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.

It may be faster and easier for you to fill in the form online. Visit the hospital website **www.thebays.com.au/hospital/our-hospital** and click on the **Patient Admission Portal** link located in Downloads and Links. By completing your admission online, some of this information will be retained for future admissions and will only require updating.

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

Vale Street, Mornington 3931
Phone 5975 2009
Fax 5975 2373
Email reception@thebays.com.au

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

MR 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 financial member of The Bays? Individual ☐ Family ☐

ADDRESS

State Postcode

TELEPHONE Home No. Mobile Work

EMAIL

Medicare No. - - **Card Ref. No** **Valid to** **Please bring in on admission**

☐ Health Care Card ☐ Government Pension Card Number

☐ DVA Pension Card DVA CARD - GOLD ☐ WHITE ☐ 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** ☐ **UNINSURED** ☐ **DVA** ☐

Health Fund/Insurance Co. Membership No.

DVA Number

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

Reason for admission:

ADMITTING DOCTOR/SURGEON

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

CPMAY2020

MR/001

THE BAYS

The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

Please fill in if no Patient label available

If you are under the care of any other Medical Specialists please give details below			
	Last review date		Last review date
Physician		Cardiologist	
Vascular Doctor		Diabetes Educator	
Kidney specialist		Respiratory Physician	

HEALTH HISTORY - please tick yes or no to the following	WEIGHT		HEIGHT	
CENTRAL NERVOUS SYSTEM	**No**	**Yes**	**Provide details below**	
Neuromuscular disease ☐ Parkinsons ☐ Multiple Sclerosis ☐ Motor Neurone Disease ☐				
Depression ☐ Mental illness ☐ Anxiety ☐ Panic attacks ☐				
Difficulties with attention span, understanding or problem solving				
Short term memory loss ☐ Confusion ☐ Dementia ☐				
Epilepsy ☐ Fits ☐ Seizures ☐				
Migraines				
CARDIOVASCULAR	**No**	**Yes**	**Provide details below**	
Bleeding disorder ☐ Anaemia ☐ Bleeding problems ☐ Bruise easily ☐				
Heart attack ☐ Heart failure ☐ Angina ☐ Cardiomyopathy ☐				
Artificial heart valve ☐ Implantable Defibrillator ☐ Pacemaker ☐				
Cardiac stents ☐ Cardiac bypass ☐				
Blood pressure problems ☐ Low ☐ Hypertension ☐				
Irregular heart beat ☐ Murmur ☐ Palpitations ☐				
Stroke ☐ Cerebrovascular Accident ☐ TIA ☐				
History of Deep Vein Thrombosis (DVT) ☐ Pulmonary Embolus (PE) ☐				
Vascular disease ☐ Vascular aneurysm ☐				
RESPIRATORY	**No**	**Yes**	**Provide details below**	
Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Asbestosis ☐				
Do you use home oxygen?				
Sleep apnoea ☐ Disturbed sleep ☐ Snoring ☐				
Do you use a CPAP machine? Do you know the pressure? _____			*Please ensure you bring your CPAP machine to hospital with you*	
GASTROINTESTINAL	**No**	**Yes**	**Provide details below**	
Speech problems ☐ Swallowing problems ☐				
Liver disease ☐ Hepatitis ☐ Jaundice ☐				
Bowel disease ☐ Faecal incontinence ☐				
Gastric reflux ☐ Stomach ulcer ☐ Hiatus hernia ☐				
Have you had gastric banding surgery ☐ Sleeve gastrectomy ☐ Gastric bypass ☐			*If yes, please contact your Anaesthetist*	
Do you have any eating difficulties or special dietary needs?			Specify:	
Did you lose weight in the last 6 months without trying?				
Do you have a decreased appetite?				

DO NOT WRITE IN MARGIN

PATIENT HISTORY SHEET

CPAPR2020

MR/081

HEALTH HISTORY - please tick yes or no to the following			
ENDOCRINE	**No**	**Yes**	**Provide details below**
Do you have diabetes? Type 1 ☐ Type 2 ☐			
Do you manage your diabetes with: Diet ☐ Tablet ☐ Insulin ☐			
Thyroid disease			
RENAL	**No**	**Yes**	**Provide details below**
Kidney disease ☐ Kidney failure ☐ Dialysis ☐			
Bladder problems ☐ Urinary incontinence ☐			
SKIN & MUSCULO-SKELETAL	**No**	**Yes**	**Provide details below**
Rheumatoid arthritis ☐ Osteoarthritis ☐			
Spinal injury ☐ Back pain ☐ Neck pain ☐			
Have you had spinal surgery?			
Do you have any wounds, or breaks on your skin?			
Do you have or have had any pressure injuries / ulcers / bedsores?			
Do you have any implants / prosthesis (eg. hip replacement)?			
MISCELLANEOUS / RISK IDENTIFICATION	**No**	**Yes**	**Provide details below**
Cancer: specify site(s)			
Are you currently undergoing chemotherapy?			Last given: / /
Are you a registered organ donor			
Do you have an Advanced Care Directive ☐ Advanced Care Plan ☐ Enduring Power of Attorney (medical treatment) ☐			If so, please bring a copy of these documents with you
Do you have a spinal cord stimulator			If so, please bring remote into hospital
Blood tests taken for this admission			
Pathology company:			
Blood thinning medication - Warfarin, Plavix, Cartia, Astrix, Iscover, Asasantin, Pradaxa, Xarelto, Eliquis, Brillinta, Effient			Please ensure you bring your medications to hospital with you
Blood thinning medication stopped?			If stopped - when?
Warfarin Pathology Collector: Last INR: Usual Warfarin Dose:			
ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission			Please bring with you to hospital
Do you have a fear of falling or are you unsteady on your feet?			
Have you experienced fainting or dizziness in the last 6 months?			
Have you fallen / tripped within the last 6 months?			
Do you use any mobility aids? Eg. Walking stick, frame			Please ensure you bring your mobility aid to hospital with you
Have you ever had an adverse reaction to a blood transfusion or a transfusion of blood products			
Lymphoedema risk ☐ Lymphoedema condition ☐			
Organ failure ☐ Organ transplant ☐			
Any other illness / condition - please specify			
Do you or have you ever smoked? Smoker ☐ Ex-smoker ☐			Daily amount: Date ceased: / /
What is your daily alcohol intake?			
Do you use recreational drugs?			Daily amount: Type: Ceased date: / /
Impaired vision			
Impaired hearing. Please document if hearing aids are with the patient at the time of admission.			
Dentures ☐ Plate ☐ Crowns ☐ Caps ☐ Braces ☐			Upper ☐ Lower ☐ Both ☐
Any special needs during your stay?			
Are you pregnant? How many weeks?			

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The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

Please fill in if no Patient label available

If the response to any of the questions BELOW is YES please contact The Bays Hospital Pre-admission Nurse: Phone 5976 5210 prior to your admission date.

	INFECTION CONTROL SCREENING	No	Yes	Provide details below
Carbapenem Resistant Enterobacteriaceae (CRE) and Candida Auris Screening	Have you / the patient ever been informed you have had a multi-resistant organism infection?			
	Have you / the patient been directly transferred from any overseas healthcare facility?			
	Have you / the patient been admitted to any overseas healthcare facility in the past 12 months?			
	Have you / the patient resided in any overseas Residential Aged Care Facility in the past 12 months?			
	Have you / the patient been identified as a Candida auris and /or CRE contact during any hospitilisation?			
	Have you / the patient had a confirmed Candida auris and / or CRE infection?			
Creutzfeldt-Jakob Disease (CJD)	Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990?			
	Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prior disease, where a genetic cause has not been excluded?			
	Have you suffered from a recent (less than 12 months) progressive dementia illness (physical or mental), the cause of which has not been diagnosed / explained?			
	Have you received human pituitary hormones for infertility of human growth hormone for short stature, prior to 1986?			
	Have you been involved in a “Look Back” study for cCJD or in possession of a “Medical in Confidence Letter” regarding risk of cCJD?			
Acute Respiratory Infection	Do you have a fever and / or respiratory symptoms? Cough, sore throat, runny nose			
	Have you had recent contact with a person diagnosed with Acute Respiratory Infection or Acute Respiratory Illness in the last 14 days - seasonal or pandemic			
	Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or pandemic either overseas or within Australia in the last 14 days			

PREVIOUS PROCEDURES AND SURGERY (If yes, please list below)	Approximate year of surgery
Have you previously had a general anaesthetic? No ☐ Yes ☐	List any reactions below

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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

Do you use a Dose Administration Aid eg. Webster Pack/Sachets/Pill Box? ☐ No ☐ Yes Which Pharmacy? _____

Current Medication	Strength	Dose	Reason for taking?	Taking for how long?
				2 years

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.

DO YOU HAVE ANAPHYLAXIS? ☐ **Yes** ☐ **No**
If yes, what causes the **ANAPHYLAXIS?** _____
(PLEASE ENSURE YOU BRING YOUR EPIPEN AND ANAPHYLACTIC MANAGEMENT PLAN TO HOSPITAL WITH YOU)

Do you have any ALLERGIES or ADVERSE REACTIONS to any medications, latex, tapes, skin preps, antiseptics or other? ☐ **Yes** ☐ **No**
If yes, please state the name and the reaction _____

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

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

CPAPR2020