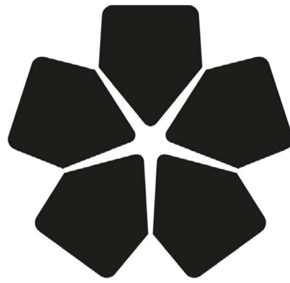


RECOMMENDATION FOR ADMISSION PACKAGE

To be used for Medical and Surgical Admissions

Includes:

- **Request for Admission Form**

For completion by Admitting Medical Officer (p1-2)
For completion by Patient/Relative/Carer (p3-4)

- **Patient History Form**

For completion by Patient/Relative/Carer

- **Discharge Planning Form**

For completion by Patient/Relative/Carer

- **General Information**

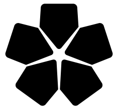
Please take or send the completed forms to the Surgical Admissions Unit Level 4, Lifehouse.

Please note that your admission cannot be processed without receipt of the completed forms.

SURGICAL ADMISSION CONTACTS

Phone: (02) 8514 1000
Fax: (02) 9383 1090
Email: daysurgery@lh.org.au

Surgical Admission Unit
PO Box M33
Missenden Rd NSW 2050



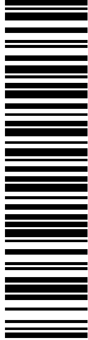
Chris O'Brien Lifehouse

REQUEST FOR ADMISSION FORM

Date [ ][ ][ ][ ][ ][ ]
D D M M Y Y

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O.
ADDRESS	
LOCATION	



LHR 030.3

ADMISSION DETAILS — PATIENT TO COMPLETE

Have you ever been a patient at Lifehouse? ☐ No ☐ Yes If Yes, most recent date ....

Mr. Mrs. Miss. Ms. Other:

Surname: Given Names: Preferred Name:

Sex: ☐ Male ☐ Female Date of Birth:

Country of Birth: Marital Status: Interpreter/Language:

Residential Address:

Suburb/Town: State: Postcode:

Postal Address: (☐ Tick if as per above)

Contact Number: Home: Business: Mobile:

Email address: *By providing an email address you consent to Lifehouse contacting you using that address*

Indigenous Status (please tick at least one box) ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Religion: ☐ Tick if no religion

Medicare Number: Number beside name on card: Expiry Date:

Pension/Concession Number:

PBS Entitlement Card Number: HealthCare Card Number:

Next of Kin	**Person to Contact** ☐ **Same as Next of Kin**
Mr. Mrs. Miss. Ms. Other:	Mr. Mrs. Miss. Ms. Other:
Surname:	Surname:
Given Name:	Given Name:
Relationship to Patient:	Relationship to Patient:
Address:	Contact No: Home: Work:
Suburb/Town: Postcode:	Mobile:
Contact Number: Home: Work:	**Do you have a nominated Medical Power of Attorney?**
Mobile:	☐ No ☐ Yes, please bring a copy of documents to the hospital

If we are unable to contact you directly, we may need to contact your above nominated next of kin to provide information relating to your admission. If you DO NOT consent to us contacting your next of kin, please tick here: ☐

BINDING MARGIN – NO WRITING

FILE IN CLINICAL RECORD

Revised March 15

RFA - REQUEST FOR ADMISSION FORM

LHR 030.3

REQUEST FOR ADMISSION FORM

Date | D | D | M | M | Y | Y |

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O.
ADDRESS	
LOCATION	

PATIENT DETAILS — PATIENT TO COMPLETE

GP Doctor Name:

Address: State: Postcode:

Phone: Fax: Email:

We routinely send information about your hospitalisation to your local GP. If you do not consent to this please tick this box ☐

Referring Specialist: Phone: Fax:

Referring Specialist Address:

Do you have a regular community pharmacist? ☐ No ☐ Yes, if yes please provide details

PERSON RESPONSIBLE FOR ACCOUNT (if not patient)

Surname: Given Name:

Home Address: State: Postcode:

Contact Number: Home: Work: Mobile:

INSURANCE DETAILS

We recommend you contact your Private Health Insurer to check if your reason for admission, including any surgery is covered under your level of insurance. You may wish to ask if there are any additional costs you should expect, such as excess or copayments. All out of pocket expenses are required to be paid prior to your admission.

☐ Privately Insured

Fund: Membership Number: Level of Cover:

☐ Self Insured ☐ Overseas Patient ☐ CAFAT ☐ DVA - Card Number: ☐ Gold Card ☐ White Card ☐ Orange Card

I understand that the hospital may contact my Health Fund and/or Medicare for verification of my eligibility for treatment

WORKCOVER / TAC

Approval of your application is necessary prior to your admission. Workcover/TAC will not be liable for the cost of providing treatment to you unless they confirmed you are a client and accepted liability for your hospitalisation, treatments and other associated costs.

☐ Workcover ☐ TAC Claim Number:

Date of Injury: Name of Insurance Company:

Employer's Name:

Employer's Address: State: Postcode:

Contact Person: Contact Number: Fax Number:

CHRIS O'BRIEN LIFEHOUSE

Chris O'Brien Lifehouse is a not-for-profit hospital which relies on the generosity of its community to assist it to continue to deliver excellence in cancer treatment and care.

From time to time, we contact patients to share information regarding Lifehouse.

☐ I do not consent to being contacted by Lifehouse ☐ I would like to receive the Lifehouse Supporter Newsletter

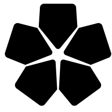
ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES AND CONFIRMATION OF COMPLETENESS OF FORM

I have read and understand the section entitled Patients' Rights and Responsibilities in this Pre-Admission booklet and will discuss any queries with staff. I certify the information on this form to be true and complete to the best of my knowledge.

Patient Name: .... **Signature:** .... **Date:** ....

BINDING MARGIN – NO WRITING
FILE IN CLINICAL RECORD

Revised March 15



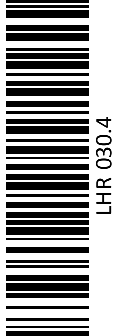
Chris O'Brien Lifehouse

PATIENT HISTORY FORM

Date ☐☐☐☐☐☐
D D M M Y Y

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. _______/_______/_______	M.O.
ADDRESS	
LOCATION	



LHR 030.4

PATIENT DETAILS — PATIENT TO COMPLETE

Reason for Admission, Procedure or Presenting Illness:

Do you see any other Specialist for any other conditions? ☐ No ☐ Yes If yes, list any names and details
(e.g. Cardiologist)

ALLERGIES AND SENSITIVITIES

Please document any known allergies or sensitivities eg. medications, latex, plants, tape

Allergies	Sensitivities	Reaction

Food allergy:

PATHOLOGY/X-RAYS OR OTHER TEST RESULTS

Have blood tests / pathology / autologous blood been taken for this admission ☐ No ☐ Yes

Which company? When?

Have you had a recent ECG / Echocardiogram? ☐ No ☐ Yes

Have ☐ X-rays ☐ CT Scan ☐ MRI been taken for this admission?

If so, please bring with you for this admission

Your current Medications

Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. Consult your GP or surgeon if you are unsure of any details about your medications or which medications should be ceased prior to your surgery. **Bring to the hospital all current medication you are taking, in their original individual packaging (ie. not in Webster or Doset packs)**

Do you take or have recently taken blood thinning medication (e.g. aspirin, warfarin, Coumadin, clopidogrel, Iscover, Plavix or natural blood thinning medication)? ☐ No ☐ Yes

Have you been told to cease this? ☐ No ☐ Yes, by who:

Date to cease? Date Last Taken?

Have you been told to start any other treatment e.g. Clexane or Fragmin ☐ No ☐ Yes

Medication	**Strength**	**Dose & Frequency** (ie. how much / how often?)

Chemotherapy	**Protocol**	**Last Treatment Date**

If you are taking any **non-prescription medication eg. Complementary therapies,** natural therapies, herbal preparations or vitamins, please specify
NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)

Non-Prescription Medication	**Strength**	**Dose & Frequency**	**Purpose**

BINDING MARGIN – NO WRITING

FILE IN CLINICAL RECORD

Revised March 15

RFA - PATIENT HISTORY FORM

LHR 030.4

PATIENT HISTORY FORM

Date ☐☐☐☐☐☐ (D D M M Y Y)

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O.
ADDRESS	
LOCATION	

GENERAL MEDICAL HISTORY			PATIENT TO COMPLETE
CIRCLE N (NO) / Y (YES) AND PROVIDE DETAIL IN RIGHT HAND COLUMN			
CARDIAC			
Heart Conditions: Heart Attack / Chest Pain / Angina	N	Y	
Pacemaker / Defibrillator	N	Y	Make: Model: Date last checked:
Cardiac Surgery: Prosthetic valve / Grafts / Stents / Angioplasty	N	Y	
Heart irregularities: Palpitations / Irregular Heart Beat / Murmur	N	Y	
High Blood Pressure	N	Y	When was your blood pressure last checked?
High Cholesterol	N	Y	
RESPIRATORY			
Diagnosed Sleep Apnoea	N	Y	Bring CPAP machine to hospital
Asthma / Bronchitis / Emphysema / Tuberculosis / shortness of breath on exertion / Hay Fever / Pneumonia / COPD	N	Y	Specify .... Do you use ☐ Oral Steroids ☐ Puffer ☐ Nebulisers ☐ Home oxygen Bring all asthma medication
ENDOCRINOLOGY			
Diabetes ☐ Type 1 ☐ Type 2	N	Y	Controlled by: ☐ Diet ☐ Tablet ☐ Insulin ☐ Pump
Do you have instructions on how to manage your diabetes pre-surgery?	N	Y	
Thyroid problems: Overactive / Underactive	N	Y	
HAEMATOLOGY			
Blood Clots: Legs (DVT) or Lungs (PE)	N	Y	Is Surgeon aware? ☐ No ☐ Yes
Bleeding Disorders: Haemophilia	N	Y	Type?
Blood Disorders: Anaemia	N	Y	
NEUROLOGY			
Stroke / Mini Stroke / TIA / MS / Motor Neuron Disease	N	Y	Any residual weakness or symptoms?
Do you have Parkinson's Disease?	N	Y	Treatment:
Short Term Memory Loss / Confusion?	N	Y	
Epilepsy / Fits / Seizures	N	Y	Date of last seizure: Treatment:
Faints / Blackouts / Dizzy Spells / Migraine	N	Y	
GASTROINTESTINAL			
Reflux / Stomach Ulcers / Hiatus Hernia / Liver Disease / Hepatitis / Jaundice / Crohn's Disease / IBD / Ulcerative Colitis	N	Y	
GENITOURINARY			
Kidney Disease / Dialysis / Renal Impairment	N	Y	
Bladder problems: Incontinence	N	Y	
MUSCULOSKELETAL			
Arthritis: Rheumatoid / Osteoarthritis	N	Y	
Back or Neck injury or problems	N	Y	
PSYCHOSOCIAL			
Mental illness: Anxiety / Depression / Psychosis	N	Y	
OTHER			
Have you had any Anaesthetic Reactions?	N	Y	
Have you had any neck problems?	N	Y	
Do you have any prosthetic joint replacements (hip / knee)	N	Y	
History of falls	N	Y	
Have you been treated for chronic pain?	N	Y	What medications were given? Was this medication effective? ☐ No ☐ Yes
Are you pregnant?	N	Y	Due date:
Are you breastfeeding?	N	Y	

RFA - PATIENT HISTORY FORM

LHR 030.4

BINDING MARGIN – NO WRITING

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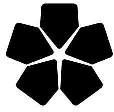
Revised March 15



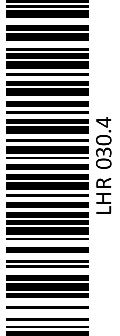
Chris O'Brien Lifehouse

PATIENT HISTORY FORM

Date [ ][ ][ ][ ][ ][ ]
D D M M Y Y

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. _______/_______/_______	M.O.
ADDRESS	
LOCATION	



LHR 030.4

SURGICAL HISTORY (list and date previous surgery and where - attach list if insufficient space) — PATIENT TO COMPLETE

Previous surgeries	Year	Specify
	Year	Specify
	Year	Specify
	Year	Specify

INFECTION CONTROL ASSESSMENT — PATIENT TO COMPLETE

				STAFF USE
Have you been in a hospital or aged care facility in the last 12 months, for more than 48 hours?	N	Y	Where? How long were you admitted for?	Assess risks for MRO
Do you have a history of MRSA (golden staph) VRE or other recent infections?	N	Y	When? Details:	Check for alert
Have you had a recent admission into a hospital overseas? (>48hrs)?	N	Y	Details:	☐ MRO swabs D/W IC CNC
Febrile illness with history of recent overseas travel?	N	Y	When? Where?	Assess travel history D/W IC CNC
Current symptoms of respiratory illness (flu like or coughing)?	N	Y	Details:	Droplet precautions review
History of Intensive care for > 1 week?	N	Y	Details:	☐ MRO swabs
History of IV antibiotics > 4 weeks?	N	Y	Why? When?	☐ VRE swabs
History of Gastroenteritis or Diarrhoea last 48 hours	N	Y	When? Details:	Contact precautions

MRSA screening should be performed on patients with risk factors - recent hospital/aged care admissions, existing wounds, & drains or catheters if in situ.

LIFESTYLE — PATIENT TO COMPLETE

Do you smoke? Have you ever smoked?	N	Y	Amount Date ceased
Alcohol intake?	N	Y	Amount Frequency ☐ Any free days?
Illicit drugs intake?	N	Y	Type Frequency

PROSTHETICS / AIDS — PATIENT TO COMPLETE

Visual Aids	N	Y	☐ Contacts ☐ Glasses ☐ Sight Impaired ☐ Eye Prosthesis
Hearing Aids	N	Y	☐ Left ☐ Right
Walking Aids	N	Y	Specify:
Dentures	N	Y	☐ Upper ☐ Partial ☐ Full ☐ Lower ☐ Partial ☐ Full

BINDING MARGIN – NO WRITING

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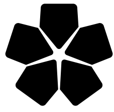
Revised March 15

RFA - PATIENT HISTORY FORM

LHR 030.4



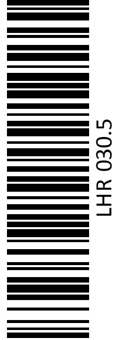
Chris O'Brien Lifehouse

DISCHARGE PLANNING FORM

Date ☐☐☐☐☐☐
D D M M Y Y

(for Lifehouse use only)

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O.
ADDRESS	
LOCATION	



LHR 030.5

DISCHARGE PLAN **PATIENT TO COMPLETE**

All patients undergoing Day Procedures must have an escort home and a carer overnight

Household Arrangement
☐ Alone ☐ With Carer ☐ With Family ☐ Other, please specify

Home Environment
☐ House/Flat ☐ Retirement Village ☐ Nursing Home ☐ Hostel ☐ Other

At home are there:
☐ Stairs internal/external, with/without rails: How many?
☐ Separate Shower ☐ Shower over bath

Activity Assessment: Do you cope independently with daily living e.g. showering, dressing?
☐ Yes ☐ No, specify assistance required:

Support Services:
☐ No services ☐ Family/friends ☐ Personal Carer Delivered Meals
☐ Shopping ☐ Home Nursing ☐ Home Help Personal Alarm
☐ Care Package ☐ Case Manager

STAFF USE
Issues Identified
Referred:

Are you planning on going to Rehabilitation? ☐ No ☐ Yes, if yes, where?

Do you plan to return to your current accommodation directly from hospital? ☐ No ☐ Yes

<u>If no</u>, where do you plan to go?

Do you care for others at home? ☐ No ☐ Yes, if yes, please specify

Any additional patient information:

DISCHARGE PLANNING	**Who will be taking you home, and be with you for 24 hours?**	
	Name:	Relationship:
	Contact Number: Home:	Mobile:

SIGNATURE **PATIENT / CARER**	**I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability** Signature .... Date......./......../20......	**If form not completed by patient please sign below:** **Carer** .... /sign. **Admitting Nurse** ....

Staff Use

Patient History reviewed:

Signature.. Print Name .... Date ..../.........../20........

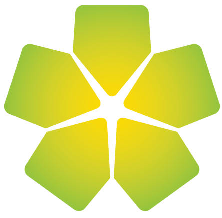
BINDING MARGIN – NO WRITING

FILE IN CLINICAL RECORD

Revised March 15

RFA - DISCHARGE PLANNING FORM

LHR 030.5



Chris O'Brien Lifehouse

Chris O'Brien Lifehouse
phone 8514 0000

Royal Prince Alfred Hospital
phone 9515 6111

to Central Station
to Sydney University
Dunblane St
to Parramatta Rd
Lucas St
St Johns College
John Hopkins Drive
Cyclotron
Grose St
Church St
New Hospital Rd
Susan St
RPA
Salisbury Rd
Rad Onc
Carillon Ave
Chris O'Brien Lifehouse
Missenden Rd
St Andrews College
Carillon Ave
RPA Medical Centre
to Newtown Station
to King Street Newtown

Legend

- Bus Stop
- Bike Parking
- Taxi Rank
- Information
- Patient Parking
- Train
- Seven Eleven

Buildings

- Royal Prince Alfred Hospital
- Chris O'Brien Lifehouse
- Radiation Oncology

15 mins

The hospital is a 10 minute walk from most bus stops and a 20-30 minute walk from major train stations

Plan your public transport travel. Timetable, fare, wheelchair access details contact the Transport Infoline 131 500 www.131500.com.au

Newtown Station is a 20 minute walk along King St and Missenden Rd. Redfern Station is a 30 minute walk through Chippendale and Sydney University

Buses run bewteen the city and inner west from Central Station

Routes

413, 436, 437, 438, 440, 483 stop on Parramatta Rd near Missenden Rd
412 travels up Missenden Rd and stops out front of the hospital
422, 423, 426, 428 runs between the city and King St near Missenden Rd, Newtown
370 between Coogee and Leichardt stops on King St near Missenden Rd
352 from Bondi Junction via Oxford, Crown and Cleveland Sts, stops on King St near Missenden Rd.

For cycling information: Bicycle NSW ph: 9281 4099
www.bicyclensw.org.au
Cycling maps RTA ph: 1800 060 607 www.rta.nsw.gov.au/bicycles.html

TAXIS Legion 131 4511 Combined 8332 8888