THE BAYS

**The Bays Healthcare Group**
Caring for the Peninsula

# Hospital admission forms

**Thank you for choosing The Bays Hospital for your upcoming admission.**

To ensure a smooth admission process, please read the following information carefully.

Please complete the enclosed and return to the hospital at least 14 days prior to your admission date; by post in the reply paid envelope, or fax 03 5975 2373. Alternatively you can drop them in to our administration desk at main reception in Vale Street.

Complete your medication chart and bring all of your current medications into hospital with you in their original packaging. If you have a medication list from your local doctor please bring this with you too.

Please contact your Private Health Fund to confirm your level of cover and whether you have an excess or co-payment on your policy. In the event that you do have an excess it is payable at the time of your admission.

Our administration staff will telephone you the business day (Monday to Friday) prior to your admission to confirm the time. This confirmation is necessary as admission times may change from the time your doctor's rooms may have given you.

Please ensure that you read the patient information brochure enclosed and further information is available at **www.thebays.com.au**

**If you have any questions regarding your admission phone us on 03 5975 2009.**

**The Bays Hospital**
Vale Street | PO Box 483
Mornington VIC 3931
Phone 03 5975 2009
Fax 03 5975 2373
ABN 35 146 117 211 | www.thebays.com.au

THE BAYS

The Bays Healthcare Group Inc

# PATIENT REFERRAL

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

***TO BE COMPLETED BY TREATING DOCTOR***

## ADMISSION DETAILS

Name of treating Doctor: .....

Date of operation: ..../..../....

Expected length of stay: ☐ Day case ☐ Overnight ☐ Longer..... nights

HDU required: ☐ Yes ☐ No

Expected item number(s): .....

## CLINICAL DETAILS

Provisional diagnosis: .....

Other conditions present: .....

.....

Allergies/sensitivities: .....

.....

VTE prophylaxis: .....

## PRE-OPERATIVE INSTRUCTIONS / TESTS REQUESTED

Pathology provider: ☐ Melbourne Pathology ☐ Dorevitch ☐ Other .....

Investigations: ☐ X-ray/ultrasound ☐ ECG ☐ Other .....

Instructions on admission: .....

.....

.....

**Drug orders on admission (drug order valid for 24 hours only):**

| Date | Medicine (print generic name) | Dose | Route | Frequency | Signature | Print Name | Time given by | Time given by |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

DO NOT WRITE IN MARGIN

PATIENT REFERRAL & CONSENT FOR TREATMENT MR/106

THE BAYS

The Bays Healthcare Group Inc

# CONSENT FOR TREATMENT

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

## *TO BE SIGNED BY PATIENT OR PERSON RESPONSIBLE*

### CONSENT FOR OPERATION/PROCEDURE/MEDICAL TREATMENT

I, ..... hereby consent to the following
*(given name)* *(surname)*

being performed upon ☐ myself ☐ other: .....
*(given name)* *(surname)*

☐ **Surgical**

operation/procedure(s) .....

.....

.....

and such further operative procedures found to be necessary to be performed during the course of the operation/procedure(s)

I confirm that I understand, to my satisfaction, the nature and effect of the above operation/procedure(s) which have been explained to me by Dr ..... and I have had the opportunity to ask questions and these have been answered in a way I understand.

In conjunction with the above stated operation/procedure(s), I request the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable.

*and/or*

☐ **Medical**

medical and nursing care, including examinations, tests and administration of drugs as deemed necessary during this stay in hospital.

Blood and blood product transfusions carry some risk and the complications have been explained to me.
I consent to* / do not consent to* blood and blood product transfusions if needed.
***delete where not applicable**

The Bays Hospital staff will administer care under the treating doctor's direction, or in an emergency, medical and nursing care will be administered as required.
I may withdraw my consent at any time in writing.

Signed: ..... *(by the patient or person responsible)* Date: ... / ... / .....

Print name: ..... If signed by person responsible state relationship to patient: .....

## *TO BE COMPLETED BY TREATING DOCTOR*

I, ..... have explained to the patient/person responsible the nature and effect of the operation/operative procedure(s).
*(name of treating doctor)*

In my opinion he/she understood this explanation.

Signed: ..... *(by treating doctor)* Date: ... / ... / .....

Information has been provided in relation to the administration of blood and blood products ☐ Yes ☐ N/A

☐ Patient does NOT consent to receiving blood or blood products

☐ Advanced Health Care Directive 'No Blood' attached

DO NOT WRITE IN MARGIN

THE BAYS

**The Bays Healthcare Group Inc**

Vale Street, Mornington 3931
Phone 5975 2009
Fax 5975 2373

**PLEASE COMPLETE AND RETURN TO THE HOSPITAL AS SOON AS POSSIBLE TO CONFIRM YOUR ADMISSION**
**PLEASE USE BLOCK LETTERS**

*SHADED AREAS FOR OFFICE USE ONLY*

MRN No | | | | | | |

ADMISSION DATE | | | | | | |

ADMISSION TIME (24 hour clock) | | | | |

**EXPECTED DATE OF ADMISSION** / /

**TITLE** Mr/Mrs/Miss/Ms/Master/Doctor

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

**SURNAME**

**BIRTH DATE** / /

**AGE**

**GIVEN NAMES**

**RELIGION** (OPTIONAL)

Country of Birth:

**PREVIOUS SURNAME**

If Australia, **which** state:

**SEX** M ☐ F ☐

**MARITAL STATUS**

Are you a current Bays Member? No ☐ Yes ☐

**ADDRESS**

State Postcode

**TELEPHONE** Home No. Mobile Work

**EMAIL**

**Medicare No.** - -

**Card Ref. No**

**Valid to**

**Please bring in on admission**

☐ Health Care Card ☐ Pension Card Number

☐ DVA Pension Card ☐ Pharmaceutical Entitlement Card Expiry Date

Pharmacy Safety Net No. or Regular Pharmacist

Ambulance Victoria Subscriber? No ☐ Yes ☐ Member No.

**(Note: Not all ambulance costs are 100% covered under health insurance)**

Who is funding this admission? **Health Fund** ☐ **Workcover** ☐ **TAC** ☐ **SELF** ☐ **DVA** ☐

Health Fund/Insurance Co. Membership No.

DVA CARD - GOLD ☐ WHITE ☐ DVA Number

**Do you have a special dietary requirement?** No ☐ Yes ☐ If yes please specify:

**Reason for admission:**

ADMITTING DOCTOR

**GENERAL PRACTITIONER**

**PHONE NUMBER**

**CLINIC NAME AND ADDRESS**

NEXT OF KIN / FIRST CONTACT

Name

Address

Relationship Phone No.: Home Mobile/Work

SECOND CONTACT

Name

Relationship Phone No.: Home Mobile/Work

Have you been a patient at this hospital before? No ☐ Yes ☐ → What Year?

PATIENT'S SIGNATURE (Parent or Guardian if applicable)

Signature Date / /

*OFFICE USE ONLY*

Has the Patient been discharged from another Hospital within the last seven days? No ☐ Yes ☐ Name of Hospital Adm. Date:

Staff Initial: Pre-booking Admission Room

DO NOT WRITE IN MARGIN

PATIENT REGISTRATION

CPJAN2016

MR/001

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

***If you are under the care of any other Medical Specialists please give details below***

Physician _____ Cardiologist _____

Vascular Doctor _____ Diabetes Educator _____

Kidney specialist _____ Other specialist _____

GP _____ Phone Number _____

| **Weight** | | **Height** | |
|---|---|---|---|

| **HEALTH AND RISK ASSESSMENT: Do any of the following apply?:** | | | **If yes, please comment below** |
|---|---|---|---|
| Asthma / Bronchitis / COPD / Emphysema / Tuberculosis | No | Yes | |
| Do you use home oxygen? | No | Yes | |
| Sleep apnoea / disturbed sleep / snoring | No | Yes | |
| Do you use a CPAP machine? | No | Yes | ***Please ensure you bring your CPAP machine to hospital with you*** |
| Infection with multi-resistant organism e.g. golden staph | No | Yes | |
| Do you have any wounds, or breaks on your skin? | No | Yes | |
| Do you have or have had any pressure injuries / ulcers / bedsores? | No | Yes | |
| Do you have Diabetes? Type 1 | No | Yes | ***Please ensure you bring your medications to hospital with you*** |
| Type 2 | No | Yes | |
| Do you manage your diabetes with: Diet ☐ Tablet ☐ Insulin ☐ | | | |
| Blood thinning medication - Warfarin, Plavix, Cartia, Astrix, Iscover, Asasantin, Pradaxa, Xarelto, Eliquis | No | Yes | ***Please ensure you bring your medications to hospital with you*** |
| Warfarin Pathology Collector: _____ Last INR: _____ | | | |
| Usual Warfarin Dose: _____ Blood thinning medication stopped ☐ No ☐ Yes When _____ | | | |
| Blood tests taken for this admission | No | Yes | |
| Pathology company: | | | |
| Do you have a fear of falling or are you unsteady on your feet? | No | Yes | |
| Have you experienced fainting or dizziness in the last 6 months? | No | Yes | |
| Have you fallen within the last 6 months? | No | Yes | |
| Do you use any mobility aids? e.g. Walking stick, frame | No | Yes | ***Please ensure you bring your mobility aid to hospital with you*** |
| Do you have an Advance Care Directive, Advance Care Plan or Enduring Power of Attorney - health and medical guardian? | No | Yes | ***If so, please bring a copy of these documents with you*** |
| Difficulties with attention span, understanding or problem solving | No | Yes | |
| Short term memory loss or dementia | No | Yes | |
| Have you ever had an adverse reaction to a blood transfusion or a transfusion of blood products | No | Yes | |
| Are you a registered organ donor? | No | Yes | |
| **YOUR PHYSICAL HEALTH: Do any of the following apply?:** | | | **If yes, please comment below** |
| Heart attack / heart failure / angina or cardiomyopathy | No | Yes | |
| Artificial heart valve / implant / defibrillator / pacemaker | No | Yes | |
| Stents or Heart Bypass | No | Yes | |
| Blood pressure problems / low / hypertension | No | Yes | |
| Irregular heart beat or murmur | No | Yes | |
| Stroke / CVA / TIA | No | Yes | |
| History of Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE) | No | Yes | |
| Vascular disease / aneurysm | No | Yes | |
| Thyroid disease / disorder | No | Yes | |
| Epilepsy / fits / seizures | No | Yes | |

DO NOT WRITE IN MARGIN

PATIENT HISTORY SHEET

CPSEPT2016

MR/081

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

| | | | |
|---|---|---|---|
| Neuromuscular disease / Parkinson's / MS | No | Yes | |
| Depression / mental illness / anxiety / panic attacks | No | Yes | |
| Speech problems or swallowing problems | No | Yes | |
| Bleeding disorder or problem | No | Yes | |
| Liver disease / disorder / hepatitis | No | Yes | |
| Kidney disease / disorder / dialysis | No | Yes | |
| Bladder problems / incontinence | No | Yes | |
| Bowel disease / disorder / incontinence | No | Yes | |
| Gastric Reflux / Ulcers / Hiatus hernia | No | Yes | |
| Lap Band surgery or stomach stapling | No | Yes | |
| Rheumatoid Arthritis / osteoarthritis | No | Yes | |
| Lymphoedema | No | Yes | |
| Significant back / neck injury | No | Yes | |
| Organ failure / transplant | No | Yes | |
| Any form of cancer | No | Yes | |
| Any other illness / condition *(please specify)* | No | Yes | |

**If the response to any of the questions below is YES please contact**
**The Bays Hospital Preadmission Nurse Phone 5976 5210 prior to your admission date.**

| **Carbapenem Resistant Enterobacteriaceae (CRE) Admission Screening Questionnaire** | | |
|---|---|---|
| Have you / the patient been directly transferred from any overseas healthcare facility? | No | Yes |
| Have you / the patient been admitted to any overseas healthcare facility in the past 12 months? | No | Yes |
| Have you / the patient resided in any overseas Residential Aged Care Facility in the past 12 Months? | No | Yes |
| Have you / the patient been identified as a CRE contact during any hospitalisation, but have been shown to have negative cultures? | No | Yes |
| Have you / the patient had a past demonstrated CRE colonisation or infection? | No | Yes |

| **Creutzfeldt-Jacob Disease (CJD)** | | | **If yes, please comment below** |
|---|---|---|---|
| Have you suffered from a recent rapid progressive dementia, physical or mental, the cause of which has not been diagnosed? | No | Yes | |
| Do you have a family history of 2 or more first-degree relatives with CJD or other undiagnosed neurological illness? | No | Yes | |
| Have you received human pituitary-derived gonadotrophin (for infertility) or growth hormone (for short stature)? | No | Yes | |
| Have you received a dura mater graft in a neurological or other surgical procedure before 1990 | No | Yes | |
| Have been involved in a CJD look back? | No | Yes | |
| Do you have a "Medical In Confidence" Letter in regard to your risk of CJD? | No | Yes | |

| **Acute Respiratory Infection** | | | **If yes, please comment below** |
|---|---|---|---|
| Do you have a fever and / or respiratory symptoms? Cough, sore throat, runny nose | No | Yes | |
| Have you had recent contact with a person diagnosed with Acute Respiratory Infection or Acute Respiratory Illness in the last 7 days - seasonal or pandemic | No | Yes | |
| Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or pandemic either overseas or within Australia in the last 7 days | No | Yes | |

DO NOT WRITE IN MARGIN

CPSEPT2016

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

| Other Questions | | | | If yes, please comment below |
|---|---|---|---|---|
| Do you smoke? | No ☐ | Quit, over one month ago? ☐ | Current smoker ☐ | How many a day? |
| What is your daily alcohol intake? | | | | |
| Do you use recreational drugs? | | No | Yes | |
| Impaired vision | | No | Yes | |
| Impaired hearing | | No | Yes | |
| Any special needs during your stay? | | No | Yes | |
| Are you pregnant? How many weeks? | | No | Yes | |

| PREVIOUS PROCEDURES AND SURGERY (If yes, please list below) | Approximate Year |
|---|---|
| | |
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| Have you previously had a general anaesthetic | No | Yes | List any reactions below |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## DISCHARGE PLANNING

| | | |
|---|---|---|
| Do you live alone? | No | Yes |
| Do you have someone to care for you after discharge? | No | Yes |
| Name: Contact number: | Relationship: | |
| Are you solely responsible for the care of another person at home? | No | Yes |
| Do you currently use any community or nursing services? | No | Yes |
| Do you require assistance with daily living? | No | Yes |
| Where do you plan to go following discharge? | Home | Other: |
| Who is picking you up? | Contact number: | |

DO NOT WRITE IN MARGIN

CPSEPT2016

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

## MEDICATION SUMMARY

While you are a patient in our hospital we will endeavour to ensure that all medications prescribed for you are safe and appropriate. It is important to have an accurate record of all medication that you are already taking, or have recently ceased. **Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products.** Please also include all eye drops, patches, natural medicines or topical products. If you have any problems completing the list below please contact your Local Doctor (GP) or Local Pharmacy for assistance.

**PLEASE BRING TO HOSPITAL A PRINTED LIST OF ALL MEDICATION PRESCRIBED TO YOU BY YOUR DOCTOR AND ALL CURRENT MEDICATIONS IN THE ORIGINAL PACKAGING IF AVAILABLE**

| Current Medication | Strength | Dose | Reason for taking? | Taking for how long? |
|---|---|---|---|---|
| *e.g. Aspirin* | *100mg* | *1 daily* | *To thin blood* | *2 years* |
| | | | | |
| | | | | |
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| | | | | |

| Medication STOPPED in the past 2 weeks | Strength | Dose | Reason for taking? | When/why stopped? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Charges for medication provided during your stay in hospital will be billed to your pharmacy account according to the agreement between your Private Health Fund and the Hospital. Not all pharmacy items will be covered by your health fund. In this case a pharmacy account will be presented to you on discharge.

## ALLERGY OR ADVERSE REACTIONS

***Such as latex, food, skin prep, medication, antiseptic, tapes and other***

**Identify the allergy: If you have an allergy describe the reaction e.g. rash**

**The information I have provided here is accurate and complete to the best of my knowledge**

| | |
|---|---|
| **Patient signature:** | **Date:** |
| **Reviewed by Pre-admission Nurse - name and signature:** | **Date:** **Screen** ☐ **Phone R/V** ☐ **Clinic R/V** ☐ |
| **Admitting Nurse name and signature:** | **Date:** |

DO NOT WRITE IN MARGIN

CPSEPT2016

THE BAYS

The Bays Healthcare Group Inc

**CONSENT TO COLLECTION AND USE OF PERSONAL AND HEALTH INFORMATION**

UR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

The Bays Hospital Group Inc embraces the Australian Privacy Principles and Health Privacy Principles in relation to personal and Health Information. In summary, these principles state that:

- The Bays only collects information that is:
- Necessary to provide health services to you;
- Required by law;
- Required to meet statutory reporting requirements;
- Required to enable the hospital to receive payment for the services it provides.

Health information about an individual will only be collected from that individual, except where it is impracticable to do so (such as in the case of minors, or those who are physically or mentally incapable of doing so).

- The Bays only uses or discloses information for the purpose it was collected.
- Information collected, used or disclosed by The Bays is accurate and up-to-date.
- Information collected by The Bays is protected against unauthorised use or disclosure.
- The Bays Privacy Policy "Privacy of Personal and Health Information" is available to anyone who requests it.
- Other than in exceptional circumstances, individuals are entitled to access their health information and to seek correction of incorrect information.
- Commonwealth assigned identifiers such as Medicare number are not used by The Bays as patient identifiers.
- Individuals have the right to not identify themselves, unless this would provide impractical (for example where this would mean the hospital was unable to claim benefits from a health fund) or illegal.
- Health information is considered to be sensitive information under the privacy legislation.
- Health information shall be made available to other health service providers with the individual's consent, except where there may be a serious or imminent threat to the life of any person, and the individual is unable to provide consent, or it is required to treat the condition for which The Bays originally collected it, in which case it may be made available without consent.

I acknowledge that I have received The Bays brochure **"What Happens to Information About Me".**

**I consent to The Bays Hospital Group collecting and using personal and health information about**

……

*Insert "ME" or name of person about whom information is being collected.*

**In accordance with The Privacy Act 1988 [incorporating the Privacy Amendment (Private Sector) Act 2000]. The Health Records Act 2001 and The Bays' Policy "Privacy of Personal and Health Information". In the Residential Care facility this will include having a photograph taken.**

**I also consent to the use and disclosure of information about me (or the person on whose behalf I have consented) to the agencies and service providers listed over the page, and consent to this being disclosed via facsimile or email where deemed necessary to prevent delays in ongoing care.**

**NAME:……** **RELATIONSHIP TO PATIENT OR RESIDENT:……**

**SIGNATURE:……** **DATE……**

DO NOT WRITE IN MARGIN

CPJAN2016

CONSENT TO COLLECTION AND USE OF PERSONAL AND HEALTH INFORMATION MR/111

THE BAYS

The Bays Healthcare Group Inc

# CONSENT TO COLLECTION AND USE OF PERSONAL AND HEALTH INFORMATION

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

## AGENCIES AND SERVICE PROVIDERS TO WHOM INFORMATION IS PROVIDED

| AGENCY / SERVICE PROVIDER | INFORMATION PROVIDED |
|---|---|
| **Health Fund/Third Party Payer/Commonwealth Dept of Health and Aged Care** | Details regarding your hospitalisation to enable us to be paid for the care we provide. This may include information in code format regarding your medical condition and operations performed. This information identifies you by name. |
| **Pathology, Radiology, Ambulance Service, Pharmacy** | Socio-demographic data, health fund membership, pension and medicare details, ambulance membership number and medication prescriptions. |
| **State Health Department** | De-identified socio-demographic data and coded information regarding the medical condition you were treated for.<br>If you have a baby, information about your pregnancy and delivery will be forwarded to the Perinatal Data Collection Unit.<br>In the event that you are treated for a "notifiable" disease, information about you will be forwarded to the Health Department. This will identify you by name. |
| **Private Hospitals Data Bureau** | De-identified socio-demographic data, coded information regarding the medical condition you were treated for and information in relation to our charges. |
| **Anti-Cancer Council of Victoria** | In the event that you are treated for cancer, information about you, your admission, the type of cancer and the doctor who treated you will be provided. |
| **Local Council** | If you have had a baby, the local Council will be advised so the Maternal Child and Health Care Nurse is aware of the birth. |
| **Australian Bureau of Statistics (ABS)** | Each year, the hospital sends collective statistics in relation to hospital activity to the ABS. This does not identify any individuals. |
| **Other Healthcare Providers** | If you are transferred to another hospital or health service provider, a summary of your admission will be sent with you to ensure continuity of care. You will be given information regarding your medications on discharge to give to your community pharmacist and local doctor.<br>Once you have left hospital, your written consent will be required for us to release personal or health information about you to another health care provider, except where there may be a serious or imminent threat to life or health of *any* person, and you are unable to provide consent, or it is required to treat the condition for which The Bays originally collected it, in which case it may be made available without consent. |
| **Individuals** | You can request access to your health information. Please refer to the brochure provided on admission or contact the Health Information Manager or Hospital Supervisor at The Bays on 5975 2009. The hospital charges a fee to provide access to your health information. |
| **Hospital Medical Quality Assurance Sub-Committees** | Doctors and key hospital staff meet regularly to discuss medical clinical indicators such as unplanned return to operating theatre and reasons for induction of labour, to ensure quality care. Individual cases are discussed, but neither patients, nor their doctors are identified by name. |
| **Australian Council on Healthcare Standards** | Statistical information regarding key medical clinical indicators such as readmission rates. This does not identify any individual patient. |
| **Residential Care Validation Team** | The RCS Validation Team is entitled to view your residential care record in order to validate the care level assigned by The Bays. |
| **Court** | If your health information is subpoenaed to be presented to a law court, or the subject of a search warrant, the hospital must comply with this request. In the event of a death being the subject of a Coroner's Case, your health information must be sent to the Coroner's Court. |

DO NOT WRITE IN MARGIN

THE BAYS

The Bays Healthcare Group Inc

# SETTLING YOUR ACCOUNT

As you are aware there are out of pocket costs that are met by the patient.

These include:-

- The amount to be paid on admission – our best estimate of fees at that time
- The amount to be paid on discharge – any additional fees that **may arise** during your stay in hospital

You will be requested to meet these out of pocket charges by cheque, EFTPOS, credit card or cash.

In rare circumstances, additional costs may come to light after you have been discharged from hospital, e.g. if a health fund rejects a claim, late advice about anti-embolism stockings or disposables used in Theatre, or you may not have been able to settle your account on discharge due to Reception being closed or transfer by ambulance, etc.

In these circumstances, please indicate below your authority to utilise your credit card details to process payment of any final or late costs.

**You will receive a courtesy phone call prior to charging your credit card.**

Equally, patients are often entitled to a refund, if our early estimate of gap or deductible costs turns out to be too high. If a refund is due to you, a credit card entry will ensure quick payment of your entitlement.

## CREDIT CARD AUTHORISATION

I, ……..(please print name) authorise The Bays Hospital to process credit card transactions as follows:-

☐ Refund any overpayment
☐ Deduct any cost identified after discharge
☐ Charge all agreed expenses prior to admission

*Credit Card (Tick one)*

Cardholder's Name _____ ☐ Mastercard ☐ Visa

Card No. Verification No.

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | |

Expiry Date _____ Cardholder's signature _____

**THIS FORM WILL BE DESTROYED ONCE THE ACCOUNT IS FINALISED IN FULL**

THE BAYS

**The Bays Healthcare Group**
Caring for the Peninsula

UR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

# COMMUNICATION CONSENT FORM

The Bays Healthcare is one of the few remaining not for profit, community-owned healthcare organisations in Australia. We are also a registered charity. We rely on the generosity of the community to provide the people of the Mornington Peninsula with high quality healthcare services.

The Bays was formed in 1997 with the amalgamation of the Mornington Bush Nursing Hospital (established in 1937) and the Hastings and District Bush Nursing Hospital (established in 1930). Generations of local families have used the maternity, surgical and medical facilities over the years and, when in need of aged care services, they welcome the opportunity to have loved ones cared for within the community environment in which they have lived.

Today, we operate a Hospital in Mornington, and Aged Care and Dialysis Unit - both in Hastings. Our patients are at the heart of everything we do and every decision we make. We maintain the vision and ideals of a truly local and progressive community owned and supported hospital.

The Bays does not receive ongoing funding from either state or federal governments, we rely on the support of the local community to remain viable. All funds generated by the hospital and aged care facility are reinvested into the provision of state-of-the-art equipment, facilities and services in the best interests of patients and residents.

An essential part of our past and future success is our membership base from within the community and donations. People who elect to become members of The Bays not only play a vital role in the governance of the organisation but help us stay well-connected to the needs of our community.

**I consent to receiving communication from The Bays following my discharge on organisational updates, building projects, fundraising events and other activities.**

☐ Yes ☐ No

**I would like to be contacted by (please select only one):**

☐ Post The postal address as per your patient registration form, or

☐ Email Please enter your email your address _____

**I would like to receive (select as many as you like):**

☐ Newsletter

☐ Invitations to events, including free health information sessions

☐ Information on membership

☐ Information on how to make a donation in thanks for The Bays care

☐ Information on volunteering

☐ Information on how to leave a gift to The Bays in your will

**Thank you**