

# Pre Admission Booklet

San Day Surgery Hornsby



IMPORTANT

## PLEASE COMPLETE AND RETURN ENCLOSED FORMS AS SOON AS POSSIBLE

It is important that the completed forms are received by San Day Surgery Hornsby

**at least 3 working days prior to admission**

If faxed or emailed:

**Please bring originals on the day of your admission**

Completed forms may be forwarded to San Day Surgery Hornsby by mail, fax, email or hand delivered.

## PATIENT TO COMPLETE THESE FORMS

- Admission Form (1 page double sided)
- Patient History Form (1 page double sided)

## DOCTOR TO COMPLETE THESE FORMS

- Hospital Booking Letter
- Consent to Medical/Surgical Treatment

1a Northcote Road Hornsby NSW 2077

Ph: 02 9477 8888 | Fax: 02 9476 2921

Email: [sandaysurgeryhornsby@sah.org.au](mailto:sandaysurgeryhornsby@sah.org.au)

[www.sandaysurgery.com.au](http://www.sandaysurgery.com.au)

A division of **Adventist HealthCare** Limited ABN 76 096 452 925

 **the San DAY SURGERY HORNSBY**

## WELCOME TO SAN DAY SURGERY HORNSBY

Welcome to the San Day Surgery Hornsby, a division of Adventist HealthCare Limited. Thank you for choosing us for your surgical needs. We are committed to providing the highest standard of health care in an environment designed to help you feel at ease. The information contained in this booklet will ensure that your stay with us proceeds as smoothly as possible.

The San Day Surgery Hornsby opened in 1986 and was the first private, freestanding and licensed Day Surgery in New South Wales. We believe that day surgery is the most cost effective and efficient way of performing many investigative and surgical procedures. The advent of less invasive surgery, as well as advances in anaesthetics and modern technology, has contributed to the increase in procedures performed on a day-only basis.

## OUR GOAL

At the San Day Surgery Hornsby we are committed to helping promote your health and recovery by the best available means. Our philosophy seeks to affirm the uniqueness of the individual by looking at the integrated physical, mental, spiritual and social dimensions of each person.

## EXCELLENT CARE

The San Day Surgery Hornsby boasts a team of skilled medical professionals dedicated to providing the highest standard of care and a positive outcome for patients. Our facility has two fully equipped theatres with the latest technology, as well as a procedure room for minor surgical procedures.

Our facility offers surgical services for both children over the age of 2 years and adults. We were the first day surgery in NSW to be granted an Extended Recovery Care License by the NSW Department of Health (DOH). This means that patients who have undergone more advanced surgery can stay overnight for post-operative care.



## ADVENTIST HEALTHCARE LIMITED

San Day Surgery Hornsby is a division of Adventist HealthCare Limited. Adventist HealthCare Limited is owned by the Seventh-day Adventist Church, and is a not-for-profit organisation that operates a number of healthcare businesses including Sydney Adventist Hospital, San Day Surgery Hornsby, San Radiology and Sydney Adventist Hospital Pharmacy.

The organisation originated with the opening of 'Sydney Sanitarium' in 1903 – a place of health and healing where people learned to stay well. Sydney Adventist Hospital, fondly referred to as 'the San', is NSW's largest private hospital and remains the organisation's Australian flagship institution as it grows its services to meet community needs.

With over 115 years of service to the community, caring for our patients needs is our first priority. This spirit of caring is reflected in our mission, 'Christianity in Action – caring for the body, mind and spirit of our patients, colleagues, community and ourselves'. We aim to care for the whole person, promoting healthy living, providing state-of-the-art acute healthcare, and touching people's lives through our compassionate and expert care.

## BEFORE COMING TO HOSPITAL

We ask that you read the following information carefully and comply with all requests:

- Please ensure the following forms are delivered, emailed or faxed to us at least 3 working days prior to your surgery

1. Hospital Booking Letter
2. Consent Form
3. Admission Form
4. Patient History Form

**Address:** 1a Northcote Rd  
Hornsby NSW 2077

**Fax:** 02 9476 2921

**Email:** sandaysurgeryhornsby@sah.org.au

### PLEASE PRINT CLEARLY ON ALL FORMS.

#### Note:

If you need another set of forms, you can print from our website under Patient Information at [www.sandaysurgery.com.au](http://www.sandaysurgery.com.au)

- If your admission has been arranged at short notice, please contact us to provide admission details. Bring the completed forms with you on the day of surgery.
- Our staff will contact you between 3pm and 6pm on the working day prior to surgery to provide your admission details.

## MORE ABOUT YOUR FORMS

To assist with the completion of your forms, please find below a list of definitions of terms.

### DEFINITIONS

- An **Enduring Guardian** can make personal decisions on your behalf, such as where you should live, medical treatment and services you should receive.
- A **Power of Attorney** can make financial decisions on your behalf, for example disposing of assets or operating your bank account.
- An **Advance Care Directive** refers to written instructions that relate to the provision of health care when a person is unable to make their wishes known. It is sometimes called a 'living will'.

**Please send a copy of your Enduring Guardian, Power of Attorney or Advance Care Directive with your forms if you have one.**

## PREPARING FOR YOUR PROCEDURE

### FASTING

- You should not eat for at least 6 hours prior to your admission, unless your doctor has indicated otherwise. Sips of water are permitted up to 2 hours before your admission.
- You may clean your teeth.
- If you are having assisted local anaesthetic e.g. Cataract Surgery, you will also need to fast as outlined above.
- Fasting requirements do not apply if you are having local anaesthetic. You may have an early, light meal.

### MEDICATION

You should continue to take regular medication with a minimal amount of water unless otherwise instructed by your doctor.

### ADDITIONAL INFORMATION

- If you have acquired any illness (including a cold, red eye or chest infections) since consulting with your surgeon, please notify your surgeon prior to your admission.
- You should cease smoking as soon as possible and at least 24 hours prior to your surgery. Smoking can adversely affect your anaesthetic and increases the likelihood of complications.
- Please shower before coming to the San Day Surgery Hornsby and wear loose, simple clothing, which can be changed easily.
- You should not wear makeup, nail polish, contact lenses or jewellery, although wedding rings are permitted.
- For information on Payments and Health Insurance Funds: See page 6.



## THE DAY OF YOUR SURGERY

Please arrive on time for your appointment so that we can prepare for your surgery. If you are delayed we would appreciate you contacting us as soon as possible.

Wear loose, comfortable clothing and comfortable shoes.

### WHAT TO BRING

- Any relevant letters from your doctor
- Your original, signed Consent form (if faxed)
- Your completed Admission/Patient History form (if faxed)
- X-Rays or results of tests relevant to your condition
- Medications you would normally take during the day, including eye drops and natural therapies in the original packaging
- Reading material
- Medicare card, Pension card, Health Fund or DVA card.

### INTERPRETER SERVICES

If you require the services of an interpreter, please inform us at least 2 working days prior to admission.

### OPERATION TIMES

Although we make every effort to keep to scheduled times, please be aware that occasionally unforeseen circumstances can cause changes in surgery times.

### PROCEDURE

On arrival, please present at the reception desk where our helpful clerical staff will finalise your details. You will then be taken to the admission area according to the order of the theatre list for the day. A nurse will provide you with a gown to change into and prepare you for surgery. An anaesthetist will also visit you if this is applicable for your procedure.

Your anaesthetist may require you to have some pre-operative medication before you are taken to theatre. This will help you feel more relaxed.

## AFTER YOUR PROCEDURE

Operative procedures often involve the use of intravenous fluids and other equipment to monitor your progress. These may still be in place following surgery.

Your progress will be checked regularly by staff who will assist you in making your recovery as comfortable as possible. If you are uncomfortable, in pain or have any problems, don't hesitate to inform the nursing staff.

Light refreshments will be provided as appropriate to your surgery.

### VALUABLES

Please do not bring excessive cash and/or valuables with you. While all care of valuables is taken, San Day Surgery Hornsby does not accept liability for lost or damaged personal items or valuables.

### ALCOHOL & SMOKING

Alcohol should not be consumed for 12 hours prior to surgery as it may interact with some medications. Patients are not permitted to bring alcoholic beverages to the San Day Surgery Hornsby.

San Day Surgery Hornsby is a non-smoking environment. We ask that you and your visitors respect the health of others and refrain from smoking within our grounds.

## OVERNIGHT PATIENTS

If your surgeon deems it necessary for you to stay overnight following your procedure, you are required to bring:

- Night attire, including dressing gown and slippers
- Toiletries
- Any medication usually taken
- Written medication schedule from your GP, including dose and time to be taken

You may have visitors at any time during the afternoon or evening, at the discretion of staff.

Meals are provided for those staying overnight. If you have any special dietary needs, please contact us prior to your admission.

## AFTER DISCHARGE

### GOING HOME

If you are undergoing a procedure that requires general anaesthetic or sedation with local anaesthetic, you will need someone **to drive you home** from the San Day Surgery Hornsby and **stay with you for 24 hours** following discharge.

If your procedure is to be performed with local anaesthetic only, you may be able to drive and care for yourself if your doctor has advised that you are safe to do so.

### POST OPERATIVE CARE

For the first 24 hours following a general anaesthetic or sedation it is important that you:

- Do not drive a car
- Do not drink alcohol
- Do not remain on your own (unless approved by your specialist)
- Do not make complex or legal decisions

Your surgeon may request a follow-up appointment with you. Please contact their rooms 24 to 48 hours after your procedure to arrange this.

If you have concerns and are unable to contact your doctor, telephone our facility on **02 9477 8888**. After hours, contact Sydney Adventist Hospital's Emergency Care on **02 9487 9000** or Hornsby Ku-Ring-Gai Hospital on **02 9477 9123**.

## CHILDREN & ADOLESCENTS

The San Day Surgery Hornsby is experienced at undertaking Child and Adolescent surgery. We understand that having surgery can be stressful for both parents and children and our aim is to make you feel at ease as much as possible.

### CONSENT

- Any child under 14 years of age must have the consent of at least one parent (or guardian) for surgery.
- For children between 14 and 18 years of age, consent may be signed by both the patient and their parent or guardian.
- Adolescents over 16 years of age may legally sign the consent on their own.
- You may withdraw your consent and refuse further treatment for your child at any time.

#### Notes:

- A special orientation is available for children undergoing surgery, to help them prepare for theatre. An appointment can be made on the day of booking.

### PRE-OPERATIVELY

- Fasting – children must not eat for 6 hours before their scheduled time of surgery, or as specifically ordered by the surgeon. Sips of water are allowed up to 2 hours before surgery.
- Wherever practical and with the anaesthetist's approval, parents or guardians are permitted to remain with their child until induction of anaesthesia in the operating room. Post operatively, you can be present as soon as your child's conscious condition permits.
- If desired, the child may come in their own pyjamas, dressing gown or comfortable clothes on surgery day. It is advisable to bring a spare set of clothes, including underwear.
- Please also bring any additional items for your child eg. bottle, dummy, nappies, favourite toy or book.

### POST- OPERATIVELY

Refreshments will be offered, as appropriate, following your child's surgery.

## FINANCIAL INFORMATION

### SETTLING YOUR ACCOUNT

Your San Day Surgery Hornsby account will include charges for accommodation, theatre fees, surgical supplies and prosthesis, if applicable.

Payment is due at the time of admission. Cash, credit card, cheque or Eftpos are accepted. All cheques should be made payable to:

The San Day Surgery Hornsby  
1A Northcote Road  
Hornsby 2077

Accounts for your Surgeon and Anaesthetist should be settled with the respective doctor, not the Day Surgery.

If you have Private Health Insurance we will submit a benefits claim form on your behalf using the health fund details on your admission form. The gap between the hospital costs and the fund's cover is to be paid at the time of admission. The benefits available under private health insurance vary considerably from one fund to another.

Please check with your health fund prior to surgery, the level of cover you can expect and if you are excluded from receiving any benefits.

Provided your admission forms have been received by the Day Surgery prior to your admission you will be advised of any excess payable.

This estimate is a guide only and may vary depending on the treatment you actually receive.

Uninsured patients are required to pay an estimate of the total account at the time of admission and any balance on discharge.

Workers Compensation patients, whose claims have been accepted by the Insurance Company, should contact their surgeon to confirm that their account will be covered on the day. If approval has not been received by the day of surgery the patient will be required to pay the full amount on the day.

Gold Card Veterans Affairs patients do not require approval prior to admission. Prior approval for patients with a white card should be organised through your surgeon.

## WELLNESS & COMMUNITY SERVICES

Today there is a growing awareness of the importance of health. The underlying philosophy of Adventist HealthCare has always been based on the importance of disease prevention and promoting wellness through a balanced approach to health and lifestyle. Adventist HealthCare offers a wide range of services aimed at helping members of our community stay healthy and fit, and return to health following illness or surgery. Services available at Sydney Adventist Hospital include San Rehabilitation, San Physiotherapy and Hydrotherapy, Fox Valley Medical and Dental Centre, Cardiac Rehabilitation, Cancer Support Centre, Jacaranda Lodge Accommodation, and regular free public health seminars.

For further information see [www.sah.org.au](http://www.sah.org.au) or contact Sydney Adventist Hospital's Marketing and Communications on **02 9487 9871** or [comrel@sah.org.au](mailto:comrel@sah.org.au)

## HOSPITAL BOOKING LETTER

Patient ID label

Family Name .....

Given Name(s) .....

D.O.B. ....

AMO Name please print

**DOCTOR TO COMPLETE this form**

<b>Patient Details</b>		Title		Family Name		Given Name(s)	
Date of birth <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>		Unit / Street No./ Street Address				Home Ph	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Suburb		P/Code		Mobile Ph	
<b>Clinical Details</b>		<b>Provisional Diagnosis</b>					
<b>Diabetes</b>		<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 2 on insulin				<b>Diabetic instructions (if applicable)</b>	
<b>* VTE Prophylaxis</b>		Chemical <input type="checkbox"/> Yes <input type="checkbox"/> No Mechanical <input type="checkbox"/> Stockings <input type="checkbox"/> SCD <input type="checkbox"/> No  If No, state reason.....				<b>Co-morbidities / Alerts</b> (leave blank if nil applicable)	
<b>Confirmed MRO</b>		(MRSA, VRE, ESBL, MRAb) <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Latex allergy</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Weight</b>		<b>NB patients &gt; 140kg cannot be admitted:</b> <input type="checkbox"/> < 110 kg <input type="checkbox"/> 110-140 kg <input type="checkbox"/> Weight > 140kg				<b>Allergies</b>	
<b>Admission Details</b>		<b>Admission date</b> <input type="checkbox"/> Overnight expected # <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>					
<b>Planned Anaesthetic</b>		<input type="checkbox"/> GA <input type="checkbox"/> LA <input type="checkbox"/> ALA <input type="checkbox"/> Topical  Overnight booking confirmed <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>					
<b>Procedure Details</b>		<b>Operation /Procedure Date</b> <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>				<b>CMBS Item No.(s)</b>  	
<b>Planned Procedure(s)</b>							
<b>Equipment Details</b>		Implantable device <input type="checkbox"/> Implanting Device <input type="checkbox"/> Removing device		Type  Company <input type="checkbox"/> Contacted		Type  Company <input type="checkbox"/> Contacted	
Will the prosthesis used attract a gap payment? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, gap estimate \$.....				Has informed financial consent been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Signature .....	
<b>Pre-operative consultation</b>					<b>Other instruction notes</b>		
Anaesthetist .....							
<b>Pre-operative tests</b>		Please organise the following tests <input type="checkbox"/> ECG <input type="checkbox"/> Other					
Could this patient be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> <b>Consent to Medical / Surgical Treatment completed</b> <input type="checkbox"/> <b>Specific medication orders at admission (see over)</b>		
AMO Signature .....					Date ...../...../20.....		

# HOSPITAL BOOKING LETTER

# MR 1ABS

## PERF & PUNCH POSITIONING AS PER PREVIOUS BOOKLETS

**Doctor / Secretary:**

**FOR ALL ADMISSIONS**  
Please fax this side to 9476 2921

**Doctor / Secretary:**

Please fax this & copy of consent form  
Photocopy for your records and hand  
originals to patient





**Medication orders at admission - please print clearly (orders valid for 24 hours after admission)**  
**To ensure timely administration, list medication to be given first, followed by current medication**

[illegible]



## CONSENT TO MEDICAL OR SURGICAL TREATMENT

Family Name		MRN	
Admission Date		Given Name(s)	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Admitting Doctor	

I, Dr ..... have discussed with  
..... D.O.B ...../...../.....  
the need for him / her to have the following medical treatment and/or procedure .....

We have discussed what alternatives are available; the nature and risks of this medical treatment and/or procedure; the risk that it may not give the expected result, and the possibility of altered or additional procedures being required. We have also discussed the fact that the medical treatment and/or procedure may involve anaesthetics, medications and/or blood transfusions, blood products and that these also carry risks. On the basis of this understanding, we agree that I perform, and he/she consent to, this medical treatment and/or procedure.

Doctor ..... (Name) ..... Date...../...../20.....  
(Signature)  
Patient ..... (Name) ..... Date...../...../20.....  
(Signature)

OR

## CONSENT BY PERSON RESPONSIBLE TO MEDICAL OR SURGICAL TREATMENT

I, Dr ..... have discussed with  
..... the person responsible for  
..... D.O.B ...../...../.....  
the need for the latter to have the following medical treatment and/or procedure .....

We have discussed what alternatives are available; the nature and risks of this medical treatment and/or procedure; the risk that it may not give the expected result, and the possibility of altered or additional procedures being required. We have also discussed the fact that the medical treatment and/or procedure may involve anaesthetics, medications and/or blood transfusions, blood products and that these also carry risks. On the basis of this understanding, we agree that I perform, and he/she consent to, this medical treatment and/or procedure.

Doctor ..... (Name) ..... Date...../...../20.....  
(Signature)  
Person Responsible..... (Name) ..... Date...../...../20.....  
(Signature)

**This page is intentionally left blank**

# ADMISSION FORM

Family Name .....

Given Name(s) .....

D.O.B. ....

**PATIENT TO COMPLETE BOTH SIDES of this form**

[illegible]

## PERF & PUNCH POSITIONING AS PER PREVIOUS BOOKLETS

**Return address:** San Day Surgery Hornsby  
1a Northcote Road  
Hornsby 2077

# ADMISSION FORM

MR 1AAS

Family Name	Given Name(s)	D.O.B.	<b>OFFICE USE ONLY P2 OF MR 1AAS</b>	
			MRN .....	

  

<b>ENTITLEMENTS</b> <b>Medicare / Veterans' Affairs</b>	
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<b>Medicare Card</b>	Card No <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	Medicare ID No <table border="1" style="width: 40px; height: 20px; border-collapse: collapse;"></table>	Left of name <table border="1" style="width: 40px; height: 20px; border-collapse: collapse;"></table> Expiry ____/____/____
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If you do not intend to claim your hospitalisation costs through the DVA please complete Medicare Entitlement Section above

<b>Veterans' Affairs</b>	<input type="checkbox"/> Gold <input type="checkbox"/> Orange* <input type="checkbox"/> White	DVA No <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	* (Pharmaceutical benefits only)  Expiry ____/____/____
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White cardholders only: Your doctor must obtain approval from the Department of Veterans' Affairs prior to day of admission

  

<b>WORKERS' COMPENSATION / PUBLIC LIABILITY / THIRD PARTY PATIENTS ONLY</b>	<b>Type of claim</b> <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Third Party motor vehicle <input type="checkbox"/> Public Liability
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Date of accident ____/____/____	Name of Insurer at time of accident	Insurer's Claim No.
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Insurer's address	P/code	Insurer's fax no.	Phone No.
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<b>WCC Cases only</b>	Name of employer	Contact person	Phone no.
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<b>PERSON RESPONSIBLE FOR PAYMENT (if other than patient)</b>	Name
---	------

Postal address for account (if different to above)	Home Ph
--	---------

Suburb	P/Code	Work Ph	Mobile
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<b>ADVANCE CARE DIRECTIVE</b> <i>(If yes, a copy of this is required)</i>	Do you have an Advance Care Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

<b>ENDURING GUARDIAN</b> <i>(If yes, a copy of this is required)</i>	Have you appointed an Enduring Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Phone No.
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<b>POWER OF ATTORNEY</b> <i>(If yes, a copy of this is required)</i>	Have you appointed a Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Phone No.
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<b>CONSENT TO USE PERSONAL INFORMATION</b>
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I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the section on the San Day Surgery Homsby Personal Information & Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital. I understand that my contact details may be given to the Sydney Adventist Hospital Foundation. I give consent to the use of my personal information as described in this Pre-Admission booklet. I understand that I may withdraw my consent at any time.

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

  

<b>ACKNOWLEDGEMENT OF RIGHTS &amp; RESPONSIBILITIES</b>
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I have read and understand the section entitled *Patients' Rights and Responsibilities* in this Pre-Admission booklet and will discuss any queries with staff.

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

  

<b>CONFIRMATION OF COMPLETENESS OF FORM</b>
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I certify the information on this form to be true & complete to the best of my knowledge.

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



# PATIENT HISTORY FORM

- Have you had an admission to San Day Surgery within the past 6 months? ☐ No ☐ Yes If yes, please sign here if there have been no changes in your medical history in the last 6 months.

Signature ..... Date ...../...../20.....

- If there have been changes within the last 6 months, or if you have not been here within the previous 6 months, please complete the patient history form.

Family Name.....

Given Name(s) .....

D.O.B. ....

Admission Date	Admitting Doctor
<div> <div></div> <div></div> <div></div> <div></div> <div>2</div> <div>0</div> <div></div> <div></div> </div>	

Please answer EVERY question (both sides of form)

Do you have or have you had:			
Endo.	Diabetes		
	Controlled by: <input type="checkbox"/> diet <input type="checkbox"/> tablet <input type="checkbox"/> injection	Y	N
Thyroid problems		Y	N
Resp.	Bronchitis / asthma / emphysema etc	Y	N
	Specify		
Do you use:	<input type="checkbox"/> nebulisers <input type="checkbox"/> puffers <input type="checkbox"/> home oxygen	Y	N
Recent cold		Y	N
Other lung problems		Y	N
	Specify		
Chest pain / angina		Y	N
Palpitations / heart murmur / irregular heart beat / AF		Y	N
	Specify		
Artificial implants / devices / grafts:		Y	N
	<input type="checkbox"/> coronary artery bypass <input type="checkbox"/> coronary/vascular stent <input type="checkbox"/> artificial heart valve <input type="checkbox"/> pacemaker		
Gastric ulcer / reflux / hiatus hernia		Y	N
Jaundice		Y	N
Hepatitis		Y	N
Stoma		Y	N
Hip / knee replacements		Y	N
	Specify		
Other implants / devices		Y	N
	Specify		
Speech / swallowing problems		Y	N
Limb paralysis	<input type="checkbox"/> right arm <input type="checkbox"/> left arm <input type="checkbox"/> right leg <input type="checkbox"/> left leg	Y	N
Polio / meningitis		Y	N
	Specify		
NB: you may be asked to provide a family member or carer to be in attendance during your stay			
Kidney trouble / dialysis / renal impairment		Y	N
Bladder problems	<input type="checkbox"/> urinary incontinence <input type="checkbox"/> frequency <input type="checkbox"/> urgency <input type="checkbox"/> pain	Y	N
Do you, or have you smoked in the past?		Y	N
	If yes, daily amount <input type="text"/> Date ceased <input type="text"/>		
Do you drink alcohol?	<input type="text"/> standard drinks per day		
Past history of drug dependency		Y	N
	Specify		
Disturbed sleep pattern / sleep apnoea	<input type="checkbox"/> CPAP used	Y	N
Could you be pregnant?		Y	N
Do you have chronic pain?		Y	N
	Specify		
Do you have a current pressure area or any areas of broken skin?		Y	N
	Specify		
Do you have a history of a multi-resistant organism? eg. MRSA, VRE, other		Y	N
eg. Coronary artery bypass, brain, liver or pancreatic surgery, hip replacements		Y	N
	Specify		
Problems with anaesthetic eg. nausea, vomiting, malignant hyperthermia		Y	N
	If Yes, <input type="checkbox"/> self <input type="checkbox"/> family		
Cancer / Lymphoma / Leukaemia		Y	N
	Date: / / Site:		
Transplants		Y	N
	Treatment <input type="checkbox"/> surgery <input type="checkbox"/> chemotherapy <input type="checkbox"/> radiotherapy		
Do you, or any relatives, have Creutzfeldt-Jakob Disease (CJD)?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a 'medical in confidence' letter regarding CJD?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you had Human Pituitary Growth Hormone prior to 1986, or neurosurgery/spinal surgery prior to 1990?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have an unexplained progressive neurological illness in the last 12 months?		<input type="checkbox"/> No <input type="checkbox"/> Yes	

PATIENT HISTORY FORM (SDSH)

MR 26AS



Family Name .....

Given Name(s) .....

D.O.B. ....

# PATIENT HISTORY FORM

## (continued)

Height & weight details		Height <input type="text"/> cm	Weight <input type="text"/> kg
Dietary Requirements		Do you have a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify</i>	
Prosthetics / Aids / Other			
Visual aids	Y N	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Eye prosthesis	
Hearing aids	Y N	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Walking aids	Y N	<i>Specify</i>	
<b>Allergies &amp; Sensitivities</b>		<i>Please document any known allergies or sensitivities eg. medications, latex, plants, tape</i>	
<b>Allergies</b>	<b>Sensitivities</b>	<b>Reaction</b>	
Food allergy			
<b>Your current Medications</b>	<i>Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. Consult your GP or specialist(s) if you are unsure of any details about your medications or which medications should be ceased prior to your surgery. <b>Bring to the hospital all current medication you are taking, in their original individual packaging (ie. not in Webster or Doset packs)</b></i>		
<b>Prescription Medication</b>	<b>Strength</b>	<b>Dose &amp; Frequency</b>	<b>Purpose</b>
Geranin (example)	100mgs	one tablet twice a day	
<i>If you are taking any non-prescription medication eg. Complementary therapies, natural therapies, herbal preparations or vitamins, please specify</i> <b>NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)</b>			
<b>Non- Prescription Medication</b>	<b>Strength</b>	<b>Dose &amp; Frequency</b>	<b>Purpose</b>
Does someone assist you to manage your medications at home? <input type="checkbox"/> Yes (who.....) <input type="checkbox"/> No			
Discharge Planning & community support	Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, with whom?		
	Who is your main carer?		
	Do you receive community services? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Nurses <input type="checkbox"/> Home Care <input type="checkbox"/> Meals on Wheels		
Going home	Who will be taking you home and be with you for 24 hours?		
	Name	Relationship	
	Best contact phone no	Or mobile no.	
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.		<b>Form completed by:</b>
	Signature .....	Patient ...../Sign.	
	Date ...../...../20.....	Carer ...../Sign.	



# PATIENT RIGHTS

## WHAT YOU CAN EXPECT FROM US

PATIENT RIGHTS	WHAT THIS MEANS
<b>Access to Care</b> You have a right to access health care.	You will receive treatment appropriate to your health needs. You can request a Doctor of your choice, and request a second opinion.
<b>Safety</b> You have a right to receive safe and high quality care.	You will receive safe and high quality health services provided by professional, caring and competent staff.
<b>Respect</b> You have a right to be shown respect, dignity and consideration.	You will be provided with care that shows respect to you and your culture, beliefs, values and personal characteristics.
<b>Communication</b> You have a right to be informed about services, treatment, options and costs in a clear and open way.	You will receive open, timely and appropriate communication about your healthcare in a way you can understand. You will be asked to consent to treatment except when circumstances prevent this. You have the right to refuse recommended treatments, refuse experimental treatment, choose which treatments you wish to take, and withdraw consent to treatment at any time.
<b>Participation</b> You have a right to be included in decisions and choices about your care.	We encourage you to participate in making decisions and choices about your care and treatment plan. You have the right to give or withhold your permission for treatment.
<b>Privacy</b> You have a right to privacy and confidentiality of your personal information.	Your personal privacy will be maintained and your personal health and other information will be properly handled. You have the right to access information contained in your medical record. While in hospital please contact the Nursing Unit Manager. After discharge please contact the Senior Manager.
<b>Comment</b> You have a right to comment on your care and to have your concerns addressed.	You can make positive and negative comments about your care, and have your concerns dealt with properly and promptly.
<b>Parental Rights</b> You can exercise your rights as a parent or guardian of a child.	You can choose to stay with your child at all times except when the provision of healthcare precludes this. You can make decisions regarding consent to treatment of your child if they are under 14 years of age. From the age of 14, children may seek treatment and provide consent or make decisions jointly with their parents or guardian.

## PATIENT RESPONSIBILITIES

### WHAT WE WOULD LIKE YOU TO DO

PATIENT RESPONSIBILITIES	WHAT THIS MEANS
<b>Safety</b> Tell us of your safety concerns.	<p>You should let staff know if you think something has been missed in your care or that an error might have occurred.</p> <p>You should explain any circumstances that may make your healthcare riskier or any other safety concerns that you have.</p>
<b>Respect</b> Consider the wellbeing and rights of others.	<p>You should always respect the wellbeing and rights of other patients, consumers and staff by conducting yourself in an appropriate way. This includes respecting the privacy and confidentiality of others.</p> <p>Patients and their visitors are requested to be respectful to all healthcare professionals who care for them. Verbal and physical abuse will not be tolerated.</p> <p>You should respect hospital property, policies, regulations and the property of other persons.</p>
<b>Communication</b> Provide information regarding your medical history and ask questions.	<p>Be as open and honest with staff as you can, including giving comprehensive and accurate details of your medical history, past surgeries and all medications you may be taking.</p> <p>Ask questions of staff if you would like more information about any aspect of your care.</p>
<b>Participation</b> Follow your treatment, cooperate and participate where able.	<p>Where possible you should take an active role in your healthcare and participate as fully as you wish in the decisions about your care and treatment. We also encourage your family, other carers or chosen support person to be actively involved. With your consent, they can also receive information and be involved in making decisions about your care with you.</p> <p>You should endeavour to follow your treatment, and inform your health provider when you are not complying with your treatment.</p> <p>You should cooperate fully with the doctor and clinical team in all aspects of your treatment.</p> <p>You must let staff know if there are changes to your condition or new symptoms.</p> <p>You should keep appointments or let the health provider know when you are not able to attend.</p>
<b>Advanced Care Directive / Power of Attorney / Guardianship</b>	<p>Please inform your health professional if you have a current Advance Care Directive or Power of Attorney for any health or personal matters, or if you are subject to a guardianship order.</p>
<b>Pay Fees</b>	<p>You should promptly pay the fees of the hospital and your attending doctor.</p>
<b>Complaint / Feedback</b>	<p>You should direct any complaint to a staff member or the Manager of the area so immediate and appropriate action can be taken to remedy your concern.</p>

## HOW TO MAKE COMPLIMENTS OR COMPLAINTS ABOUT YOUR CARE

San Day Surgery Hornsby welcomes any feedback so that we can continually strive to improve our standards and service. Your comfort, care and safety are extremely important to us and if we are doing something well or we need to improve in any area of our work we welcome your comments and suggestions.

The information below outlines how you can provide feedback either directly to the San Day Surgery Management as well as other options for you to consider if you are not comfortable with providing direct feedback or not satisfied with how your feedback was dealt with.

### Our contact details for compliments, complaints or concerns

Senior Manager  
San Day Surgery Hornsby  
1a Northcote Road  
Hornsby NSW 2077  
**Phone** 02 9477 8888  
**Fax** 02 9476 2921  
**Email** customerfeedbackSDSH@sah.org.au

### For direct feedback:

#### Compliments

We welcome your feedback. Feedback forms are available in reception or Discharge Lounge in the Day Surgery. The form can be mailed or faxed. (See contact details below).

#### Complaints or concerns

You have a right to make comments or complain about your care. We welcome your feedback and will appoint an appropriate person to address your concerns. Your care will not be adversely affected by making a complaint.

#### Who to contact regarding complaints or concerns

You should contact the manager or person in charge for problems experienced while you are at San Day Surgery Hornsby.

### For non direct feedback to Adventist HealthCare Limited senior management:

Should you want to speak with someone outside the centre you can also contact the Adventist HealthCare Limited Quality Management Department.

Quality Management Department  
Adventist HealthCare Limited  
185 Fox Valley Road Wahroonga  
NSW 2076  
**Phone** 02 9487 9888  
**Email** customerfeedback@sah.org.au

It is always best to try and resolve your complaint with your health service provider. If you have tried this and are still unsatisfied, you can make a complaint to the Health Care Complaints Commission.

[www.hccc.nsw.gov.au](http://www.hccc.nsw.gov.au)

## PERSONAL INFORMATION & PRIVACY FOR PATIENTS

San Day Surgery Hornsby is a division of Adventist HealthCare Limited (AHCL). The following AHCL policy applies to Personal Information and Privacy.

Adventist HealthCare Limited (AHCL) recognises and respects every patient's right to privacy. We will collect and use the minimum amount of personal information needed for us to ensure that you receive a high level of health care. AHCL will always endeavour to manage your information to protect your privacy.

**This includes both paper & electronic records.**

### Personal information we usually hold:

- Your name, address, telephone and email contact details
- Health fund details
- Date and country of birth
- Next of kin
- Occupation
- Health information
- The name and contact details of your General Practitioner and your referring doctor
- Returned Service information
- Religious beliefs or affiliations (if provided)
- Marital status
- Transaction details associated with our services
- Indigenous status and language spoken at home (for the Department of Health)

### What we do with personal information:

1. We will collect it discreetly.
2. We will store it securely.
3. Subject to what we say in this section, we will only provide your personal information to people involved in your care.
4. We will provide relevant information to your health fund, or the Department of Veterans' Affairs, Medicare Australia, Cancer Council, NSW Department of Health or to other entities when we are required by law to do so.

5. After removing details that could identify you, we may use the remaining information to assist with research and service improvement projects. We are also required to provide this kind of information to government agencies.
6. AHCL operates teaching hospitals and we may use personal information in the training and education of medical, nursing and other allied health students.
7. We will destroy our record of your information when it has become too old to be useful or when we are no longer required by law to retain it.
8. We may use the information to contact you. By providing your email address, we assume permission to use this address for administrative communications (for example, receipts) regarding your hospital visit, and information about the hospital.
9. We may share your contact details with the San Foundation. The San Foundation provides patients with information, newsletters and details about fundraising appeals. The San Foundation may use the information to contact you.



## NEWSLETTERS & OTHER MAILED INFORMATION

In the future AHCL and/or the San Foundation may send you information about our programs, services and activities in the form of newsletters and details about fundraising activities. If you do not wish to receive this information, you may notify the Privacy Officer (see contact details at end of this section). Mail outs to you will cease as soon as possible after your notification.

### Your rights

1. You may give consent for us to use your personal information to provide you with health care services, or you may withdraw your consent at any time. If you withdraw consent for AHCL to use your personal information, this may reduce our ability to provide you with services.
2. You may ask us to limit access to your information. You may separately a) refuse to be seen by a chaplain or representative of your faith while in hospital, b) refuse to have your Discharge Summary sent to your General Practitioner or c) refuse to receive information about future AHCL events, services and fundraising appeals by signing the 'Use of Personal Information' form. These forms are available on admission or through the Privacy Officer (see contact details at end of this section).  
  
If you have a specific requirement for restricting access by someone to your information please also inform us about this as soon as possible.
3. You may ask us to give you (or another individual) access to your personal information. In most cases we will allow you to have access to your personal information. We may also provide a person to assist you and we may charge a fee for providing printed copies of reports.  
  
We may not provide you (or your responsible person) with access to your personal information if a doctor feels that it may be harmful to do so.
4. You may ask us to correct any error in your personal information.
5. You may make a privacy-related complaint if you feel that the Hospital has not kept your information confidential or has not maintained your privacy.

## PRIVACY CONTACT DETAILS

San Day Surgery Hornsby

**Phone:** 02 9477 8888

**Email:** [privacySDSH@sah.org.au](mailto:privacySDSH@sah.org.au)

**or write to:**

San Day Surgery Hornsby  
1a Northcote Road, Hornsby NSW 2077

You may contact the Privacy Commissioner if you are not satisfied that the Hospital has resolved your complaint.

## TEACHING HOSPITAL

An important component of Adventist HealthCare's role in meeting community healthcare needs is the provision of clinical education and placements for medical, nursing and other allied health trainees – which may involve education and placement at San Day Surgery Hornsby. Participation of trainees may include observation and involvement in your care while under appropriate supervision. You are free to refuse to allow a trainee to participate in your care at any time. Your refusal will not adversely affect the treatment you receive.

## CHAPLAINS

AHCL is a Christian organisation and we are committed to wholistic care, including your spiritual needs while you are receiving care, whatever your faith.

Chaplains and Spiritual Caregivers are part of our care team and accredited community representatives regularly visit our hospitals.

You may request a visit from a representative of your faith, or you may request that no chaplain or visiting faith representative call on you while you are a patient in an AHCL hospital.

## HOW TO FIND US



**There is a range of public transport options available, enabling easy access.**

- Hornsby train station on the North Shore line is 2km from the hospital
- A regular bus service is available from Hornsby Station to Palmerston Road  
Visit [www.transdevnsw.com.au](http://www.transdevnsw.com.au) to view the timetable
- Reception will happily call a taxi for your convenience

**Free parking is available onsite and in adjacent streets**

1a Northcote Road, Hornsby NSW 2077

Ph: 02 9477 8888 | Fax: 02 9476 2921

[www.sandaysurgeryhornsby.com.au](http://www.sandaysurgeryhornsby.com.au)

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