THE BAYS

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

# Maternity admission forms

**Welcome to The Bays Hospital Maternity Unit. Please accept our congratulations on your pregnancy.**

### Midwifery Booking-In Process

To ensure a smooth booking process, please read the following requirements so we receive the necessary information for the Booking-In process:

- Booking-In pack information obtained from the Doctor's rooms is divided into:

| Part A | Part B |
|---|---|
| *(available on our online Patient Portal)* | Edinburgh Scale MR/101 |
| Patient Registration MR/001 | Collection of Information MR/111 |
| Patient History Sheet MR/081 | Paediatric Services MR/141 |
| Obstetric Booking Form MR/288 | Use of Mobile Phones MR/151 |

You may choose to complete:

**Option 1.** It may be faster and easier for you to fill in Part A online via our Patient Portal. 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 the information will be retained for future admissions and will only require updating. Part B needs to be completed by hand.

or

**Option 2.** Part A (patient information) and Part B (specific maternity information) by hand

- If you have chosen the 'Option 1', then you need to inform the reception staff when you hand in Part B that this needs to be added to the Part A you completed online.
- When both Sections of the paperwork are complete, you will need an appointment with our Maternity Liaison Midwife. These are 30-minute telephone appointments where our midwife will review your completed documents as well as answer any questions you might have.
- Prior to your appointment time, please ensure this completed pack is returned to The Bays reception where you will be given an Antenatal Pack with information regarding your stay.
- Appointment is made by ringing reception on **5975 2009** or alternatively, you could also arrange your appointment whilst you are dropping your pack to The Bays Reception and our friendly front of house team will assist you with this.

Financial information is overleaf.

On your admission day, make sure you bring all of your current medications with you in their original packaging. If you have a medication list from your local doctor please bring this with you too.

Maternity unit tours are available. Visit our website to check our current maternity tour options. Bookings are essential.

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

**To book your appointment 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

Allanby TB0031 Oct 2021

# Maternity services financial information

### Patients with private health insurance

Please ensure you contact your Health Fund to verify your membership entitlements, i.e. all waiting periods served and no exclusions apply on your policy.
A health fund excess may apply which is payable on admission.

Health fund excess may also apply if your baby needs any additional care requiring admission into the Special Care Nursery. Ensure your baby is covered and if an excess is applicable.

The cost of ambulance transfer to another hospital is your responsibility and we recommend you have ambulance cover for yourself and your baby.

### Patients without private health insurance and medicare ineligible patients

If you elect to self-fund your stay in hospital there will be fees payable for:

- Birthing suite or theatre fee for Caesarean Section
- Private room fee per day
- Special Care Nursery (if baby needs admission) per day
- Doctor's fees are separate to any hospital costs.

Please call 03 5975 2009 for a quote and fee estimation.

A deposit of $100 is payable at the time of booking and full payment is required at least *one month prior* to your expected birthing date. There is a cancellation fee of $50.

Ambulance charges apply to yourself and your baby and are not the responsibility of The Bays Hospital.

### Childbirth sessions

Childbirth sessions are available to all couples booked into The Bays. Session dates will be organised on the day of booking in with the midwife.

### Special Care Nursery

The Bays Hospital has a special care nursery for babies who are premature, unwell or have more complex care needs. It is important that you check your health insurance as many single memberships do not cover newborn babies. If not covered, please call 03 5975 2009 for a quote and fee estimation.

# Part A

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

MR/001

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

MR 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* | | | |
|---|---|---|---|
| | Last review date | | Last review date |
| Physician | | Cardiologist | |
| Vascular Doctor | | Diabetes Educator | |
| Kidney specialist | | Respiratory Physician | |

**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 dietary/foods or other?** ☐ **Yes** ☐ **No**

**If yes, please state the name and the reaction** _____

Any special dietary requirements? ☐ No ☐ Yes If so, please specify: _____

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

| **HEALTH HISTORY** - please tick yes or no to the following | **WEIGHT** | | **HEIGHT** | | **BMI** | |
|---|---|---|---|---|---|---|
| **CENTRAL NERVOUS SYSTEM** | **No** | **Yes** | **Provide details below** | | | |
| Neuromuscular disease ☐ Parkinsons ☐ Epilepsy ☐ Multiple Sclerosis ☐ Motor Neurone Disease ☐ Seizures ☐ | | | | | | |
| Depression ☐ Mental illness ☐ Anxiety ☐ Panic attacks ☐ | | | | | | |
| Short term memory loss ☐ Confusion ☐ Dementia ☐ | | | | | | |
| **CARDIOVASCULAR** | **No** | **Yes** | **Provide details below** | | | |
| 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 ☐ | | | | | | |
| History of Deep Vein Thrombosis (DVT) ☐ Stroke ☐ T/A ☐ Pulmonary Embolus (PE) ☐ | | | | | | |
| Vascular disease ☐ Vascular aneurysm ☐ | | | | | | |
| Blood thinning medication - Aspirin (Cartia/Astrix) ☐ Plavix/Isocover ☐ Warfarin ☐ Asasantin ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Brillinta ☐ Effient ☐ | | | Please ensure you bring your medications to hospital with you | | | |
| Has your doctor advised you to stop your blood thinning medication? | | | If stopped - when? | | | |
| **RESPIRATORY** | **No** | **Yes** | **Provide details below** | | | |
| Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Asbestosis ☐ | | | | | | |
| Do you use home oxygen? | | | | | | |
| Sleep apnoea ☐ Snoring ☐ | | | | | | |
| Do you use a CPAP machine? *Please ensure you bring your CPAP machine to hospital with you* | | | | | | |
| **GASTROINTESTINAL** | **No** | **Yes** | **Provide details below** | | | |
| Speech problems ☐ Swallowing problems ☐ | | | | | | |
| Liver disease ☐ Hepatitis ☐ | | | | | | |
| Bowel disease ☐ Faecal incontinence ☐ Coeliac disease ☐ | | | | | | |
| 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 a Stoma? | | | | | | |

DO NOT WRITE IN MARGIN

PATIENT HISTORY SHEET

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 failure ☐ Dialysis ☐ Kidney disease ☐ | | | |
| Bladder problems ☐ Urinary incontinence ☐ | | | |
| | | | |
| **SKIN & MUSCULO-SKELETAL** | **No** | **Yes** | **Provide details below** |
| Rheumatoid arthritis ☐ Osteoarthritis ☐ | | | |
| Do you have a spinal cord stimulator | | | If so, please bring remote into hospital |
| Do you have any wounds, or breaks on your skin? | | | |
| Do you have or have had any pressure injuries / ulcers / bed sores? | | | |
| | | | |
| **ONCOLOGY** | **No** | **Yes** | **Provide details below** |
| Cancer: specify site(s) | | | |
| Are you currently undergoing chemotherapy? | | | Last given: / / |
| Are you currently undergoing radiation therapy? | | | Last given: / / |
| Do you have a Central Venous Access device (eg. Portacath, PICC, Hickman) | | | |
| **INVESTIGATIONS** | **No** | **Yes** | **Provide details below** |
| Blood tests taken for this admission | | | |
| Pathology company: | | | |
| ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission | | | Please bring with you to hospital |
| | | | |
| **ALERTS** | **No** | **Yes** | **Provide details below** |
| 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? Glasses ☐ Contact Lenses ☐ | | | Please bring glasses with name on frame and case |
| Impaired hearing. Hearing aids ☐ | | | Please bring hearing aids in named case |
| Dentures ☐ Plate ☐ Crowns ☐ Caps ☐ Braces ☐ | | | Upper ☐ Lower ☐ Both ☐ |
| Any special needs during your stay? | | | |
| Are you pregnant? How many weeks? | | | |
| Do you use any mobility aids? Eg. Walking stick, frame, wheelchair | | | Please ensure you bring your mobility aid to hospital with you |
| Have you fallen / tripped within the last 6 months? | | | |
| Lymphoedema risk ☐ Lymphoedema condition ☐ | | | |
| Any other illness / condition - please specify | | | |

DO NOT WRITE IN MARGIN

THE BAYS

The Bays Healthcare Group Inc

# PATIENT HISTORY SHEET

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

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 Production Enterobacteriaceae (CPE) and Candida Auris Screening | Have you / the patient ever been informed you have had a multi-resistant organism infection (eg. MRSA, VRE, ESBL)? | | | |
| | 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 CPE contact during any hospitilisation? | | | |
| | Have you / the patient had a confirmed Candida auris and / or CPE 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 |
|---|---|
| | |
| | |
| | |
| | |
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| | |
| | |
| Have you previously had a general anaesthetic? No ☐ Yes ☐ | List any reactions below |
| | |
| | |

DO NOT WRITE IN MARGIN

## 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* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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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.

| DISCHARGE PLANNING | No | Yes | Provide details below |
|---|---|---|---|
| Do you live alone? | | | |
| Do you have someone to care for you after discharge? | | | Please note: if going home on the same day as surgery you must have someone to care for you overnight |
| 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? | | | |
| Following discharge are you going home ☐ staying with friends/family ☐ rehab ☐ respite ☐ | | | |
| 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

THE BAYS

The Bays Healthcare Group Inc

# OBSTETRIC BOOKING FORM

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

**HOSPITAL USE ONLY** Please fill in if no Patient label available

## PLEASE COMPLETE BOTH SIDES & BRING BACK TO HOSPITAL WHEN BOOKING IN

Date of last normal menstrual period (LNMP): Due date by menstrual date / ultrasound:

Preferred name: Partner's name:

Obstetrician: Blood Group: ----------

Date of 1st visit to GP/O&G relating to pregnancy: ___/___/___ Gestation - 1st visit to GP/O&G ---------- weeks

Pre Pregnancy weight: ---------- Height: ---------- Is this a twin pregnancy? ☐ No ☐ Yes

Have you had any pregnancy related problems during this pregnancy (eg. gestational diabetes / pregnancy induced hypertension)? ☐ No ☐ Yes

If yes, please specify (including treatment): ----------

Do you have a history of depression or anxiety? ☐ No ☐ Yes

If yes, please specify (including treatment): ----------

Edinburgh score for this pregnancy: ---------- Weeks gestation completed: ----------

(Midwife to complete)

Plan for vaginal birth after a previous caesarean ☐ N/A ☐ Yes ☐ No

Do you intend to have pre-natal classes? ☐ Yes ☐ No

How do you plan to feed your baby? ☐ Breast ☐ Bottle ☐ Both ☐ Undecided

Have you had breast surgery (eg. breast reduction) or issues that could impact breast feeding ☐ Yes ☐ No

If yes, please specify: ----------

Previous breast feed experiences / services accessed ☐ No ☐ Yes

If yes, please specify: ----------

If you have any concerns you can discuss at booking-in with your midwife and/or request to see the Lactation consultant prior to the birth.

Lactation Consultant review requested ☐ Yes ☐ No ☐ Declined

**Investigations/Procedures:-**

| | | | | | |
|---|---|---|---|---|---|
| Ultrasound | ☐ Yes | ☐ No | If yes, how many weeks: | | |
| Maternal Serum Screening | ☐ Yes | ☐ No | Non Invasive Perinatal Testing (NIPT) | ☐ Yes | ☐ No |
| CVS | ☐ Yes | ☐ No | Amniocentesis | ☐ Yes | ☐ No |
| Assisted conception / IVF | ☐ Yes | ☐ No | | | |

Please specify if yes to IVF: ----------

DO NOT WRITE IN MARGIN

OBSTETRIC BOOKING

MR/288

THE BAYS

The Bays Healthcare Group Inc

# OBSTETRIC BOOKING FORM

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

**HOSPITAL USE ONLY** Please fill in if no Patient label available

**Please include all details of previous pregnancies, including miscarriages**

**GRAVIDA:** **PARITY:**

| Date | No. of weeks of pregnancy | Place of Birth | Type of Birth (Vaginal/Forceps/ Casesarean) | Length of Labour | Pain relief during labour | Gender | Weight | Breast/ Bottle/ Both | Name of child |
|---|---|---|---|---|---|---|---|---|---|
| eg. 1.1.2018 | 38 | The Bays | Forceps | 8 hrs | Pethidine, Epidural | M | 3500 | Both | Scott |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Did you have any complications during your previous pregnancies (eg. gestational diabetes / pregnancy induced hypertension? ☐ No ☐ Yes If yes, please specify (including treatment): ----------

Did you have any complications after the birth of your previous child(ren) (eg. post partum haemorrhage)? ☐ No ☐ Yes Please specify: ----------

Was your previous baby admitted to Special Care Nursery? ☐ No ☐ Yes

If yes, please specify: ----------

**Lifestyle**

Does your partner smoke? ☐ No ☐ Yes

If Yes, would you like a referral for QUIT information ☐ No ☐ Yes

If you have ceased smoking was it: before 20 weeks gestation ☐ No ☐ Yes

: after 20 weeks gestation ☐ No ☐ Yes

**Do you or your partner have a family history of:**

Multiple births ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Is the father of the baby of Aboriginal or Torres Strait Islander descent: ☐ Yes ☐ No

Genetic disorders ☐ Yes ☐ No

If yes, please specify: ----------

Other ☐ Yes ☐ No

If yes, please specify: ----------

**PATIENT'S SIGNATURE:**

**Midwife's Signature:** **Midwife's Name:** **Date:**

**DO NOT WRITE IN MARGIN**

# Part B

THE BAYS

The Bays Healthcare Group Inc

**EDINBURGH PRE & POST NATAL DEPRESSION SCALE CHECKLIST**

MR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

We would like to know how you have been feeling in the past week. **Please indicate which of the following comes closest to how you have felt in the past week**, not just how you feel today. Please **tick one box** for each question, which is the closest to how you have felt in the **past seven days**.

Please fill in prior to booking in appointment

| | |
|---|---|
| **1. I have been able to laugh and see the funny side of things.** | ☐ As much as I always could<br>☐ Not quite so much now<br>☐ Definitely not so much now<br>☐ Not at all |
| **2. I have looked forward with enjoyment to things.** | ☐ As much as I ever did<br>☐ Rather less than I used to<br>☐ Definitely less than I used to<br>☐ Hardly at all |
| **3. I have blamed myself unnecessarily when things went wrong.** | ☐ Yes, most of the time<br>☐ Yes, some of the time<br>☐ Not very often<br>☐ No, never |
| **4. I have been anxious or worried for no good reason.** | ☐ No, not at all<br>☐ Hardly ever<br>☐ Yes, sometimes<br>☐ Yes, very often |
| **5. I have felt scared or panicky for no very good reason.** | ☐ Yes, quite a lot<br>☐ Yes, sometimes<br>☐ No, not much<br>☐ No, not at all |
| **6. Things have been getting on top on me.** | ☐ Yes, most of the time I haven't been able to cope at all<br>☐ Yes, sometimes I haven't been coping as well as usual<br>☐ No, most of the time I have coped quite well<br>☐ No, I have been coping as well as ever |
| **7. I have been so unhappy that I have had difficulty sleeping.** | ☐ Yes, most of the time<br>☐ Yes, sometimes<br>☐ Not very often<br>☐ No, not at all |
| **8. I have felt sad or miserable.** | ☐ Yes, most of the time<br>☐ Yes, quite often<br>☐ Not very often<br>☐ No, not at all |
| **9. I have been so unhappy that I have been crying.** | ☐ Yes, most of the time<br>☐ Yes, quite often<br>☐ Only occasionally<br>☐ No, never |
| **10. The thought of harming myself has occurred to me.** | ☐ Yes, quite often<br>☐ Sometimes<br>☐ Hardly ever<br>☐ Never |

*Source Cpx JL: Holden JM Sagovsky R (1987) Detection of postnatal depression: development of the 10 item Edinburgh postnatal depression scale. Brit J Psychiatry 150:782-86. Developed as the Edinburgh Postnatal depression Scale and validated for use in both pregnancy and the postnatal period to assess for possible depression and anxiety.*

DO NOT WRITE IN MARGIN

EDINBURGH PRE & POST NATAL DEPRESSION SCALE CHECKLIST

MR/101

THE BAYS

The Bays Healthcare Group Inc

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

MR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

The Bays Healthcare 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 prove 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 Healthcare 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 ORRESIDENT:…….....**

**SIGNATURE:……** **DATE……**

**DO NOT WRITE IN MARGIN**

THE BAYS

The Bays Healthcare Group Inc

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

MR NUMBER _____

SURNAME _____

GIVEN NAMES _____

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. |
| **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 After Hours Coordinator 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

# PAEDIATRIC SERVICES & CHARGES FOR PATIENTS

MR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

It is important that expectant parents understand the services provided by paediatricians and the cost of those services.

The paediatrician's fee is not included in the fee raised by your obstetrician or by the hospital.

In some circumstances, for example, if you have a caesarean section or if there is concern about your baby after the birth, your obstetrician may call on the services and expertise of a paediatrician.

That assistance might be required at any time of the day or night.

Specialist paediatricians provide an 'on call' roster at The Bays. If your paediatrician is not immediately available out of normal hours, you may initially see one of the other paediatricians who works at the hospital.

The paediatricians may have slightly different fee structures. For more information on these different fee structures you will need to contact the individual paediatrician.

Please note:-

1. A proportion of those fees are eligible for rebate through Medicare.
2. Your private health fund may also contribute to those fees if you have 'Family Cover' and if your baby is admitted as a patient in its own right.*
3. You may be required to meet full paediatrician costs and then pursue rebates from Medicare and your health fund.

* If the baby does not have a significant medical problem, the health fund considers the baby to be a boarder, not a hospital inpatient.

Please contact the Maternity Unit at The Bays Hospital or your paediatrician if you have any queries about these arrangements.

I (name) _____
hereby acknowledge that I understand the contents of this document and accept full responsibility for the payment of fees for paediatric services that my baby might require.

Signed _____

Full Name (print) _____

Date _____

DO NOT WRITE IN MARGIN

THE BAYS

The Bays Healthcare Group Inc

**USE OF MOBILE PHONES & RECORDING DEVICES IN MATERNITY for Patients & Support Persons**

MR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

The Bays Healthcare Group recognises special and unique moments arise whilst in hospital which you or your family and friends may wish to capture on film.

For the safety and privacy of our patients, staff members and medical personnel, we do not allow mobile, video or sound recording devices to be used in the birthing rooms, theatre or special care nursery.

Single shot devices which do not record sound are permissible, if agreed to by the care team members present at the time.

Provided the privacy of other patients and staff members is not compromised, film and sound may be recorded in the privacy of your own room.

Signature _____ Signature of Support Person _____

Print Name of Patient _____ Print Name of Support Person _____

Date _____ Date _____

DO NOT WRITE IN MARGIN

USE OF MOBILE PHONES & RECORDING DEVICES IN MATERNITY for Patients & Support Persons