MACQUARIE
HOSPITAL SERVICES

Minchinbury Community Hospital

Cnr. Rupertswood Rd. & Great Western Highway Rooty Hill, NSW 2766
Phone: (02) 9625 2222 Fax: (02) 9675 9704

PRE - ADMISSION FORM

It is very important you complete ALL details below immediately and forward this form to the Admissions Office at the hospital.

Admission Date: ...../...../..... Admission Time: ..... am/pm

A. PATIENT'S PERSONAL DETAILS

Title: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. Surname: ..... Given Name/s: .....

Address: ..... Suburb: ..... Postcode: .....

Telephone: Home: ( ) ..... Work: ( ) ..... Mobile: .....

Religion: ..... Sex: ☐ Male ☐ Female

Date of Birth: ...../...../..... Age: ..... Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Next of Kin: Surname: ..... Given Name: ..... Relationship: .....

Address: ..... Suburb: ..... Postcode: .....

Telephone: Home: ( ) ..... Work: ( ) ..... Mobile: .....

B. HEALTH FUND DETAILS

Fund: ..... Membership No.: ..... Table/Schedule: ..... Excess: .....

Contributor's Surname: ..... Given Name/s: ..... Date of Birth: ...../...../.....

Address: ..... Suburb: ..... Postcode: .....

C. PATIENT'S MEDICAL DETAILS

Allergies: .....

Special Diet: ☐ Diabetic ☐ Vegetarian ☐ Low Fat ☐ Other (explain): .....

Nature of Illness / Operation : Surgical: ..... Item No.: .....

Admitting Doctor/ Specialist: ..... Address: .....

Referring Doctor: ..... Address: .....

Has your doctor ordered any pre- admission tests? e.g. ☐ Pathology ☐ X-ray Other: .....

D. DETAILS REQUIRED FOR HOSPITAL (Patient MUST supply these)

Medicare No: ..... ID No.: ..... Expiry:.....

Pension No.: ..... Veterans Affairs No: .....

Accommodation Details: ☐ Day Only ☐ Private ☐ Shared Country of Birth: .....

Language Spoken at Home: ..... ☐ Aboriginal ☐ Torres Strait Islander

Occupation: ..... Student: ☐ Yes ☐ No Name of School: .....

Have you been a patient in any other hospital in the past 28 days? ☐ Yes ☐ No If Yes, which hospital: .....

Have you been admitted to Minchinbury Hospital before? ☐ Yes ☐ No **Which Year ?** .....

Has your surname changed since your last admission? ☐ Yes ☐ No If yes, previous name: .....

PLEASE COMPLETE APPROPRIATE DETAILS ON REVERSE SIDE OF FORM

PRE - ADMISSION FORM

MCH 0019/1

PRE - ADMISSION FORM- Continued

E. WORKERS COMPENSATION DETAILS

Date accident/injury occurred: ...../...../..... How injury occurred.....

.....

Employed By Company: ..... Contact: .....

Address: ..... Suburb: ..... Postcode: .....

Telephone: ( ) ..... Fax ( ) .....

Has insurance company accepted liability? ☐ Yes ☐ No Name of Insurance Company: .....

Address: ..... Suburb: ..... Postcode: .....

Insurance Company Contact: ..... Claim No. .....

F. MOTOR VEHICLE THIRD PARTY DETAILS

Approved Claim No. and Insurance Details including letter or fax are required prior to admission.

Date accident/injury occurred: ...../...../..... Name of the driver of vehicle in which patient was travelling:.....

Address: ..... Suburb: ..... Postcode: .....

Telephone: ( ) ..... Mobile .....

Has insurance company accepted liability? ☐ Yes ☐ No Name of Insurance Company: .....

Address: ..... Suburb: ..... Postcode: .....

Insurance Company Contact: ..... Claim No. .....

Patient Financial Consent

I, ... (Patient's Name) have been informed of the estimate of fees to be charged and hereby undertake to pay any known gaps between the level of cover provided by my insurance company or health fund on admission. Further, I agree to pay my account or any outstanding fees within 21 days of being advised that liability or rebates have been rejected or paid at a lessor rate, by my insurance company or health fund.

I also acknowledge that there may be charges to the planned management of my condition, which may lead to a variation to the estimate of costs provided to me upon admission and agree to pay this amount on discharge.

I also agree to pay all additional charges incurred by me, not covered by my insurance company or health fund, which are identified after the admission.

Signature: ..... Date: ...../...../.....

Witness Signature: ..... Date: ...../...../.....

MINCHINBURY COMMUNITY HOSPITAL
DAY CARE UNIT

Cnr. Great Western Highway & Rupertswood Rd.
ROOTY HILL
Phone: (02) 9625 2222 Fax: (02) 9675 9704

SURNAME: _____
OTHER NAMES: _____
DOB _____ AGE _____ SEX _____
SPECIALIST: _____
REFERRING DOCTOR: _____
UNIT NO.

DATE OF PROCEDURE: ARRIVAL TIME:

DIAGNOSIS _____

OPERATION _____

CLINICAL HISTORY: _____

ALLERGIES _____

SPECIFIC PRE-OPERATIVE INSTRUCTIONS _____

_____ _____
SURGEON DATE

REQUEST FOR SURGICAL OPERATION/PROCEDURE

I, _____

of _____

request that the following operation/procedure be performed _____

*upon me/upon _____

Following a discussion of *my/the patient's present condition including the nature and likely results of the operation / procedure, I accept the profession opinion of Dr. _____ that this is the appropriate operation / procedure.

I also request and consent to the administration of anaesthetics, medicines, blood transfusion or other forms of treatment normally associated with this operation / procedure. I understand that other unexpected operations / procedures many be necessary and I request that these be carried out if required.

Although this operation / procedure is carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complications may occur with any operation / procedure and i accept the possible risks associated with tthis operation / procedure.

I have had the opportunity to ask questions about the above operation / procedure and I am satisfied with the information I have received.

I understand that these is always a possibility of transfer to another hospital.

_____ _____
Signature of Witness Signature of patient/guardian/relative

DAY SURGERY RECORD

YR0018.1

PRE-OPERATIVE ASSESSMENT

To be completed by all patients

OTHER NAMES:
DOB AGE SEX

SPECIALIST
UNIT NO.

Have you had any major illness during the past two years? **YES** ☐ **NO** ☐

If so, give details

Are you allergic to penicillin or any other drugs or medicine? **YES** ☐ **NO** ☐

Which ones?

Have you ever had any treatment for excessive bleeding? **YES** ☐ **NO** ☐

Have you ever had any anaesthetic before? **YES** ☐ **NO** ☐

Have you/ or any relative had any complications due to a previous anaesthetic? **YES** ☐ **NO** ☐

If so, describe what happened

Do you smoke? **YES** ☐ **NO** ☐ No. per day _____

Do you drink Alcohol? **YES** ☐ **NO** ☐ How many per day _____

Have you taken any drugs including Aspirin in the past 7 days?. **YES** ☐ **NO** ☐

If yes, give details.

PLACE A TICK BEFORE ANY OF THE FOLLOWING YOU HAVE HAD

☐ HEART DISEASE	☐ STROKE	☐ EPILEPSY	☐ HEAD COLD/FLU IN AST 2 WEEKS
☐ CHEST PAIN/PALPITATIONS	☐ LIVER DIS/HEPATITIS	☐ DIABETES	☐ PREGNANCY
☐ HIGH BLOOD PRESSURE	☐ CANCER	☐ LUNG DISEASE/ASTHMA	☐ ARE YOU IN HIGH RISK GROUP FOR AIDS?
☐ OTHER			

PLEASE LIST & BRING TO HOSPITAL, ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Questions relating to Creuctzfeldt Jacob Disease (CJD)

1. Have you had a dura mater graft between 1972-1989? Yes☐ No☐ Specify Details

2. Do you have a family history of 2 or more relatives with CJD or other specified progressive neurological disorder? Yes☐ No☐ Specify Details

3. Have you received human pituitary hormones (growth hormones) prior to 1985? Yes☐ No☐ Specify Details

4. Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed? Yes☐ No☐ Specify Details

For CJD patients who answer yes, Surgeon, Anaesthetist and theatres are to be notified immediately.

PRE-OPERATIVE CHECK LIST TO BE COMPLETED BY ADMITTING NURSE

TEMPERATURE ☐ PULSE ☐ BLOOD PRESSURE ☐ WEIGHT ☐ B.SL. ☐

☐ IDENTIFICATION BANDS	☐ CONSENT SIGNED
☐ DOCUMENTATION, X-RAYS	☐ FASTED FROM
☐ CONTACT LENSES REMOVED	☐ THEATRE CLOTHING
☐ JEWELLERY REMOVED	☐ BLADDER EMPTIED
☐ NAIL POLISH REMOVED	☐ ECG
☐ DENTURES	☐ ALLERGIES
☐ CROWN, CAPS	☐ ESCORT ARRANGED

(Name) _____

(Phone) _____

COMMENTS: _____

DATE: _____ TIME: _____ SIGNATURE (ADM NURSE): _____

CHECKED BY (MEMBER OF OPERATING TEAM): _____
Signature

PRIOR TO ADMISSION

We require you to visit the hospital at least one week prior to admission. This enables us to verify fund details and obtain all relevant information.

You will be given an estimation of your hospital account prior to booking the date for your surgery. Where possible, the hospital will claim this directly from the health fund for privately insured patients. Any balances not covered by your health fund will be payable by you on admission to the hospital. Credit card facilities are available but we do not accept personal cheques.

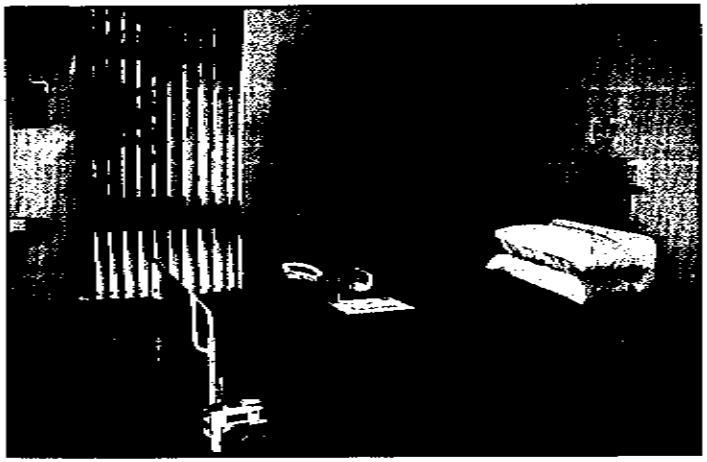
WORKERS COMP / THIRD PARTY

Patients admitted under the above act are advised that they are primarily responsible to the hospital for all fees and charges incurred. We will give you every assistance in claiming from the nominated insurance company once it has authorised the admission.

WHAT TO BRING

You need to bring the following items with you when you check into Minchinbury:

- > Current Medications
- > Private X-Rays
- > Personal Toiletries
- > Nightware, Robes, Slippers
- > Pension/Repatriation Card
- > Health Fund Card
- > Pharmacy Entitlement Card
- > Safety Net Card
- > Medicare Card



VISITING HOURS

Rehabilitation: Mon - Fri 4:00pm - 8:00pm.
Sat - Sun Midday - 8:00pm.

Surgical Ward: Mon - Sun Midday - 8:00pm.

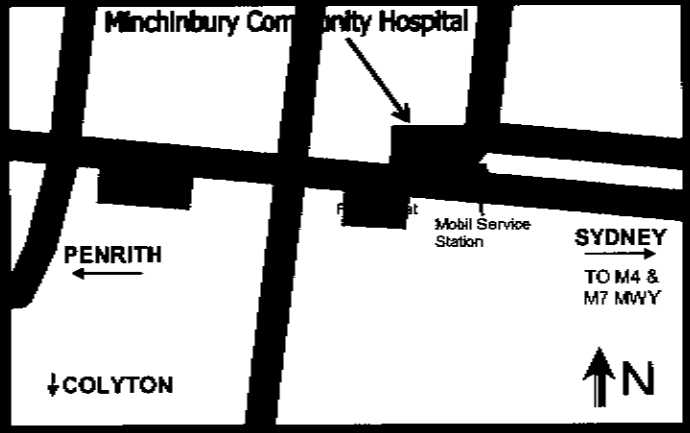
PUBLIC TRANSPORT

Our Hospital is situated only a few minutes away from Mt Druitt Railway Station. Just catch bus routes 739 and 737 from Mt Druitt Station to the Rooty Hill stop located at the front of the hospital.

PARKING

We offer convenient parking close to all entrances of the hospital. For ease of access ramps and gradients are provided to assist mobility. Disabled parking is available.

WHERE TO FIND US



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Cnr Rupertswood Rd and Great Western Hwy, Rooty Hill NSW 2770
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MACQUARIE HOSPITAL SERVICES

Minchinbury Community Hospital

[redacted]ocal
ospital

Providing the understanding and care that the residents of Western Sydney have the right to expect.

www.mhsminchinbury.com.au

WELCOME

The management and staff welcome you to Minchinbury Community Hospital. This brochure has been prepared to inform you about our high surgical and rehabilitation standards. Our committment is to maintaining a personal, professional and caring environment.

Nestled amongst landscaped gardens, we have been providing hospital care to the local community for the past 25 years. We provide excellent accomodation for our customers including:

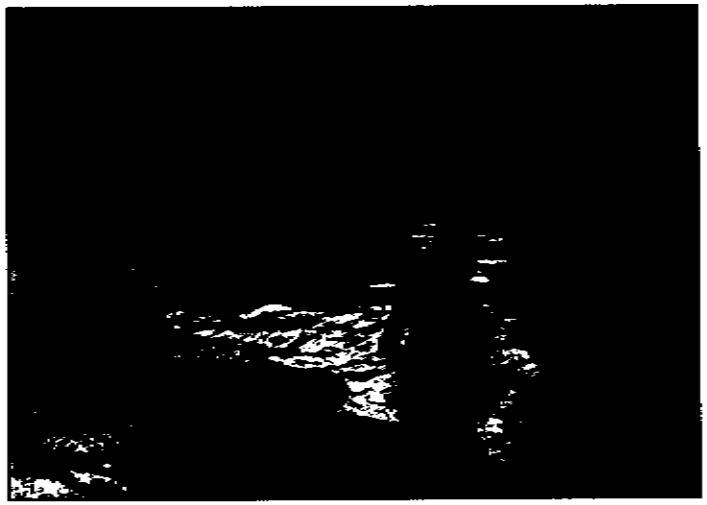
> Private Rooms with ensuite and TV
> Shared Rooms (2 Beds) with shared ensuite
> Shared Rooms (4 Beds)

Your comfort and care are of the utmost importance to us. If there is anything we can do to provide a better service, please advise us via our satisfaction surveys or one of our staff.

Thankyou for choosing Minchinbury Community Hospital and giving us the opportunity to provide a service of quality and value.

DAY SURGERY

The Day Surgery is designed for people having minor surgery that requires only a short stay in hospital with minimal disruption of lifestyle.



SURGICAL SERVICES

Minchinbury provides an extensive range of private facilities for Doctors and their patients.

The hospital's highly professional staff will make you feel welcome from the time you book your surgery until you leave. Our modern technology and instrumentation caters for such specialty services including:

- Urology
- Dentistry
- Gynaecology
- ENT Surgery
- Gastro Enterology
- Endoscopy
- Plastic and Cosmetic Surgery
- General and Vascular Surgery
- Facio-Maxillary Surgery
- Orthopaedic Surgery
- Ophthalmic Surgery

REHABILITATION UNIT

The pleasant rural surroundings of Minchinbury Community Hospital lend themselves to those recovering within the Rehabilitation Unit. We also offer medical facilities where you can be assured of a professional, highly skilled service in a caring environment. There is also a well equipped gymnasium and hydrotherapy pool.

ALLIED HEALTH SERVICES

Services provided include:

- Physiotherapy
- X-Ray
- Occupational Health
- Pathology
- Dietician
- Pharmacy
- Podiatrist
- Hydrotherapy

DISCHARGE

Discharge time is between 9am and 11am. Prior to leaving, please call at the office to complete any documentation and finalise the balance of your account. If you have had a General Anaesthetic, you must not drive a car for 24 hours. Make sure you have recieved all your follow up instructions from your nurse before you leave.

CHILDREN

Children and their parents are especially welcome at Minchinbury. We advise you bring your child to visit the hospital prior to admission. This allows for them to familiarise themselves with both the environment and the faces that will care for them during their stay. For infants, you will need to bring disposable nappies, formulas and bottles. Also, please don't forget their favorite toy.

HOSPITAL STAFF

NURSING STAFF:
Minchinbury prides itself on the professional care provided by its nursing staff. They are dedicated to providing the understanding and care that patients have a right to expect.

MEDICAL STAFF:
A Medical Officer, on duty or on close call, is always available to deal with any medical emergency that may arise.

HOTEL SERVICE STAFF:
The catering department serves excellent meals designed to meet all dietary needs from well balanced individual menus. Special requests about meals may be made to the Nurse Unit Manager.