Waikiki Private Hospital

221 Willmott Drive, Waikiki WA 6169
T: (08) 9550 0222 F: (08) 9592 4187
E: admin@waikikiprivate.com.au

SURNAME	UMRN
GIVEN NAMES	
D.O.B.	SEX
DOCTORS NAME	

PATIENT ADMISSION FORM

Please complete and return to Waikiki Private Hospital at least 7 days prior to your admission					
Admission Date:		Surgeon's Name:			
Have you been a patient at Waikiki Private Hospital before? ☐ No ☐ Yes					
Patient Details:					
Title:		Surname:		Given name(s):	
Preferred name:		Preferred pronoun:			
Previous name(s):					
Date of birth:		*Sex:		**Gender:	
Residential Address:					
Postal Address (if different to above):					
Mobile phone:		Home phone:			
Preferred form of phone contact:	☐ Mobile ☐ Home				
Email address:					
Marital status:	☐ Single/never married ☐ Married/defacto ☐ Divorced ☐ Separated ☐ Widowed				
Indigenous status:	☐ Neither Aboriginal or Torres Strait Islander ☐ Both Aboriginal and Torres Strait ☐ Aboriginal ☐ Torres Strait Islander				
Employment status:	☐ Employed ☐ Student ☐ Unemployed ☐ Child not yet at school ☐ Home duties ☐ Retired ☐ Pensioner				
Country of birth:		State if born in Australia:			
Preferred language:		Interpreter required:	☐ No ☐ Yes		
Next of Kin, Carer / Guardian Details:					
Title:		Surname:		Given name:	
Relationship to patient:		Contact number:			
Emergency Contact Details: **Tick if same as Next of Kin, Carer / Guardian ☐**					
Title:		Surname:		Given name:	
Relationship to patient:		Contact number:			
Referring Doctor Details:					
Referrer's surname:		Referrer's given name:			
Practice address:		Practice phone number:			
General Practitioner Details: **Tick if same as referring doctor ☐**					
GP's surname:		GP's given name:			
Practice address:		Practice phone number:			

*Sex is understood in relation to sex characteristics, such as chromosomes, hormones and reproductive organs
** Gender is about social and cultural differences in identity, expression and experience

PATIENT ADMISSION FORM

MR05

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Claim Details:
If you have private health insurance, you are advised to contact your fund prior to admission to confirm your level of cover for your proposed procedure and to check whether you have an excess or co-payment to pay to the hospital on admission. The item numbers provided by your Doctor will help your fund to determine this.

Do you have private health insurance?	☐ Yes ☐ No		
Health Fund name:		Membership number:	
Have you been a member of this fund for more than 12 months?		☐ Yes ☐ No	
Do you have an excess or co-payment to pay?		☐ Yes ☐ No	

Person responsible for account:

☐ Patient (if patient is responsible for the account, proceed to next question)
☐ Other, e.g. parent – please complete details below:

Title:		Surname:		Given name:	
Mobile number:				Home number:	
Preferred phone contact:	☐ Mobile ☐ Home				
Address:					
Email address:					
Relationship to patient:					

Will you be claiming through Department of Veterans Affairs for this admission? If Yes, complete below details, if No proceed to next question.

Veterans Affairs number:		Card colour:	☐ Gold ☐ White
Expiry date:			

Will you be claiming through Workers' Compensation, Motor Vehicle or other third-party insurance for this admission? If Yes, complete below details, if No proceed to next question.

Claim number:		Date of accident:	
Insurance company name:		Contact number:	
Employer name (Workers' Comp. only):		Contact number:	
Employer's Address:			

Department of Defence Details:

Australian Defence Force – Service Number / EP ID:	

Healthcare Concession Details:

Do you have any pension/concessional benefits cards?

☐ Pension card Number: ..... Expiry date: ..... /..... /.....

☐ Concession card Number: ..... Expiry date: ..... /..... /.....

☐ Safety Net card Number: ..... Expiry date: ..... /..... /.....

☐ Other (specify): ..... Number: …… Expiry date: ……

Medicare Details:

Medicare number:		Card reference number:		Expiry date:	

☐ Australian Resident ☐ Eligible (reciprocal rights) ☐ Ineligible for Medicare ☐ Overseas visitor
☐ Not known

Confirmation of details provided:

Patient/Guardian name:		Signature:		Date:	

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PATIENT HEALTH QUESTIONNAIRE

Allergies and adverse reactions			
Do you have any allergies or adverse reactions to medication, latex, sticking plaster/tapes, dyes, skin lotions, or food? ☐ No ☐ Yes If yes, specify below.			
Allergy	**Reaction**		**Date/year of reaction**

Do you have any special dietary requirements	☐ No	☐ Yes	Specify:
Anaesthetic Risk and Previous Operations			**If Yes, provide further details:**
Have you had an anaesthetic before	☐ No	☐ Yes	
Have you, or any blood relatives, had problems with anaesthetics in the past	☐ No	☐ Yes	
Do you have a history of post operative aggression	☐ No	☐ Yes	
Do you have dentures, caps, crowns, loose teeth, implants or veneers	☐ No	☐ Yes	
Have you had any previous operations	☐ No	☐ Yes	If yes, complete details below:

Procedure:		Date performed:	
Procedure:		Date performed:	
Procedure:		Date performed:	
Procedure:		Date performed:	

Cardiovascular History			**If Yes, provide further details:**
Have you ever had a heart attack	☐ No	☐ Yes	Year:
Have you ever had heart surgery (e.g. pacemaker, internal defibrillator, prosthetic heart valves, grafts, stents, other implants/devices)	☐ No	☐ Yes	Year:
Do you have a pacemaker/internal defribillator/cardiac stent/prosthetic heart valve	☐ No	☐ Yes	
Do you have angina or chest pain	☐ No	☐ Yes	
Do you have atrial fibrillation, palpitations or other irregular heartbeat	☐ No	☐ Yes	Specify:
Rheumatic fever	☐ No	☐ Yes	
Heart failure or heart/valve disease	☐ No	☐ Yes	
High blood pressure	☐ No	☐ Yes	
Low blood pressure	☐ No	☐ Yes	
Blood clots in legs (DVT) or Lungs (PE)	☐ No	☐ Yes	
Stroke (CVA) or TIA	☐ No	☐ Yes	
Tendency to bleed or bruise easily	☐ No	☐ Yes	
Blood disorder	☐ No	☐ Yes	

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Respiratory History			**If Yes, provide further details:**
Do you currently smoke	☐ No	☐ Yes	Daily amount:
Do you have a history of smoking	☐ No	☐ Yes	Date ceased:
Do you have Asthma	☐ No	☐ Yes	
Sleep Apnoea	☐ No	☐ Yes	Do you use a CPAP machine?
Tuberculosis	☐ No	☐ Yes	
Bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asbestosis, pneumonia or shortness of breath	☐ No	☐ Yes	Specify:
Endocrinology			**If Yes, provide further details:**
Do you have diabetes	☐ No	☐ Yes	☐Type I ☐Type II ☐ Unsure
If Yes, is it controlled by ☐ Diet ☐ Tablets ☐ Insulin If you take insulin, has your Doctor given you instructions regarding your diabetic medication? ☐ Yes ☐ No If No, please call them for advice			
Do you have any thyroid problems	☐ No	☐ Yes	
Gastrointestinal			**If Yes, provide further details:**
Have you ever suffered from reflux or heart burn	☐ No	☐ Yes	
Do you have hiatus hernia/gastrointestinal ulcers	☐ No	☐ Yes	
Do you have a gastric band in place	☐ No	☐ Yes	If yes, is your surgeon aware?
Bowels problems (e.g. Crohn's, stoma, incontinence, Irritable Bowel Syndrome)	☐ No	☐ Yes	
Liver disease, hepatitis, jaundice	☐ No	☐ Yes	
Musculoskeletal, mobility and falls			**If Yes, provide further details:**
Do you have back/neck/jaw problems	☐ No	☐ Yes	
Arthritis (e.g. osteoarthritis, rheumatoid arthritis)	☐ No	☐ Yes	
Osteoporosis	☐ No	☐ Yes	
Have you experienced fainting, dizziness or fallen in the last 6 months	☐ No	☐ Yes	
Do you use walking aids or a wheelchair	☐ No	☐ Yes	
Neurology and Mental Health			**If Yes, provide further details:**
Parkinson's, multiple sclerosis or motor neuron disease	☐ No	☐ Yes	
Epilepsy or fits	☐ No	☐ Yes	
Delirium or confusion when unwell	☐ No	☐ Yes	
Dementia, Alzheimer's	☐ No	☐ Yes	
Difficulties with problem solving, attention span or understanding	☐ No	☐ Yes	
Anxiety, depression, PTSD or other mental health disorder	☐ No	☐ Yes	

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Prostheses, Aids			**If Yes, provide further details:**
Do you wear glasses/contact lenses	☐ No	☐ Yes	
Do you have a hearing aid/hearing appliance	☐ No	☐ Yes	
Do you have any implanted devices (Artificial joints or limbs, metal plates or pins, pacemaker, stents, lap band, body piercing)	☐ No	☐ Yes	
General health and lifestyle			**If Yes, provide further details:**
Do you drink alcohol	☐ No	☐ Yes	Daily amount:
Do you use recreational drugs	☐ No	☐ Yes	Type and frequency:
What is your weight (kg) _____ height (cm) _____ and Body Mass Index (BMI) _____			
Are you pregnant or breast feeding	☐ No	☐ Yes	
Do you live alone	☐ No	☐ Yes	
Do you have any cultural or religious needs	☐ No	☐ Yes	
Do you require assistance with day to day living	☐ No	☐ Yes	
Skin integrity			**If Yes, provide further details:**
Do you currently have wounds, pressure sores or skin ulcers	☐ No	☐ Yes	
Eczema or dermatitis	☐ No	☐ Yes	
Infection risk screening			**If Yes, provide further details:**
Do you have a fever and/or respiratory symptoms (e.g. cough, sore throat, runny nose)?	☐ No	☐ Yes	
Have you had, or been in contact with anyone who has had an infectious illness within the past 3 weeks (e.g. measles, chicken pox, shingles, conjunctivitis, gastroenteritis)?	☐ No	☐ Yes	
Have you had COVID-19 in the past?	☐ No	☐ Yes	Date of last positive test:
Have you ever been infected with a multi-resistance colonized infection (MRSA/VRE/CRE/CPE)?	☐ No	☐ Yes	
Do you have any blood borne infections (e.g. hepatitis B or C, HIV)?	☐ No	☐ Yes	
Have you had vomiting or diarrhoea in the past 48 hours?	☐ No	☐ Yes	
Have you been an inpatient in a hospital, resided in a residential care facility or worked in a hospital or residential care facility outside of Western Australia in the past 12 months?	☐ No	☐ Yes	
Medications and alternate therapies			**If Yes, provide further details below or attach/upload a medication list**
Do you take any medications (e.g. blood thinners, diabetic medications), including all over-the-counter medications and vitamins (e.g. ginko, fish/grapeseed oil, St John's Wort)?	☐ No	☐ Yes	

Medication Name	Dose	Frequency	Taken For

Are you taking any blood thinning or arthritis medication (e.g. Warfarin, Plavix, Aspirin) ☐ No ☐ Yes
If Yes, please ensure you contact your Doctor to determine whether you will need to stop any medications prior to admission.

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Creutzfeldt Jacob Disease (CJD)			**If Yes, provide further details:**
Complete these questions about CJD if you are having an operation on your eye, brain, spinal cord, pituitary gland or nerve root ganglia			
Have you had brain or spinal cord surgery that included a dura mater graft prior to 1990?	☐ No	☐ Yes	
Have you taken human pituitary hormone (growth hormone/gonadotrophin) prior to 1986?	☐ No	☐ Yes	
Do you have a family history of CJD?	☐ No	☐ Yes	
Have you received a 'look back or medical in confidence' letter for CJD?	☐ No	☐ Yes	
Have you had an unexplained progressive neurological illness of less than 12 months?	☐ No	☐ Yes	

What Matters to you?
Let us know what you hope to achieve from this hospital stay, or if you have any concerns or worries regarding your admission and what are the things that are currently important to you?

Legal documents - Please attach or bring a copy of any relevant documentation			
Do you have a current Advance Care Directive? *An Advance Care Directive is a set of written instructions that a person gives that specifies what actions should be taken for their health if they are no longer able to make decisions because of illness or capacity.*	☐ No	☐ Yes	
Do you have an Enduring Power of Attorney or legally appointed medical treatment decision-maker?	☐ No	☐ Yes	Complete details below:

Name:	
Relationship to patient:	
Contact number:	

Plan your discharge
You must not engage in the following activities for 24 hours following your operation/procedure or as directed by your doctor: • drive a motor vehicle, ride a bicycle or operate machinery or potentially dangerous appliances; • make any important decisions or sign legal documents; • drink alcoholic beverages. You must arrange and advise the hospital of a responsible adult to drive you home and stay with you overnight. As this is important for your safety after receiving an anaesthetic, failure to do this may result in your procedure being cancelled or postponed.

Name of responsible adult collecting you/the patient:	
Relationship to patient:	
Contact number:	

Patient/Guardian declaration
I understand my healthcare rights as presented to me in the Waikiki Private Hospital admission paperwork ☐ Yes ☐ No
I certify that the information I have provided is true and accurate to the best of my knowledge and I have read and understood the discharge planning requirements as above.

Patient/Guardian name (please print):					
Signature:				**Date:**	
Adm. Nurse Name:		**Signature:**		**Date:**	