



25 Queenslea Drive CLAREMONT WA 6010

## PATIENT BOOKING INFORMATION

TO CONFIRM YOUR BOOKING, PLEASE COMPLETE THE ATTACHED PAGES AND FORWARD TO  
BETHESDA HOSPITAL AS SOON AS POSSIBLE PRIOR TO YOUR ADMISSION DATE

### SCAN and EMAIL TO

admissions@bethesda.org.au

### FAX TO

Attention: Admissions  
(08) 9340 6343

### POST TO

Admissions, PO Box 45  
Claremont WA 6910

### TO BE COMPLETED BY PATIENT OR GUARDIAN

#### ADMITTING DOCTOR:

Have you been a patient at Bethesda Hospital previously?  
No ☐ Yes ☐ if yes, in which year? \_\_\_\_\_  
Surname for previous admission: \_\_\_\_\_

#### ADMISSION DATE:

GP (General Practitioner)  
Name: \_\_\_\_\_ Ph: \_\_\_\_\_  
Address: \_\_\_\_\_

Overnight patient's room preference:  
☐ Private room ☐ Shared room

While every effort will be made to meet your room request allocation will depend on room availability at the time of your admission and additional payments may apply.

#### PERSONAL DETAILS (PLEASE PRINT)

Mr ☐ Patient's surname: \_\_\_\_\_  
Mrs ☐ \_\_\_\_\_  
Ms ☐ Given name(s): \_\_\_\_\_  
Miss ☐ \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Residential address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Postal address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (m) \_\_\_\_\_

Email: \_\_\_\_\_

Are you of Aboriginal or Torres Strait Islander descent?

Yes ☐ No ☐

Marital status: ☐ Never married ☐ Married/Defacto  
☐ Separated ☐ Divorced ☐ Widow/Widower

Employment status:

☐ Employed ☐ Unemployed ☐ Home duties  
☐ Retired ☐ Pensioner ☐ Student

Language spoken at home: \_\_\_\_\_

Interpreter services required: ☐ Yes ☐ No

Country / State of birth: \_\_\_\_\_

Religion: \_\_\_\_\_

#### PERSON TO CONTACT

Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (m) \_\_\_\_\_

#### PERSON TO CONTACT IN AN EMERGENCY

As above ☐

Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (m) \_\_\_\_\_

#### PLEASE BRING ALL RELEVANT CARDS TO HOSPITAL

MEDICARE NUMBER

Position no: ☐ Expiry date: \_\_\_\_\_ / \_\_\_\_\_

PHARMACEUTICAL / PENSION ENTITLEMENT NO: \_\_\_\_\_

SELF FUNDED: ☐

Full estimated fee is payable 24 hours prior to admission

#### HEALTH INSURANCE DETAILS:

Fund name: \_\_\_\_\_

Membership no: \_\_\_\_\_ Table: \_\_\_\_\_

#### DEPARTMENT OF VETERANS' AFFAIRS DETAILS:

DVA file no: \_\_\_\_\_

DVA card colour: ☐ Gold ☐ White

#### DEFENCE FORCE:

Service no: \_\_\_\_\_ Barracks: \_\_\_\_\_

#### ADMISSION FOR:

☐ Workers Compensation ☐ MV CTP Insurance

Procedure approval is required prior to admission. If approval has not been received, you may choose to use your private health insurance or self fund.

Date of accident: \_\_\_\_\_

State where accident occurred (e.g. WA, NSW): \_\_\_\_\_

Insurance co: \_\_\_\_\_

Phone no: \_\_\_\_\_ Fax no: \_\_\_\_\_

Claim number: \_\_\_\_\_

Employer's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone no: \_\_\_\_\_

#### DISCHARGE SUPPORT

For your safety, you are required to have a responsible adult accompany you at discharge and stay with you for 24 hours after your anaesthetic or after sedation given during your procedure

PATIENT PRE-ADMISSION FORM

MR 4



## CLINICAL HISTORY

TO BE COMPLETED BY PATIENT OR GUARDIAN

Names: \_\_\_\_\_

D.O.B. \_\_\_\_\_

or

Patient ID Label \_\_\_\_\_

Allergies ☐ No ☐ Yes

Please list any allergies (e.g. food, drugs, lotions, latex) and the reaction.

### MEDICATIONS

Are you taking anticoagulants or blood thinning medications?

☐ No

☐ Yes, date last taken \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you taking or have you taken aspirin recently?

☐ No

☐ Yes, date last taken \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list all regular medications prescribed and over the counter (not listed above). Attach an additional sheet if required.

MEDICATION	DOSE & FREQ.	MEDICATION	DOSE & FREQ.

### HEALTH HISTORY

Please tick any relevant boxes if you have, or have ever had, any of the following:

Heart disease e.g. heart attack, angina or chest pain

☐

Diabetes:

Type I

☐

Type II

☐

Heart surgery e.g. bypass surgery

☐

Controlled by:

Diet

☐

Tablets

☐

Insulin ☐

Palpitations/irregular heartbeat, heart murmur

☐

Hepatitis (if yes, please specify type \_\_\_\_\_)

☐

Implants, prostheses such as breast implants,  
pacemaker, joint replacement

☐

Kidney or bladder problems

☐

High blood pressure

☐

Thyroid problems

☐

Blood clots in your lung or leg (DVT/PE)

☐

Reflux, indigestion, hiatus hernia, GI ulcer

☐

Bleeding tendencies or blood disorders

☐

Bowel disorder

☐

Stroke, blackouts, TIA (mini stroke)

☐

Arthritis

☐

Epilepsy or fits

☐

Back/neck problems

☐

Depression, dementia, other mental illness

☐

Recent sore throat, cold or flu

☐

Asthma / Bronchitis / Pneumonia

☐

Recent infection - wound, bladder or other

☐

Emphysema or other respiratory disease

☐

Are you or could you be pregnant?

☐

Sleep apnoea (if yes, state treatment type below)

☐

A blood transfusion

☐

Serious illness or accidents

☐

Please provide more information on any of the boxes you have ticked. Please attach additional sheets if required.

#### Previous Procedures and Operations

Please list any previous procedures and operations you have had.

#### Anaesthetic History

Have you had any problems with anaesthetics? ☐ Yes ☐ No

Do you have a family history of  
problems with anaesthetics?

☐ Yes ☐ No

Please provide more information



Names: \_\_\_\_\_

D.O.B. \_\_\_\_\_

or

Patient ID Label \_\_\_\_\_

## LIFESTYLE INFORMATION

TO BE COMPLETED BY PATIENT OR GUARDIAN

Please tick all relevant boxes if you have, or have had, any of the following:

### Previous Hospitalisation

Have you been admitted overnight to any hospital outside of WA, including overseas, in the past 12 months?

☐ Yes

Have you lived in a residential healthcare facility, for example a nursing home outside of WA, including overseas, in the past 12 months?

☐ Yes

Have you been admitted overnight to any hospital within WA in the past 12 months? If yes, name of hospital \_\_\_\_\_

☐ Yes

Do you live in a residential healthcare facility, for example a nursing home within WA?

☐ Yes

Have you worked in any hospital or residential healthcare facility outside of WA, including overseas, within the past 12 months?

☐ Yes

Have you ever been told, or received a letter from the Department of Health, telling you that you have had a resistant bug, such as MRSA, VRE or CRE?

☐ Yes

- ☐ Methicillin resistant staphylococcus (MRSA)
- ☐ Vancomycin resistant enterococci (VRE)
- ☐ Carbapenem resistant enterobacteriaceae (CRE)

### Prostheses, Aids and others

Glasses/ contact lenses ☐ Yes ☐ No Dentures / bridge work / other ☐ Yes ☐ No

Hearing aid or other appliance ☐ Yes ☐ No Walking aid ☐ Yes ☐ No

### Lifestyle

Do you smoke? Daily number \_\_\_\_\_ ☐ Yes ☐ No

Will you require nicotine replacement therapy during your stay? \_\_\_\_\_ ☐ Yes ☐ No

Have you ever smoked? When did you stop? \_\_\_\_\_ ☐ Yes ☐ No

Do you drink alcohol? Average daily amount \_\_\_\_\_ ☐ Yes ☐ No

Do you use recreational drugs? \_\_\_\_\_ ☐ Yes ☐ No

Dietary choice or special diet required? \_\_\_\_\_ ☐ Yes ☐ No

Do you become short of breath walking up stairs or up a hill? \_\_\_\_\_ ☐ Yes ☐ No

Do you have a fear of falling? \_\_\_\_\_ ☐ Yes ☐ No

Have you fallen in the last three months? \_\_\_\_\_ ☐ Yes ☐ No

Do you require assistance when walking? \_\_\_\_\_ ☐ Yes ☐ No

Do you have any broken skin or reddened areas due to pressure? \_\_\_\_\_ ☐ Yes ☐ No

Have you travelled overseas in the past three months? \_\_\_\_\_ ☐ Yes ☐ No

If yes, where to? \_\_\_\_\_

Do you have an Advanced Care Directive? \_\_\_\_\_ ☐ Yes ☐ No

(a document in which you give instructions about your future health care)

If yes, the hospital will require you to provide a signed copy at admission.

### Discharge Planning

Do you live alone? \_\_\_\_\_ ☐ Yes ☐ No

Will you have someone at home after discharge? \_\_\_\_\_ ☐ Yes ☐ No

Do you have any responsibilities to care for others? \_\_\_\_\_ ☐ Yes ☐ No

Do you currently receive community support services? \_\_\_\_\_ ☐ Yes ☐ No

Do you require any assistance with daily activities? \_\_\_\_\_ ☐ Yes ☐ No

Do you have any concerns on how you will manage after discharge? \_\_\_\_\_ ☐ Yes ☐ No

### Staff use

Questions answered  
yes initiate IPC  
notification

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Initial \_\_\_\_\_

☐ ePAS alert for diet

☐ Falls Risk  
Assessment  
(FRAMP)

☐ PI management plan

☐ Day surgery, discuss  
escort/ overnight  
care

☐ Discharge services  
required?



## CONSENT TO USE AND DISCLOSE PERSONAL INFORMATION

Names: \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
or  
Patient ID Label \_\_\_\_\_

### PATIENT OR PERSON RESPONSIBLE FOR PATIENT TO READ AND SIGN

Bethesda Health Care is committed to managing your personal health information according to the current Australian Privacy Act. More information is available on our website [www.bethesda.org.au](http://www.bethesda.org.au) or by contacting our Privacy Officer on (08) 9340 6300

#### COLLECTION

Bethesda Health Care staff will collect your personal information:

- that is necessary for your safety, optimal care and treatment;
- that is required by law;
- that is necessary for billing and the business management of our service; and
- that enables us to monitor our service quality and customer satisfaction.

We may also need to obtain and share information from other sources such as your GP, other healthcare providers and hospitals, including pathology laboratories. In emergency situations we may need to collect personal information from your next of kin, your relatives or other sources.

#### USE AND DISCLOSURE

Your information will be used as listed above and also:

- to inform manufacturers of any prosthetic or medical devices you may receive as part of your treatment, for safety and regulatory purposes. These manufacturers may be located overseas;
- to inform the person you have nominated of your health status;
- for account keeping and billing, including sharing information with health insurer's, Medicare and, if required, outside collection agencies;
- for the management of patient safety, training and education, quality assurance and accreditation purposes; and
- where legally required, such as producing records to court and mandatory reporting of information to State and Federal authorities, including the notification of certain communicable diseases.

#### ACCESS TO YOUR MEDICAL RECORD

You are entitled to access your own medical record at any time convenient to both yourself and the hospital. Requests or queries must be directed to our Privacy Officer. The request will be actioned within 30 days of receipt and a charge for photocopying, staff time and processing your request may be made.

Access may be denied where:

- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another person;
- your request is frivolous;
- the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings;
- it is in the interests of National Security; or
- it would create a serious threat to life or health if access was granted.

#### SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION

We have policies, processes and storage systems that comply with relevant legislation to ensure your information is protected from misuse, interference, loss, unauthorised access, modification or disclosure. Information will be retained for the period of time determined by current Australian legislation and will be disposed of confidentially in line with legislated document disposal schedules.

#### MAKING AMENDMENTS TO YOUR MEDICAL RECORD

You are entitled to amend the information on your medical record. We will take steps to record, all of your amendments, and place them with your medical record but will not erase the original record. Please contact our Privacy Officer.

#### WITHHOLDING SENSITIVE INFORMATION

You may request certain information be withheld for personal reasons. Bethesda may not be able to admit or treat you where it considers the information is not comprehensive enough to provide quality health care.

#### USE OF A PSEUDONYM

You may choose to be known by a pseudonym (alias) while in hospital, however your accurate identifying details may be required for our billing purposes but will be kept confidential.

#### WITHDRAWING CONSENT

If you provide your consent to release information to other parties or for other purposes and would like to withdraw this consent, please contact our Privacy Officer

#### FEEDBACK AND COMPLAINTS PROCESS

Please lodge any feedback via our Patient Feedback Surveys, via our website [www.bethesda.org.au](http://www.bethesda.org.au) or contact our Privacy Officer.

#### CONSENT:

**I consent to Bethesda Health Care managing my personal information as detailed above.**

Patient's name: .....

Signature: .....

If consenting on behalf of the patient as a person responsible / other please print and sign:

Guardian's name: .....

Signature: .....

Relationship to patient: .....

Date: ...../...../ 20.....

Names: \_\_\_\_\_  
 D.O.B. \_\_\_\_\_  
 or  
 Patient ID Label \_\_\_\_\_

**CONSENT TO USE PROCEDURE**  
**TO BE COMPLETED BY PATIENT**  
**OR GUARDIAN**

**PATIENT OR PERSON RESPONSIBLE FOR PATIENT TO READ AND SIGN**

<b>SECTION A</b>	<b>BOOKING DETAILS</b>		
ADMITTING DOCTOR:		ADMISSION TYPE <input type="checkbox"/> LA DAY CASE <input type="checkbox"/> DAY CASE <input type="checkbox"/> OVERNIGHT	
ADMISSION DATE:		ADMISSION TIME:	
PROVISIONAL DIAGNOSIS:			
CMBS CODE (S):			
PROSTHETICS:		PROSTHETIC CODE (S):	
<b>ADMISSION CRITERIA</b> <b>HEIGHT:</b> <b>WEIGHT:</b> <b>BMI:</b> <i>For safety reasons patients whose weight exceeds 150 kgs and/or BMI &gt;45 will not be admitted to Bethesda</i>			
<b>SECTION B</b>	Patient name.....DOB...../...../.....		
I, _____ (full name of person giving consent) of _____ (address) hereby consent to the following procedure (s) _____ _____ _____ (no abbreviations, please print) being performed upon _____ (full name of patient if different from self) the nature and effect of which has been explained to me by Doctor _____ I also consent to: <ul style="list-style-type: none"> <li>further procedure(s) as may be found necessary to be performed during the course of the procedure(s), stated above and to the required post-operative treatment;</li> <li>digital images being made during my procedure and, if made, copies being retained as part of my medical record;</li> <li>the administration of such anaesthetics and medicines as may be considered by the anaesthetist to be necessary or advisable;</li> <li>to the transfusion of blood products if needed <input type="checkbox"/> Yes <input type="checkbox"/> No (please tick). The risks have been explained to me.</li> <li>blood being collected and tested for infectious agents (including Hepatitis and HIV antibody) in the event of a biohazard exposure to a staff member. I understand I will be informed that blood has been taken for testing, that there will be no additional cost to myself and the results of the test will be made available to me, the staff member and the infection control officer of the hospital. <b>All health care workers are bound to maintain confidentiality of the test results.</b></li> </ul>			
Patient/Guardian signature _____ Relationship to patient _____ Date ____/____/20____ (if not self)			
I (Doctor's name) _____ confirm that I have explained to the patient (or person legally responsible for the patient) the nature, purpose, benefits and risks of the proposed procedure(s) and in my opinion he/she understands my explanation. <b>Medical practitioner's instruction:</b> _____ <b>Medical practitioner's signature:</b> _____			
<b>Interpreter's declaration: Specific language requirements (if any).</b> I declare that I have interpreted the dialogue between the patients and health professional to the best of my ability, and have advised the health professional of any concerns about my performance. <b>Interpreter's full name:</b> _____ <b>Date</b> ____/____/20____ <b>Time</b> _____ <b>Agency name:</b> _____ <b>Interpreter's signature:</b> _____			
<b>MEDICAL USE ONLY</b> <b>CRUETZ-JAKOB DISEASE RISK</b> Will the intended procedure involve higher infectivity tissues? <input type="checkbox"/> Brain, pituitary gland, dura mater, cranial and dorsal root ganglia, spinal cord, olfactory epithelium <input type="checkbox"/> Posterior segment of eye- includes retina, optic nerve or lower - infectivity tissue of the anterior	<b>CJD RISK ASSESSMENT TOOL</b> Questions to be asked prior to undergoing procedure involving any listed tissues <input type="checkbox"/> Do you think the patient may have CJD? <input type="checkbox"/> Has the patient had two or more first or second-degree relatives with CJD? <input type="checkbox"/> Does the patient have unexplained progressive neurological illness of less than 12 months? <input type="checkbox"/> Does the patient have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature prior to 1986? <input type="checkbox"/> Has the patient had brain or spinal cord surgery that included a Dura mater graft pre 1990?		

#### MEDICAL USE ONLY

##### CRUETZ-JAKOB DISEASE RISK

Will the intended procedure involve higher infectivity tissues?

- ☐ Brain, pituitary gland, dura mater, cranial and dorsal root ganglia, spinal cord, olfactory epithelium
- ☐ Posterior segment of eye- includes retina, optic nerve or lower - infectivity tissue of the anterior segment of eye includes cornea
- ☐ NO
- ☐ YES - complete assessment tool

#### CJD RISK ASSESSMENT TOOL

Questions to be asked prior to undergoing procedure involving any listed tissues

- ☐ Do you think the patient may have CJD?
- ☐ Has the patient had two or more first or second-degree relatives with CJD?
- ☐ Does the patient have unexplained progressive neurological illness of less than 12 months?
- ☐ Does the patient have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature prior to 1986?
- ☐ Has the patient had brain or spinal cord surgery that included a Dura mater graft pre 1990?
- ☐ Has the patient been involved in 'look back' for CJD or presented a 'medical in confidence' letter regarding the risk for CJD?

**ACTION: For questions ticked 'yes' contact Bethesda Hospital Infection Control Manager.**

**Medical Practitioners Signature:** \_\_\_\_\_

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25 Queenslea Drive CLAREMONT WA 6010

## Thank you for choosing Bethesda Health Care

Please visit our website [www.bethesda.org.au](http://www.bethesda.org.au)

This page is for your information

**ENQUIRIES** For all queries regarding your admission please call us on (08) 9340 6300

### PARKING AND ACCESS

Our visitor's carpark is located at the front of the hospital. Paid parking is applicable. Monday – Friday from 8.00 am - 6.00 pm. Coins are required. Street parking is available within walking distance however please observe parking signage as clearways and restricted hours may apply.

### DISABLED ACCESS

Access is available at the main entrance to the hospital with set down bays and disabled parking both available

### VISITING HOURS

Inpatient: 8.00 am - 6.00 pm

Day Procedure Unit: Due to limited space we ask that only one adult accompany the patient.

### NO SMOKING POLICY

Smoking is not permitted in the hospital or on the hospital grounds.

We ask that both patients and visitors support our non-smoking policy for the comfort of others.

### WHAT TO BRING TO HOSPITAL

- Health fund membership details, Medicare card, pension card;
- Letters or referrals or forms from your doctor;
- Relevant X-rays;
- Crutches if requested by your doctor - Bethesda does not provide crutches;
- Glasses / contact lens with cases and, if appropriate, your hearing aid; and
- **All your current medications in their original boxes with the pharmacy label or a letter from your GP or Pharmacy listing your current medications.**

### LOCAL ACCOMMODATION

If you, or any of your family or friends, require accommodation before or after your surgery we suggest you visit <http://accommodationperth.com.au> for a range of accommodation options.



### PASTORAL CARE

Pastoral care and chaplaincy services are available. Please speak to your nurse if you would like to use these services.

### CAFE

There is a café and additional seating available on the ground floor. The café is open to the public:

Mon-Fri: 8.00 am - 3.30 pm

Saturday: 9.00 am - 3.00 pm

Sunday: 9.00 am - 3.30 pm

Public Holidays: closed

**\* Closing hours may be subject to change.**

### INTERNET

Wireless internet access is available for your convenience.

### VISITOR BOARDING

Boarders who wish to stay with a minor, or as a support person may do so at the manager's discretion. Please notify the hospital to confirm if boarding is possible.



## PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

### FINANCIAL INFORMATION

#### **PAYMENT OF ACCOUNTS, HOSPITAL AND THEATRE FEES**

As a service to our patients we provide an estimate of the likely medical costs you will be required to pay in relation to your stay at Bethesda.

Our estimates are based on eligibility information provided by your health fund. We advise you to check with your health fund before admission to verify your level of cover and any potential gap fees.

If you have private health insurance you will be required to pay any excess or room co-payments you have linked to your level of cover at the time of your admission. The amount you will be required to pay will depend on your health insurance fund, your level of cover and any excess gap you have elected. On admission we require payment for any amount you are responsible for.

It is your surgeon's responsibility to inform you if there are any out of pocket expenses for any surgically implanted prosthetics or supplies they choose to use. Depending on your procedure your surgeon may recommend a device that requires a gap payment by you which you will need to pay to the hospital.

On admission we will request authorisation so we can arrange payment of your account directly to the hospital from your health fund. If your account has a balance owing after receipts from your health fund you will be responsible for payment of that balance.

#### **DVA ADMISSIONS**

Gold card holders are fully covered for all inpatient hospital services.

White card holders require approval prior to admission

#### **DEFENCE PERSONNEL, MOTOR VEHICLE AND**

#### **WORKERS COMPENSATION INSURANCE**

Approval for your procedure is required prior to admission. If approval has not been received you may elect to use your private health insurance or self fund. An estimate of fees will be provided for self funded patients.

Patients will be covered for a shared room. Should you elect a private room additional charges will apply.

#### **SELF FUNDED PATIENTS**

If you are uninsured, or your procedure is not covered under your insurance, or it is cosmetic, you will be required to pay estimated costs for your theatre and hospital fees **24 hours prior to admission**. You can obtain an estimate by contacting Patient Accounts on (08) 9640 6318

We endeavour to provide an accurate estimate of your costs. This may change for reasons such as:

- your surgeon may vary the proposed treatment, procedure or length of stay;
- your procedure may require provision of disposable patient appliances; or
- your doctor may use a different prosthesis .

#### **PAYMENT FACILITIES**

The hospital has EFTPOS facilities and major credit cards are welcome. Please be aware daily limits may apply to your account. We suggest that you check with your financial institution as we require payment in full at the time of admission.

#### **ROOM ALLOCATIONS**

While every effort will be made to provide the accommodation you have requested, room allocation depends on room availability on the day of your admission. Where a shared room is requested and a private room is allocated additional payments may apply. Sometimes patients staying overnight may be admitted through the day procedure unit.

#### **POST DISCHARGE AND ADDITIONAL ACCOUNTS**

You may receive an account after discharge for additional costs (pharmacy, prosthetics, room charges, consumables) incurred during your stay at Bethesda Hospital.

Depending on your procedure you may also receive additional accounts from:

- your surgeon;
- your anaesthetist; and
- the assistant to the surgeon.

#### **RADIOLOGY AND PATHOLOGY SERVICES**

These services are partly covered by Medicare. For these services you will receive separate accounts which will be sent following your discharge.

Self funded patients may also receive additional accounts for services such as physiotherapy.

#### **AMBULANCE SERVICES**

There may be a charge for using ambulance services for transfer to or from home to hospital and for inter-hospital transfers. Please check with your health fund and/or St John's Ambulance to verify your cover.





## PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

### CLINICAL INFORMATION

#### WHAT TO BRING TO HOSPITAL

- Healthfund membership details, Medicare card, pension card;
- Letters or referrals / forms from your doctor;
- Relevant X-rays;
- Crutches if requested by your doctor;
- Glasses / contact lens with cases and, if appropriate, your hearing aid; and
- **All your current medications in their original boxes with the pharmacy label or a letter from your GP or Pharmacy listing your current medications.**

#### PRE-ADMISSION NURSE

To prepare for your stay you may be contacted by the pre-admission nurse to confirm your health history and to answer any questions or concerns you may have.

Some procedures will require you to come in and meet with the nurse who will contact you to make an appointment time.

#### VALUABLES

Valuables and jewellery are best left at home.

The hospital cannot accept responsibility for the security of personal items.

#### DAY SURGERY

Day surgery patients will be in hospital between 3 and 6 hours depending on the procedure, and refreshments will be offered to you before discharge. You do not need to bring sleeping attire.

For your safety you are required to have a responsible adult **accompany you at discharge and stay with you for 24 hours** after the anaesthetic or sedation given during your procedure.

You are not permitted to drive or operate heavy machinery for 24 hours after your anaesthetic or sedation given during your procedure.

#### OVERNIGHT STAY

We require all overnight stay patients to be discharged between 9:30 and 10:30 am.

You will receive instructions specific to your procedure from nursing staff. Please ensure you follow these instructions, and speak with the nursing staff if you have any questions or concerns before you go.

### HELP US CARE FOR YOU

#### INFECTION PREVENTION

You may wish to discuss with your doctor ways to reduce your risk of infection. **You must tell your doctor if you have a cold, a fever or if you have been unwell prior to your surgery.**

Please advise friends and relatives not to visit you if they are unwell.

#### HAND HYGIENE

Hand hygiene means cleaning your hands either by using soap and water or by using alcohol based hand rubs at times such as after going to the toilet or bathroom and before eating.

This will help stop germs spreading and reduce your chance of infection.

You should ask your visitors to clean their hands before and after visiting you.

Staff at Bethesda participate in the National Hand Hygiene Initiative. While with us, you will see our staff and your doctors cleaning their hands before and after attending to your care. If they don't, please ask them to - we don't mind being reminded!

#### PRE-OPERATIVE SHOWERING

Before coming to the hospital please shower on the day of your surgery. Do not use deodorant or talc. Dress in clean, comfortable clothing. You may be asked to have an antiseptic wash or shower after admission. Use a chlorhexidine wash if your surgeon or the pre-admission nurse has instructed you to.

#### CARE OF YOUR WOUND AND DRIP SITE

Keep all dressings clean and dry and tell the nurses immediately if your dressing becomes loose or wet. Please let your nurse know of any increasing pain, redness or swelling around your wound or drip site while you are in the hospital.

#### AIDING YOUR RECOVERY

Follow instructions regarding deep breathing and leg exercises.

#### LOOKING AFTER YOURSELF

**CALL, DON'T FALL.** Remember: medication and having surgery may make you dizzy and affect your balance. Before getting up for the first time after surgery call for a nurse by using the nurse call button on the patient hand console and wait for assistance.



## PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

### PATIENT RIGHTS AND RESPONSIBILITIES

#### YOU HAVE THE RIGHT TO:

- receive an explanation of any treatment and its associated risks before agreeing to the treatment;
- request other medical opinions if you wish;
- receive advice from your health fund, doctor(s) and hospital about the likely cost including the possible costs of a prosthetic;
- discuss with your doctor the choice of prosthetics, including the option of selecting a prosthetic with no out-of-pocket costs (a no gap prosthetic);
- be treated with respect and dignity;
- receive care and support from nurses and allied health professionals;
- receive advice before you leave hospital about planning your future health care;
- make a compliment, suggestion or complaint about your health care and treatment;
- obtain access to your medical records and expect confidentiality for your personal information; and
- receive clear, timely and accurate information from your health fund.

#### YOU HAVE THE RESPONSIBILITY TO:

- request advice from your health fund, doctor(s) and hospital about likely costs;
- check with your health fund before receiving hospital treatment about your level of cover;
- provide all relevant information to your doctor and hospital to assist with your care and treatment (for example, information about allergies, or medications you are taking);
- participate in decisions about your treatment and care (or as necessary, by a person responsible for your welfare); and
- participate before you leave hospital in planning your future health care.

#### Further information is available at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-charter-language.htm>

<http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights>

### OUR MISSION

Bethesda Health Care's mission is to deliver the highest quality healthcare experience for patients.

### OUR VALUES

<b>Teamwork</b>	We create an environment of unity and togetherness
<b>Respect</b>	We recognise and acknowledge the uniqueness and value of every individual
<b>Integrity</b>	We demonstrate honesty and trust
<b>Compassion</b>	We work to express God's love through a caring expression of kindness, tolerance and tenderness
<b>Excellence</b>	We excel in all that we do so that we can promote the mission of our hospital
<b>Professionalism</b>	We have pride in the high level of care and service we offer.