East Sydney Private Hospital

Pre-admission Booklet

East Sydney Private Hospital

East Sydney Private Hospital remains focused on providing all of our patient, excellent healthcare in a caring, supportive and safe environment.

Please ensure the following forms are completed and returned to East Sydney Private Hospital at least 2 weeks prior to your date of admission.

- **Request for Consent form & Admission** (pages 6 & 7) *To be completed by your referring doctor or specialist*
- **Pre-admission form** (pages 9 &10)
- **Patient History form** (pages 11, 12 & 13)

Completed forms should be returned to:
Pre-admission Office
Level 4, 75 Crown Street, Woolloomooloo NSW 2011
or **Email:** admit@esphospital.com
or **Fax:** (02) 9001 2001

The remainder of the booklet is for your information.

Welcome to

East Sydney Private Hospital

We thank you for choosing East Sydney Private Hospital for your procedure. ESPH was established in the iconic Sydney Ford Motor building in 2014.

At East Sydney Private Hospital we are committed to providing patients with the highest standards of health care. Our staff will ensure that throughout your stay you will be looked after with the utmost respect and dignity.

East Sydney Private Hospital remains focused on providing all of our patients with excellent health care in a caring supportive and safe environment.

East Sydney Private Hospital acknowledge and pay respects to the traditional owners - the Gadigal people of the Eora Nation. We also pay our respects to their leaders- past, present and emerging.

Anaesthesia and your procedure

Virtually all surgical procedures require some form of anaesthesia which will be administered by an anaesthetist. You may be phoned by your anaesthetist prior to your admission. In all cases, you will get to see them before your procedure.

Your medications

If you take any regular medication (including non-prescription medications) you should discuss this with your doctor. You may need specific instructions regarding which medications you should cease and which you should continue.

On admission to hospital please provide your nurse with any tablets or medicines that you have been taking before admission. These will be secured in a personal drug cabinet. Any additional medication you require whilst you are in hospital will be ordered by your doctor and supplied to you. Please note that some medications which you took prior to your surgery, your doctor may decide to withhold temporarily. When you are discharged, medications that you are required to take will be either provided to you as a prescription or as pharmacy supplied medications.

What to bring

- **All entitlement cards** e.g. Medicare / Safety Net / Veterans' Affairs and Health Fund cards
- Any paperwork not already forwarded to the Hospital
- Relevant x-rays, scans or films
- Current medication (in their original containers) and prescriptions
- Payment for estimate of gap between fund benefits and hospital fees, or total estimated costs of hospitalisation if you have no health insurance
- Aids such as walking sticks, hearing aids
- For a child – a favourite toy, formula, bottle and any special dietary needs (if applicable)
- Children may go to the procedure/theatre in their own pyjamas – these must be cotton with plastic buttons (no metal press studs) and be loose fitting.

If you are staying overnight, please remember to also bring (in a small overnight bag):

- Sleepwear, dressing gown and slippers
- Personal toiletries
- Any garments instructed by doctors.

Do not bring:

- Valuables, **including jewellery,** and large sums of money (unless settling your account in cash on admission)
- Unnecessary clothing
- Large luggage and suitcases (these cannot be accommodated).

Infection Control

The hospital is committed to promoting infection control awareness to both staff and patients. All patients and visitors are encouraged to either wash their hands or use the alcohol based hand rubs to assist with reducing the risk of infection.

We also ask that visitors with colds, gastroenteritis or other contagious diseases do not visit the hospital, in order to prevent the spread of these infections.

The day of your procedure

Fasting

The fasting time may vary, depending on the type of anaesthetic you are having. You will be advised when to commence fasting by hospital staff prior to your admission.

If fasting instructions are not followed, your procedure may have to be postponed in the interests of your safety.

Visiting Hours

Here at ESPH we understand that family and friends are an important part of recovery, which is why there are no visiting hours. However, we would appreciate your consideration to avoiding overcrowding the rooms and allowing patients time to rest.

Visitors Lounge

Lounge areas are provided for patients, their families and friends. Tea and coffee are provided.

Prior to your procedure

Please:

- Shower with soap on the day of your procedure
- Do not apply any powder, creams, lotions or makeup
- Please follow instructions from your doctor and hospital nursing staff, including fasting instructions
- Wear comfortable clothing
- Do NOT smoke
- Remove all piercings.

Paediatric Patients (Children)

We welcome children to our hospital as patients and aim to make their stay comfortable and fearless. Parents are welcome to bring their child's favourite toys, food or drinks. If the child is in nappies we suggest to bring your own supply. If your child is staying overnight we can accommodate one parent, however, we do not validate car parking tickets for the parent staying overnight.

What costs could I incur that will not be covered by my health fund

Fees from your Doctor, Surgeon, Anaesthetist or other provider e.g. High cost disposables, Prostheses, Excessive theatre time, Pathology, Radiology, Pharmacy, Physio are invoiced separately. These fees **are not** included in this estimation of total hospital costs provided to you. **Patient transfers with private or state owned ambulance service will incur a fee for service. It is the patients responsibility to be aware of eligibility prior to interhospital transfer.**

Pathology on site

Pathology fees

During your stay at this hospital, your doctor may require you to obtain pathology services. These services may be provided by Laverty, being the main provider of pathology services at this hospital.

Pathology is not able to predict in advance the total cost of services that will be provided to you. Normally, payment for the pathology services provided to you comes from a combination of:

(a) Medicare rebates;
(b) Payments from your private health insurance fund; and/or
(c) Payment from you.

Your admission and hospital stay

All patients will be admitted via the Reception located on Level 4.

If you are unable to keep your appointment for admission or if you have any questions about your admission process, please contact us as soon as possible on (02) 9001 2000.

Leaving the hospital after Surgery

For the first 24 hours after your procedure it is important that you:

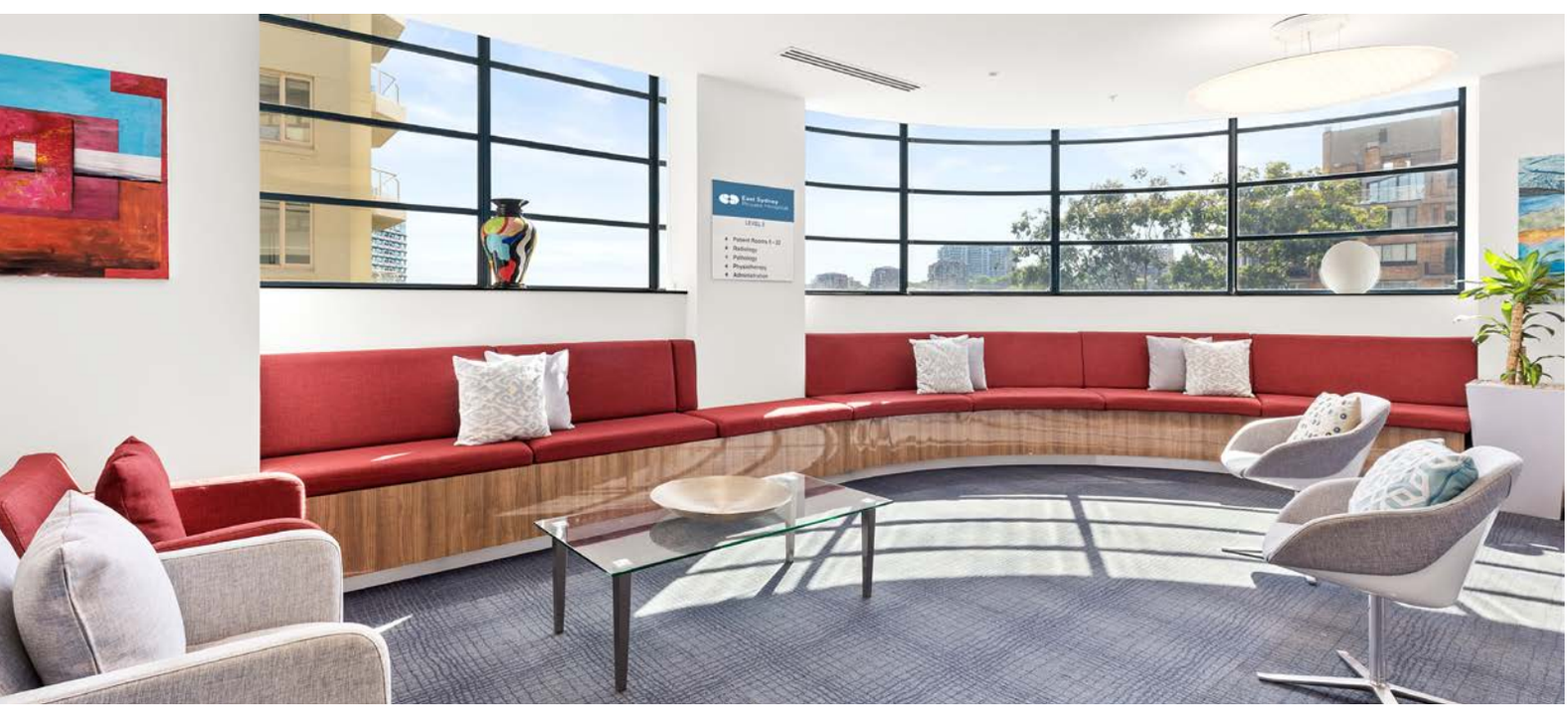
- Do not drive a car
- Do not drink alcohol
- Do not remain on your own (unless approved by your specialist)
- Do not make complex or legal decisions

You should be in the company of a responsible adult for 24 hours after a procedure.

After your operation you may need to follow detailed instructions. These may include wound or medication instructions. As you may have had an anaesthetic, we advise that a responsible adult be with you during these discussions as it is important your discharge instructions are understood.

Following discharge from the hospital, you will require someone to drive or accompany you home. Day patients can be met in the Day Surgery Discharge Lounge located on Level 4.

For overnight patients, discharge is prior to 10.00am. We ask you to vacate your room by this time to allow us to prepare for the next patient.



My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights.**

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access

- Healthcare services and treatment that meets my needs

Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that choose and am able to
- Include the people that I want in planning and decision-making

Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information ask a member of staff or visit safetyandquality.gov.au/your-rights

Commitment to improvement

The hospital values the contribution of our patients to our continuous improvement program. East Sydney Private Hospital complies with the National Safety and Quality Health Service (NSQHS) Standards and we have a quality management system based on the ISO 9001 standards (2nd edition).

Security and Safety Cameras

Patients and visitors are advised that security monitoring cameras are used within public areas of the hospital and car parks.

All cameras and clinical monitoring devices are in accordance with the *Privacy and Personal Information Protection Act 1998 and Health Records & Information Privacy Act 2002*.

Feedback and Complaints

The hospital values patient feedback. If you have a suggestion, wish to report an incident or to give a compliment, there are several options.

- Use the feedback form in your room, in the discharge lounge, or scan the QR Code from the back page of the Inpatient booklet.
- Speak to the person in charge of the department, usually the Nursing Unit Manager.
- Should you prefer to speak to someone outside the department, please contact the The Director of Clinical Services during office hours Monday to Friday on telephone (02) 9001 2003

Or you can write to:

Director of Clinical Services
East Sydney Private Hospital
Level 4, 75 Crown Street
Woolloomooloo, NSW-2011

You may contact the Healthcare Complaints Commission if you are not satisfied that the Hospital has resolved your complaint.

Health Care Complaints Commission
Locked Mail Bag 18
Strawberry Hills NSW 2012
Telephone: 1800 043 159
Website: www.hccc.nsw.gov.au

Your Right to Privacy

You have the right to have your personal space and privacy respected.

Your visitors have the right to privacy for your visits during patient visiting hours

Details concerning your medical care and treatment are confidential. No information or records pertaining to your care will be released without your permission, or the permission of your representative, unless such a release is required or authorised by law or necessary to enable another health care worker to assist with their care

Patient and Visitor Code of Conduct

Patients of East Sydney Private Hospital are requested to:

- Provide, to the best of your knowledge, accurate information about your current medical problems, previous illnesses, medications, visits to hospital, allergies and other matters relating to your state of health, in order to help our staff care for you.
- Ask staff for a clear explanation of treatments, tests and medications recommended for your care and let them know immediately if you do not understand instructions or advice given to you
- Discuss any worries or concerns with a relevant member of staff, preferably at the time.
- Inform staff if you intend to leave the ward for any reason
- Be courteous and considerate to other patients and to hospital staff
- NOT exhibit aggressive, violent or demeaning behaviour towards staff, other patients or visitors. It will not be tolerated
- Observe the hospital's 'No Smoking' (including vaping) rule
- Not consume alcohol or illicit drugs
- Ask your relatives and friends to visit in small groups within visiting hours, preferably no more than two or three people at a time
- Carers are not permitted to stay overnight after visiting hours unless by prior arrangement with the Hospital Director of Nursing.
- In shared rooms, keep the volume of radio and television sets to a minimum and, where possible, use earphones.
- Ensure children are supervised at all times

EAST SYDNEY PRIVATE HOSPITAL

CONSENT FOR USE OF INFORMATION

Health Records Information Privacy Act 2002 No 71 and the Australian Privacy Principles prohibit the use of the personal information that the East Sydney Private Hospital collects and holds about you for certain purposes in the event that you do not consent to use of such information of those purposes

The East Sydney Private Hospital would like you to indicate in this form whether or not you consent to the use of personal information it holds about you for the purposes described below.

You should note that in the event you do provide consent, the information would be used in an identified format. That is, your identity will be clear in any material generated for which you provide your consent.

You are under no obligations to provide consent to the use of our personal information for any of the purpose described below. In the event that you do not consent, we will respect your wishes and ill not use the information for that purpose in any identified format.

Please provide your consent to the use of your personal information for the purposes described below, by signing and dating the form.

To assist other medical practitioners or institutions who may treat me in the future but only to the extent necessary to threat the particular condition I have consulted to medical practitioner or institution about. This may include a requirement to forward relevant prior information for example anaesthesia records.
To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I may not be able to provide such consent.
To assist in the development of service delivery and planning
For research and development projects undertaken by the East Sydney private hospital in its own right or in conjunction with medical practitioners who work in the facility or drug companies.
To assist the hospital in undertaking **quality improvement activities**.
To provide members of **Returned Service Organisations and Minsters of Religion** with sufficient details to enable them to visit me whilst I am a patient in this facility.
To provide access to my information to the Health Fund of which I am a member if requested by the Health Fund to do so.
To receive educational materials on the condition I was treated for at East Sydney Private Hospital.
Photographic images may be taken during your procedure. This information will be maintained in your medical records. Should your doctor require this information for use outside of the hospital, a separate consent is required by your doctor.

Please indicate consent on page three of the PRE-ADMISSION FORM MR3 below.

East Sydney Private Hospital

Admissions Office
Level 4, 75 Crown St, Woolloomooloo NSW 2011
Email: admit@esphospital.com
Ph: 02 9001 2000 Fax: (02) 9001 2001

Place ID Label Here

PRE-ADMISSION FORM

To be completed by Patient and forwarded to admit@esphospital.com two weeks prior to admission

Have you been a patient in this Hospital before: ☐ Yes ☐ No Year _____

Have you been Hospitalised within 7 days prior to this admission: ☐ Yes ☐ No

Which Hospital? _____ Date: ___ /___ /____

Admitting Doctor: _____

Date of Admission: ___ /___ /____ Date of Operation: ___ /___ /____ Admission Type: ☐ Inpatient ☐ Day Patient

Procedure / Reason for Admission: _____

PERSONAL DETAILS

Title: Mr., Mrs., Miss., Ms. _____ Surname: _____

Previous Surname (if applicable): _____

Given Names: _____ Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Not Specified Date of Birth: ___ /___ /____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Are you an Australian Resident? ☐ Yes ☐ No

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Email: _____

Are you of Aboriginal/Torres Strait Islander (TSI) descent?

☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal and TS ☐ Prefer not to say

Religion: _____

Country of Birth _____ Nationality: _____

Language spoken at home: _____

Interpreter Required: ☐ Yes ☐ No

PERSON TO CONTACT (NEXT OF KIN)

Name: _____ Relationship to patient: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Email: _____

Second Contact/Enduring Guardian: _____ Telephone: _____

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ENTITLEMENTS

Medicare Card Number: _____ Medicare Reference No: _____

Medicare Expiry Date: _____ Pension/Health Care Card Number: _____

Expiry Date: _____ Safety Net Number: _____

Repatriation Number: _____

GP / LOCAL DOCTOR

Full name of GP: _____

GP Address: _____

_____ GP Telephone: _____

GP Email: _____ GP Fax: _____

Permission to share discharge information: ☐ Yes ☐ No

MY HEALTH RECORD

☐ I DO NOT give permission for my information to be uploaded to the national electronic My Health Record.

ADVANCED CARE DIRECTIVE (LIVING WILL)

Do you have an advanced care directive (such as a living will, or a NFR order?) ☐ Yes ☐ No

If yes, you must bring a copy with you on the day of your surgery and present this to your admissions nurse.

SECTION A: PRIVATE HEALTH INSURANCE

Fund Name: _____ Membership No: _____ Date Joined: ___ /___ /___

Type of cover: ☐ Single ☐ Family ☐ Other Level of cover (if known): _____

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

Do you have an excess? ☐ Yes ☐ No Amount $ _____

Have you paid an excess this year? ☐ Yes ☐ No Amount $ _____

Date aware of present symptoms/condition: ___ /___ /___

SECTION B: WORKCOVER OR THIRD PARTY

☐ Work cover or ☐ Third Party (Please tick one box)

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

Insurance Company Details: Name of Insurance Company: _____

Claim No: _____ Date of Accident: ___ /___ /___

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: _____

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HOW WILL YOU CLAIM FOR THIS ADMISSION

(please tick ✔ one box only)

☐ Private Health Insurance - Please complete Sections A and C

☐ Work cover/Third Party - Please complete Sections B and C

☐ Repat/Veterans Affairs - Please complete Entitlements and Section C

☐ Uninsured - Please complete Section C only

SECTION C: PAYMENT OF ACCOUNT - ALL PATIENTS TO COMPLETE

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.
By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent ☐ Payment Information

Person responsible for payment of accounts - *Please provide your name, signature and today's date.*

Name: _____ Signature: _____ Date: ___ / ___ / ___

Patient's Signature: _____ Signature: _____ Date: ___ / ___ / ___

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

☐ Preadmission, Admission and Discharge information (Page 3-4)

☐ Australian Charter of Healthcare Rights (see page 5 “”My Healthcare Rights””)

☐ Your right to privacy under the Privacy Act (see page 6)

☐ Feedback and complaints process (see page 6)

☐ Patient and Visitor Code of Conduct (see page 6)

I consent to the use of my personal information for the purposes outlined above (See page 7) ☐ Yes ☐ No

PHYSIO REFERRAL

Physio Name: _____

Physio Contact: _____

Physio Fax: _____

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PATIENT HEALTH QUESTIONNAIRE

To be completed by Patient or Carer and forwarded to admit@esphospital.com two weeks prior to admission
Please *PRINT* clearly. Your responses are valuable in planning your admission and caring for you during your stay.

ADMISSION DETAILS

Please specify the reason for your admission _____

Is this admission due to a past or present injury? *(If yes please provide further information below)* ☐ Yes ☐ No

Cause of Injury: _____

Place: _____ Date: ___ /___ /___

Have you been instructed to cease any medication? *(If yes please provide further information below)* ☐ Yes ☐ No

Name of Medication/s: _____

Date last taken ___ /___ /___ or ☐ still taking

Have you taken any steroids or cortisone tablets/injections in the last 6 months? ☐ Yes ☐ No

(If yes please provide further information) Date last taken ___ /___ /___ or ☐ still taking

Are you taking any other prescription or non-prescription medications? ☐ Yes ☐ No

List the medications you are currently taking (include name of medication).

If you need more space please attach a current list of all medications and bring this with you on admission.

- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____
- Medication: _____ for Treatment of _____
  Frequency _____ Dose _____

Please bring all medications you are currently taking with you on admission in the original packaging including herbal medicines.

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GENERAL MEDICAL CONDITION

Weight:	**Height:**	**BMI:**

Diabetes	☐ Yes ☐ No	If yes, what type? ☐ Type 1 ☐ Type 2 Managed by: ☐ Insulin injection ☐ Tablet ☐ Diet What medication do you take?
Cancer	☐ Yes ☐ No	Site: Date:
Stroke	☐ Yes ☐ No	Date: Residual problems:
High Blood Pressure	☐ Yes ☐ No	
Cardiac history Have you ever seen a cardiologist or had heart problems?	☐ Yes ☐ No	If yes, provide details:
Pacemaker	☐ Yes ☐ No	Make: Model: Last checked: / /
Prosthetic heart valve	☐ Yes ☐ No	Type:
Tendency to bleed / bloodclots / DVTs / bruise easily	☐ Yes ☐ No	If yes, provide details:
Asthma / Bronchitis / Sleep Apnea / Bearthlessness / Pneumonia etc	☐ Yes ☐ No	Please specify:
Liver disease / hepatitis (Specify type A, B, C)	☐ Yes ☐ No	If yes, provide details:
Kidney / bladder problems	☐ Yes ☐ No	If yes, provide details:
Hiatus hernia / gastrointestinal ulcers / bowel disorder	☐ Yes ☐ No	If yes, provide details:
Thyroid problems	☐ Yes ☐ No	If yes, provide details:
Epilepsy / fits / febrile convulsions	☐ Yes ☐ No	If yes, provide details:
Migraines	☐ Yes ☐ No	
Eye disease	☐ Yes ☐ No	
History of pressure injuries	☐ Yes ☐ No	
Female patients could you be pregnant?	☐ Yes ☐ No	Number of weeks:
Do you have any other medical conditions not listed here?	☐ Yes ☐ No	Please provide details:

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PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations, please list dates and operations performed:

Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:

Have you or anyone in your immediate family ever had a severe reaction to an anesthetic? e.g. malignant hyperthermia	☐ Yes	☐ No	Details of reaction:
Have you ever had a blood transfusion?	☐ Yes	☐ No	Details of reaction:

PROSTHESIS / AIDS / OTHER			DETAILS
Glasses / Contact Lenses	☐ Yes	☐ No	
Body Piercing	☐ Yes	☐ No	
Hearing aid or other hearing appliance	☐ Yes	☐ No	
Dentures / Caps / Crowns / Loose Teeth / wires	☐ Yes	☐ No	
Artificial joints or limbs / Metalware in body	☐ Yes	☐ No	

LIFESTYLE			DETAILS
Have you ever smoked?	☐ Yes	☐ No	Daily amount: or date ceased:
Do you drink alcohol?	☐ Yes	☐ No	Daily amount:
Do you use recreational drugs?	☐ Yes	☐ No	Type: Daily amount: How Often:
Do you exercise?	☐ Yes	☐ No	How Often:

DIET			DETAILS
Do you require a special diet?	☐ Yes	☐ No	Type of Diet:

COMMUNICATION			DETAILS
Do you require an interpreter?	☐ Yes	☐ No	Language spoken at home:
Do you have someone to interpret for you?	☐ Yes	☐ No	Name of Person / Relation:
Are you hearing or vision impaired?	☐ Yes	☐ No	Details:

MOBILITY AND FALLS RISK			DETAILS
Have you a fear of falling or have fallen within the last 6 months?	☐ Yes	☐ No	
Do you use mobility aids?	☐ Yes	☐ No	Type:
Can you walk up one flight of stairs?	☐ Yes	☐ No	
Have you experienced fainting or dizziness in the last 3 months?	☐ Yes	☐ No	

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ALLERGIES

Food allergies ☐ Yes ☐ No

Food:	Reaction:
Food:	Reaction:
Food:	Reaction:
Food:	Reaction:

Medication allergies ☐ Yes ☐ No

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Other allergies (Latex / sticky plasters etc):

PSYCHOLOGICAL / MENTAL HEALTH

Do you experience:	What are your triggers?	What controls work for you?
Anxiety ☐ Yes ☐ No		
Phobias ☐ Yes ☐ No		
Mood Disorders ☐ Yes ☐ No		
Eating Disorders ☐ Yes ☐ No		
Other psychosis ☐ Yes ☐ No		

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INFECTION RISK

Have you travelled to a country with a health alert in the last 7 days?	☐ Yes ☐ No
Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose?	☐ Yes ☐ No
Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic)? eg. COVID-19, SARs/H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms.	☐ Yes ☐ No
Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal of Pandemic)? eg. SARs/H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms	☐ Yes ☐ No
Have you ever had a Multi-Resistant Organism such as MRSA/Golden Staph, VRE, ESBL or Clostridium dificille?	☐ Yes ☐ No
Do you have any chronic non-healed wounds or breaks on your skin?	☐ Yes ☐ No
Do you have any other conditions or infections?	☐ Yes ☐ No
Have you had vomiting and diarrhoea in the last 48 hrs?	☐ Yes ☐ No

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990?	☐ Yes ☐ No
Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prion disease, where a genetic cause has not been excluded?	☐ Yes ☐ No
Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been diagnosed?	☐ Yes ☐ No
Have you received human pituitary hormones for infertility or human growth hormone for short stature, prior to 1986?	☐ Yes ☐ No
Have you been involved in a "Look Back" study for cCJD or are in the possession of a "Medical in Confidence Letter" regarding risk of cCJD?	☐ Yes ☐ No

DISCHARGE PLANNING

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

Are you over 80 years of age?	☐ Yes ☐ No
Do you live alone?	☐ Yes ☐ No
I have someone to look after me after discharge.	☐ Yes ☐ No

Name of person and Relationship:

Are you solely responsible for the care of another person at home?	☐ Yes ☐ No
Do you currently receive community support services?	☐ Yes ☐ No
Do you require assistance with any aspect of day to day living?	☐ Yes ☐ No

Where do you plan to go after discharge?

How will you get there?

Do you have any concerns about how you will manage at home after discharge?

Name of person completing form:

Relationship: ..... Date: .....

Location/Travel

Transport

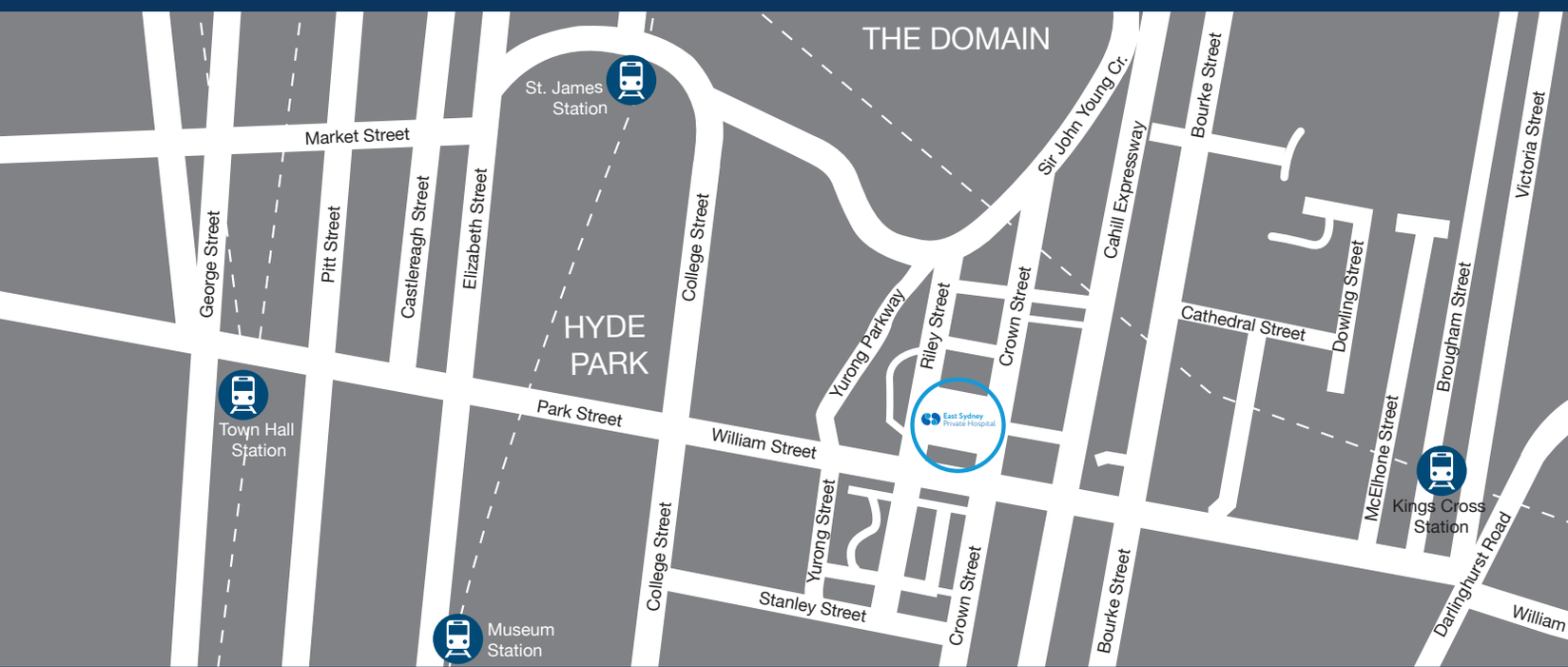
Regular bus services can be found in William Street and Crown Street within easy walking distance from the hospital. For timetable information, contact the Transport Infoline on 131 500.

The nearest train station to the hospital is Kings Cross station which is an approx. 10-15 minutes walk. You also have St James and Museum Station within walking distance.

Car Parking

Car parking facilities are available in Secure carpark which is accessed via Kennedy Street. First 20 minutes are free. Fees apply for a longer stay. Additional car parking can be found at The Sydney Boulevard Hotel, 90 William Street (3 min walk), or the Domain Car Park- entry via St Mary's road (5 min walk).

Patients attending East Sydney Private Hospital consultant room can enter via the corner of Crown and Kennedy Street and take the main lifts to the 6th floor Suite 2.



East Sydney Private Hospital

East Sydney Private Hospital
Level 4, 75 Crown Street, Woolloomooloo NSW 2011 | t (02) 9001 2000 OR 1300 377 400 | f (02) 9001 2001
www.eastsydneyprivatehospital.com