pharmacy Concession Card No.: Expiry: /

Ambulance Service Membership No.: Expiry: /

**GENERAL PRACTITIONER DETAILS**

Can we notify your GP of your admission and discharge? ☐ Yes ☐ No

Local Doctor:

Name of Practice:

Address:

Suburb: State: Postcode:

Telephone: Fax:

**PRIVATE HEALTH INSURANCE DETAILS**
***Please bring your card to hospital with you***

Health fund:

Level of cover / table:

Member number:

PATIENT REGISTRATION FORM

MR054N

# Healthe Care Australia

## PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, ideally within 7 days prior to admission.

TO BE COMPLETED BY PATIENT

Unit Record Number | | | | | | | | |

Family Name _____

Given Names _____

Date of Birth | | | | | | | | | Age | |

Sex | | Room No. | | | |

OR USE LABEL

### EMERGENCY DETAILS

**NEXT OF KIN**

Given name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient:
☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter
☐ Other (specify):

Telephone (Home):

Telephone (Work):

Mobile:

Email:

**CONTACT 1**

Given name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient:
☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter
☐ Other (specify):

Telephone (Home):

Telephone (Work):

Mobile:

Email:

**Do you have ENDURING POWER OF ATTORNEY?**

Enduring Power of Attorney — Medical ☐ Yes ☐ No

Enduring Power of Attorney — Financial ☐ Yes ☐ No

Enduring Power of Attorney — Guardianship ☐ Yes ☐ No

Name of Enduring Power of Attorney

Contact Telephone

*If Yes to any of above, please bring your documents to the hospital on admission*

**PERSON RESPONSIBLE FOR ACCOUNT**

Given name(s):

Surname:

Address:

Suburb: State: Postcode:

Relationship to patient:
☐ Spouse ☐ Partner / Defacto ☐ Son ☐ Daughter
☐ Other (specify):

Telephone (Home): (Work)

Mobile:

### POSTAL ADDRESS

☐ Same as residential address

Address:

Suburb: State: Postcode:

### WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY DETAILS

*Written approval will be required prior to admission*

☐ Work Cover* ☐ Third Party* ☐ Public Liability

**Work Cover & Third Party patients accommodated at patient's request in a private room will incur some out of pocket expenses*

Employer:

Address:

Suburb: State: Postcode:

Employer Phone:

Cause of injury

Contact Name:

Date of accident: | | | | | | | | | Location:

Insurance Company:

Claim Number:

Claim approved? ☐ Yes ☐ No

Person / Company Responsible for Account

Name:

Address:

Suburb: State: Postcode:

Relation:

Phone (Home): (Work)

### RESPONSIBILITY

**I certify that the information provided on this form is true and accurate to the best of my knowledge and I have read and understand the *Admission Information* provided with these forms.**

**Patient or Guardian's Signature:** .....

**Patient or Guardian's full name:** .....

**Date:** ...../...../.....

COMMENTS / SPECIAL INSTRUCTIONS / REQUESTS

Healthe Care Australia

Unit Record Number

Family Name

Given Names

Date of Birth  Age

Sex  Room No.

OR USE LABEL

# PATIENT HEALTH HISTORY

It is preferable that this form is received by the hospital as soon as possible, ideally within 7 days prior to admission.

TO BE COMPLETED BY PATIENT

PATIENT TO COMPLETE

**NURSING STAFF TO CHECK DETAILS WITH PATIENT**

**If you have been a patient at our hospital in the last three months, this admission is for the same reason as your previous admission and no details have changed about your medications or medical history, please tick the box to the right, and proceed to the end of this form and sign.** ☐

**Grey shaded areas to be completed by nursing staff and initial all actions. Document as necessary**

## *MEDICATIONS*

| **Please tick (✓) Yes or No to all of the following questions.** Please bring to the hospital all medication, including complementary therapies you are currently taking, in the original dispensed packaging and repeat / authority prescriptions. On admission, please bring with you a list of your current medications from your G.P. | **NO** | **YES** | **Provide details if requested below** | **Nursing Staff Use ONLY** Consider commencement of Medication Management Plan. * Notify Surgeon if appropriate |
|---|---|---|---|---|
| Do you use any strong pain medications regularly at home? (ie. Morphine)<br>Do you have chronic pain? | ☐<br>☐ | ☐<br>☐ | Name of Medication: .....<br>Date last taken: ...../...../..... or still taking ☐<br>***If you take more than one, please list details in chart below*** | * |
| Do you take or have you recently taken blood thinning medication ie. Aspirin, Pradaxa, Warfarin, Clopidogrel, Plavix or anti-inflammatory drugs? | ☐ | ☐ | Name of Medication: .....<br>Date last taken: ...../...../..... or still taking ☐ | * |
| Have you taken any Steroids or Cortisone tablets / injections in the last 6 months? | ☐ | ☐ | Name of Medication: .....<br>Date last taken: ...../...../..... or still taking ☐ | * |
| Are you taking any other medications, prescription medications or non-prescription medications or complementary medicines including vitamins / mineral / herbal remedies / fish oil / glucosamine? | ☐ | ☐ | If Yes, please list your current medications below, (please attach a separate list if insufficient space). | If patient on ≥ 4 medications notify Pharmacist |
| Do you use non-prescription or illicit drugs? | ☐ | ☐ | Specify: | Notify Surgeon if appropriate |

| Medication | Dose | Frequency |
|---|---|---|
| EXAMPLE: *Aspirin* | *100mg* | *Once a day* |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ATTACH LIST IF NOT ENOUGH SPACE**

PATIENT HEALTH HISTORY

MR055N

Print Media Group – HEOZXBCH002A 05/16

Healthe Care Australia

Unit Record Number ☐☐☐☐☐☐☐☐

Family Name _____

Given Names _____

Date of Birth ☐☐☐☐☐☐☐☐ Age ☐☐

Sex ☐ Room No. ☐☐☐

OR USE LABEL

# PATIENT HEALTH HISTORY

It is preferable that this form is received by the hospital as soon as possible, ideally within 7 days prior to admission.

TO BE COMPLETED BY PATIENT

## *PRE-ADMISSION /ANAESTHETIC HEALTH INFORMATION*

| Please tick (✓) Yes or No to all of the following questions. | NO | YES | Provide details if requested below | Nursing Staff Use ONLY |
|---|---|---|---|---|
| Do you have any allergies or sensitivities?<br>Have you had an allergic reaction to any drugs / tapes, lotions, foods (eg. peanuts), latex or rubber?<br>ATTACH LIST IF NOT ENOUGH ROOM | ☐ | ☐ | Specify allergy and reaction:<br>.....<br>.....<br>..... | Document on anaesthetic & Medical Record<br>- Alert Sheet, NIMC, Red ID Band<br>If latex allergy, follow latex policy. |
| What is your: **Height:** ..... **Weight:** ..... **Body Mass Index** *(if known)*: .....<br>Reason for admission:.....<br>.....<br>Past / Surgical history (attach a list if insufficient space). Have you had any previous operations? Please list operations and dates performed. (Most recent first)<br>.....<br>.....<br>.....<br>..... | | | | Elective Admission ☐<br>Emergency Admission ☐<br>Unexpected re-admission within 28 days ☐<br>Transfer from:<br>..... |
| Have you or any family member had any reactions / side effects to anaesthetic? (eg. malignant hyperthermia) | ☐ | ☐ | Specify: | If yes - inform Anaesthetist |
| Do you or have you ever smoked? | ☐ | ☐ | Current daily amount:<br>Date ceased: ...../...../..... | |
| Do you suffer from blood disorders / anaemia / bleeding problems / bruise easily? | ☐ | ☐ | Details: | Advise surgeon if relevant |
| Have you ever had a blood clot in your legs or lungs (ie. DVT or PE)? | ☐ | ☐ | Specify: | If yes - inform treating Doctor |
| Have you had an organ transplant? | ☐ | ☐ | Specify: | |
| Have you had Laparoscopic Gastric Banding / Sleeve Gastrectomy / Gastric Bypass? | ☐ | ☐ | Date of procedure: ...../...../.....<br>If YES, is band deflated? ☐ Yes ☐ No<br>Does your surgeon or anaesthetist know that you have a band?<br>Surgeon ☐ Yes ☐ No<br>Anaesthetist ☐ Yes ☐ No | |
| Do you drink alcohol? | ☐ | ☐ | Daily amount: | |
| Have you ever had jaundice / liver problems or disease? | ☐ | ☐ | Specify: | |
| Have you had any blood tests / autologous blood or other pathology taken for this admission? | ☐ | ☐ | If yes specify where: .....<br>When? .....<br>Where are the results? ..... | Results in medical record |
| Have ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission? | ☐ | ☐ | If yes, with you ☐ or with your Doctor ☐<br>**Please bring with you to hospital** | Films with patient or Doctor |
| Have you ever had a blood transfusion? | ☐ | ☐ | Last transfusion: ...../...../..... | If reaction - inform admitting Doctor and record reaction on Alert Sheet |
| Any reaction? | ☐ | ☐ | | |
| Do you have any implants / prosthesis? (eg. hip replacement, cardiac valve or stent) | ☐ | ☐ | Specify: | Document on operation checklist |
| Do you have any body piercings or hair extensions? | ☐ | ☐ | Specify: | |

Healthe Care Australia

Unit Record Number

Family Name

Given Names

Date of Birth  Age

Sex  Room No.

OR USE LABEL

# PATIENT HEALTH HISTORY

*-CONTINUED*

## *HEALTH HISTORY*

| Please tick (✓) Yes or No to all of the following questions. | NO | YES | Provide details if requested below | Nursing Staff Use ONLY |
|---|---|---|---|---|
| **DIABETES** | | | | |
| Do you have Diabetes? Type 1 ☐ Type 2 ☐ Gestational ☐ | ☐ | ☐ | Managed by Diet ☐ Tablets ☐ Insulin ☐ Specialist: ..... | Document Consider check BSL if required |
| Do you have any side effects related to your diabetes? (eg. reduced sensation in feet) | ☐ | ☐ | Specify: | Consider Podiatry referral |
| **HEART** | | | | |
| Have you ever suffered from chest pain / discomfort /heart attack? | ☐ | ☐ | Details: | Document |
| Have you ever had? High Blood Pressure ☐ ☐ High Cholesterol ☐ ☐ Family History of heart disease ☐ ☐ | | | Details: | Document |
| Have you seen a Cardiologist? | ☐ | ☐ | Name: ..... Last appointment ...../...../..... | |
| Do you have a pacemaker or implantable defibrillator? | ☐ | ☐ | Type of Device ..... Date last Checked: ...../...../..... Has your Surgeon or Anaesthetist been informed? Surgeon ☐ Yes ☐ No Anaesthetist ☐ Yes ☐ No | Advise Surgeon / Anaesthetist if present Document on Alert Sheet |
| Have you had bypass surgery? | ☐ | ☐ | Date of procedure: ...../...../..... | |
| Do you have palpitations / irregular heartbeat / heart murmur? | ☐ | ☐ | Specify: | |
| Have you ever had Rheumatic Fever? | ☐ | ☐ | If yes, when? | |
| **AIRWAYS** | | | | |
| Do you suffer from Asthma / Bronchitis / Emphysema / shortness of breath on exertion / Pneumonia? | ☐ | ☐ | Do you use - Nebulisers? ☐ Puffers? ☐ | Suggest referral to Physio with Doctors consent |
| Do you have any sleep problems/ snoring? | ☐ | ☐ | Specify: | |
| Do you suffer from sleep apnoea? | ☐ | ☐ | Please bring CPAP machine to hospital if applicable. | If yes - inform Anaesthetist |
| Are you receiving home oxygen therapy? | ☐ | ☐ | | |
| **NEUROLOGICAL** | | | | |
| Do you suffer from strokes / mini strokes / Multiple Sclerosis / Motor Neurone Disease / Parkinson's Disease? | ☐ | ☐ | Specify any residual weakness / symptoms: | If functional deficit notify Doctor |
| Do you suffer from migraines? | ☐ | ☐ | Specify: | |
| Do you suffer from faints / blackouts / dizzy spells / TIA's? | ☐ | ☐ | Specify: | |
| Do you suffer from epilepsy / fits / seizures? | ☐ | ☐ | Date of last seizure: ...../...../..... | |
| Do you have short term memory loss / confusion / dementia? | ☐ | ☐ | Specify: | Notify Doctor if appropriate |

Healthe Care Australia

Unit Record Number

Family Name

Given Names

Date of Birth  Age

Sex  Room No.

OR USE LABEL

# PATIENT HEALTH HISTORY

*-CONTINUED*

| Please tick (✓) Yes or No to all of the following questions. | NO | YES | Provide details if requested below | Nursing Staff Use ONLY |
|---|---|---|---|---|
| **GENERAL MEDICAL** | | | | |
| Do you have anxiety, depression or mental illness? | ☐ | ☐ | Name & contact details of specialist: ..... Current treatment ☐ Yes ☐ No | |
| Do you have, or have you had cancer? Site: | ☐ | ☐ | Diagnosed: ...../...../..... Surgery ☐ Chemotherapy ☐ Radiotherapy ☐ Current ☐ OR Complete ☐ | Check for possible risk of Lymphodema / Document on Alert Sheet (if applicable) |
| Do you have any significant neck or back injuries? | ☐ | ☐ | Specify: | |
| Do you suffer from any thyroid problems? | ☐ | ☐ | Specify: | |
| Do you suffer from bowel problems / disorders / incontinence? | ☐ | ☐ | Specify | |
| Do you suffer from kidney / bladder problems / incontinence? | ☐ | ☐ | Specify: | |
| Are you on dialysis? | ☐ | ☐ | | |
| Do you suffer from reflux / stomach ulcer? | ☐ | ☐ | Specify: | |
| Do you suffer from a hiatus hernia? | ☐ | ☐ | Specify: | |
| Do you have speech / swallowing problems? | ☐ | ☐ | Specify: | Notify Doctor if appropriate. Consider speech therapist, dietitian and kitchen |
| Do you suffer from arthritis? | ☐ | ☐ | Specify: | Document |
| Do you have impairment of: ☐ Vision ☐ Hearing | ☐ | ☐ | Specify aids used: | Aids with patient in hospital ☐ |
| Female patient - could you be pregnant? | ☐ | ☐ | Name & contact details of specialist: ..... Due Date: ...../...../..... | Inform anaesthetist |
| **Do you have any other medical conditions?** | ☐ | ☐ | Specify: | |
| **DENTAL** | | | | |
| Do you currently have loose teeth, chipped teeth, fillings? | ☐ | ☐ | | |
| Have you had any recent dental treatment? | ☐ | ☐ | Specify: | |
| Do you have any crown, caps, dentures or braces? | ☐ | ☐ | Specify: | |
| **NUTRITION** | | | | |
| Do you have any eating difficulties or special dietary needs? (eg. cultural / religious) | ☐ | ☐ | Specify: | Complete Adult Malnutrition Screening form if patient answered yes to any of these questions |
| Did you lose weight in the last 6 months without trying? | ☐ | ☐ | | |
| Do you have a decreased appetite / are you eating poorly? | ☐ | ☐ | | |
| **INFECTION CONTROL ASSESSMENT** | **NO** | **YES** | **DETAILS** | **Nursing Staff Use ONLY** |
| Have you returned from overseas within the past 14 days or been exposed to Acute Respiratory Infections? | ☐ | ☐ | Date Returned: ...../...../..... | If response to any question is YES, contact IPC contact / Department Manager / DCS /Treating Doctor as Transmission Based Precautions may be necessary |
| Do you have a fever, cold, cough or other acute respiratory symptoms or sore throat? | ☐ | ☐ | | |
| If answered "Yes" above, have you visited a country with a "Health Alert" issued? | ☐ | ☐ | Please state Country/Region visited: ..... | |
| Have you been transferred directly from an overseas healthcare facility (HCF) OR resided in an overseas Residential Aged Care facility OR been admitted overnight to any overseas HCF in the past 12 months? | ☐ | ☐ | | |
| Have you travelled overseas within the last 21 days to areas with increased prevalence for diseases such as Ebola, or other acute infectious diseases such as Measles, and do you have either: Fever, myalgia, headache, vomiting, diarrhoea, abdominal pain, unexplained bleeding, bruising, rash? | ☐ | ☐ | | |

**INFECTION CONTROL ASSESSMENT** ***continued over page*** ⮟

Healthe Care Australia

Unit Record Number | | | | | | | | |

Family Name _____

Given Names _____

Date of Birth | | | | | | | | | Age | |

Sex | | Room No. | | | |

OR USE LABEL

# PATIENT HEALTH HISTORY

*-CONTINUED*

| Please tick (✓) Yes or No to all of the following questions. | NO | YES | Provide details if requested below | Nursing Staff Use ONLY |
|---|---|---|---|---|
| **INFECTION CONTROL ASSESSMENT** *continued* | | | | |
| Have you ever had a Multi Resistant Organism, such as:<br>- Multi / methicillin resistant staphylococcus (MRSA)?<br>- Vancomycin resistant enterococci (VRE)?<br>- Clostridium difficile (c.diff)?<br>- Carbapenim Resistant Enterobacteriaceae (CRE)?<br>- Extended Serum Beta-Lactamase (ESBL)? | ☐ | ☐ | **Please specify:**<br>Date identified: ...../...../.....<br>**Site:**<br>.....<br>**Hospital** where identified:<br>..... | |
| Have you ever had Tuberculosis? | ☐ | ☐ | Specify at what age: .....<br>Year: ..... | |
| Do you have / have you ever had a blood borne infection (eg. Hepatitis B and C, HIV)? | ☐ | ☐ | Specify which type of infection: | |
| Do you have / have you ever had any Sexually Transmitted Infections (STI)? | ☐ | ☐ | Specify: | **If yes to ANY of the infection control questions**<br>1. Notify clinical manager or hospital coordinator and infection control coordinator.<br>2. Document in the medical record and on Alert Sheet.<br>3. Refer to the relevant policy. |
| Do you currently have an infection? | ☐ | ☐ | If yes, where? | |
| **CREUTZFELDT JAKOB DISEASE** | | | | |
| Have you ever been notified you may be at risk of Creutzfeldt Jakob Disease? (CJD) | ☐ | ☐ | | |
| Do you have a family history of 2 or more first degree relatives with CJD or other undiagnosed neurological illness? | ☐ | ☐ | If Creutzfeldt Jakob Disease (CJD)<br>Specify relationship: | |
| Have you been involved in a "Look Back" study for CJD or are you in possession of a "Medical in Confidence" letter regarding risk of CJD? | ☐ | ☐ | | |
| Have you received an injection of human pituitary hormone treatment for infertility or growth hormone for short stature prior to 1985? | ☐ | ☐ | When? .....<br>Why? ..... | |
| Have you had surgery on the brain (Neurosurgery) or other surgical procedure that involved a Dura Mater graft before 1990? | ☐ | ☐ | Surgeon: .....<br>Hospital: .....<br>Year: ..... | |
| Do you have a pre-existing neurological disease that is awaiting medical assessment? | ☐ | ☐ | Specify: | |
| **SKIN INTEGRITY/ PRESSURE INJURY** | **NO** | **YES** | **DETAILS** | **Nursing Staff Use ONLY** |
| Do you have any of the following?<br>◆ *If YES, please tick (✓) as many boxes as applicable*<br>☐ Skin conditions<br>☐ Existing wounds<br>☐ Pressure injuries*<br>(*ulcers, broken skin or reddened skin due to friction or pressure) | ☐ | ☐ | Specify: | Refer to Pressure Injury Risk Assessment<br>Document on Care Plan<br>Consider Wound Chart / Wound Consultant referral if required |
| Do you suffer from incontinence (urine / faeces)? | ☐ | ☐ | | |
| Do you have any fistulas or stomas? | ☐ | ☐ | If Yes, specify: | Inform stomal therapy nurse if required |
| **FALLS RISK ASSESSMENT** | **NO** | **YES** | **DETAILS** | **Nursing Staff Use ONLY** |
| Have you fallen / tripped in the last 12 months? | ☐ | ☐ | How many times? | |
| Do you have seeing / hearing problems? | ☐ | ☐ | | Falls risk assessment tool completed?<br>☐ Yes ☐ No |
| Do you use a walking aid? (eg. frame / stick) | ☐ | ☐ | If Yes, specify: .....<br>**Please bring to hospital.** | |

PATIENT HEALTH HISTORY

MR055N

Healthe Care Australia

Unit Record Number | | | | | | | | |

Family Name _____

Given Names _____

Date of Birth | | | | | | | | | Age | |

Sex | | Room No. | | | |

OR USE LABEL

# PATIENT HEALTH HISTORY

*-CONTINUED*

| **DISCHARGE ASSESSMENT**<br>*Answering these questions will assist us in planning your discharge from hospital.* | **NO** | **YES** | **DETAILS** | **Nursing Staff Use ONLY** |
|---|---|---|---|---|
| **1.** Are you aged 65 years or over? | ☐ | ☐ | ACAT / ACAS Assessment Completed?<br>Yes / No Date: ..... | Calculate readmission risk score<br>1 point for each 'YES' response.<br>Readmission risk score ☐/6 |
| **2.** Do you live alone? | ☐ | ☐ | | |
| **3.** Do you have any caring responsibilities for others? | ☐ | ☐ | Provide details: | |
| **4.** Do you usually require assistance with daily activities?<br>◆ *If YES, please tick (✓) as many boxes as applicable*<br>☐ Spouse / Family Support<br>☐ Home Help<br>☐ Hygiene / Showering Assistance<br>☐ Nursing Service<br>☐ Respite / Day Care Program<br>☐ Meal Service | ☐ | ☐ | Further details / Other:<br>.....<br>.....<br>.....<br>.....<br>..... | |
| **5.** Do you have any concerns regarding how you will manage at home after discharge? | ☐ | ☐ | Provide details: | Referral required for patients with score > 3 or any other concerns<br>Referral made to discharge planner / discharge coordinator<br>☐ Yes ☐ No |
| **6.** Have you been discharged from hospital or presented to an emergency department in the last 28 days for the same condition? | ☐ | ☐ | Provide details: | |
| How do you plan to get home? | | | Specify: | |
| Do you require extra help with your medication when you go home? | ☐ | ☐ | Specify: | Notify Hospital Pharmacist |
| **LEGAL DOCUMENTATION**<br>*Have you completed any of the following?* | **NO** | **YES** | | **Nursing Staff Use ONLY** |
| Enduring Power of Attorney (please complete the information on page 4) | ☐ | ☐ | | Note on Alert Sheet if patient indicates Yes |
| Anticipatory Directive* (SA)<br>Advanced Care Directive (all other states) | ☐ | ☐ | | |
| Are you registered with the Australian Organ Donor Register? | ☐ | ☐ | | |
| ***If yes to any of the above marked with a star (*), please provide a copy to the hospital.*** | | | | |

**DAY PATIENT ASSESSMENT ONLY**

| What is the name of the person responsible for taking you home? | Name of the person staying with you for the first 24 hours post procedure (if different to person escorting you home)? |
|---|---|
| Name: ..... | Name: ..... |
| Address: ..... | Address: ..... |
| ..... | ..... |
| Telephone: ..... | Telephone: ..... |

**Healthe Care feels it is important you understand your rights and responsibilities and how to make a complaint should you need to. Our *Rights and Responsibilities and compliments / complaints* brochure is available on the internet and in the reception at the hospital.**

**To the best of my knowledge, the above details are true and correct. I have read and understand my rights and responsibilities and how to make a compliment / complaint should I need to do so.**

Please tick if you do not wish to receive a patient satisfaction survey: ☐

**Patient Signature: X**..... **Date** ...../...../.....

**Print Name:** .....

| | |
|---|---|
| **R.N. / E.N. Signature** (as checked): ..... | **Admitting Nurse Sign** (as checked): ..... |
| **Print Name:** ..... | **Print Name:** ..... |
| **Designation:** ..... | **Designation:** ..... |
| **Date:** ...../...../..... | **Date:** ...../...../..... |