



PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME		UNIT NUMBER
GIVEN NAMES		
ADDRESS		
D.O.B.	SEX	ROOM
DOCTOR		

## PATIENT HEALTH ASSESSMENT TO BE COMPLETED BY THE PATIENT

Have you ever been treated for any of the following  
(Please answer all of the following questions by placing a tick in the box)

Weight: \_\_\_\_\_ kgs      Height: \_\_\_\_\_ cms

COMMENTS

1. High blood pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>	
2. Heart attack/chest pain/angina	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>How often/when?</i>
3. Any other heart condition e.g. pacemaker/heart valve	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
4. Shortness of breath	No <input type="checkbox"/> Yes <input type="checkbox"/>	
5. Asthma/Chronic bronchitis/Pneumonia	No <input type="checkbox"/> Yes <input type="checkbox"/>	
6. Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>Site:</i>
7. Epilepsy/Fits	No <input type="checkbox"/> Yes <input type="checkbox"/>	
8. Migraine	No <input type="checkbox"/> Yes <input type="checkbox"/>	
9. Blackouts/Fits	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>When?</i>
10. Stroke	No <input type="checkbox"/> Yes <input type="checkbox"/>	
11. Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>Insulin</i> <i>Type 1</i> <input type="checkbox"/> <i>Tablets</i> <i>Type 2</i> <input type="checkbox"/>
12. Blood clots/Bleeding disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
13. Hepatitis/Liver condition	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
14. Stomach ulcers/Hiatus Hernia	No <input type="checkbox"/> Yes <input type="checkbox"/>	
15. Thyroid problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	
16. Kidney/Bladder/Bowel problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
17. Impairment e.g. vision/hearing	No <input type="checkbox"/> Yes <input type="checkbox"/>	
18. Skin condition	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
19. Arthritis	No <input type="checkbox"/> Yes <input type="checkbox"/>	
20. Anxiety/Depression/Other mental health problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	
21. Do you smoke, or have you ever smoked?	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>Ceased</i>
22. Do you drink alcohol?	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>How much per week?</i>
23. Do you use recreational drugs?	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>What type?</i>
24. Female patients "could you be pregnant?"	No <input type="checkbox"/> Yes <input type="checkbox"/>	
25. Is this admission due to a past or present injury?	No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>Cause of injury:</i> <i>Place:</i> _____ <i>Date:</i> _____

<b>RISK ASSESSMENT</b>	<b>Comments</b>
Do you have any other conditions not mentioned e.g. acute/chronic? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you ever had an anaesthetic before? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you ever had any problems with anaesthetics e.g. nausea/vomiting? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Has any blood relative had problems with anaesthetics? e.g. malignant hyperthermia No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you had any other operations? No <input type="checkbox"/> Yes <input type="checkbox"/>	<i>Please list</i>
Have you had a cough/cold recently? No <input type="checkbox"/> Yes <input type="checkbox"/>	

**QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE**

Have you had a dura mater graft between 1972-1989? No  Yes

Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder? No  Yes

Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985? No  Yes

Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed? No  Yes

**MEDICATIONS**  
 Prescription, non-prescription or herbal medications.  
 Please bring all medications you are currently taking with you for this admission.

Medication	Dosage	Frequency

Have you recently taken blood thinning medication e.g. Aspirin, Warfarin No  Yes

Have you been instructed to cease this medication? No  Yes

Name of medication: \_\_\_\_\_

**ALLERGIES**  
 Do you have any allergies (e.g. medicines, sticking plaster, latex/rubber, food, fruit)?

Name of substance/medication	Nature of reaction

Special dietary requirements:

**DISCHARGE PLANNING**

Do you have someone to stay with the night you leave hospital? No  Yes

Do you have someone to collect you from hospital? (Day Surgery patients are unable to drive after surgery) No  Yes

Are you concerned about how you will manage after discharge? No  Yes

**PATIENT HEALTH ASSESSMENT REVIEWED BY PRE-ADMISSION NURSE**

Signature..... Print..... Designation..... Date.....

Action taken e.g. notify anaesthetist, surgeon, GP etc.

**PATIENT HEALTH ASSESSMENT REVIEWED BY ADMISSION NURSE**

Signature..... Print..... Designation..... Date.....

### TO BE COMPLETED BY THE PATIENT

Last Name: Mr / Mrs / Miss / Ms

First Name:

Middle names:

Date of Birth:

Gender:  M  F

Previous Names: (e.g. maiden name)

Occupation:

Street Number/Property name:

Street name:

Suburb:

Postcode:

Home Phone:

Business phone:

Email Address:

Mobile phone:

### Demographics

Marital Status:  Married (including defacto)  Single  Divorced  Separated  Widowed

Country of birth:

Language spoken:

Are you an Australian Resident?  Yes  No Interpreter required?  Yes  No

Indigenous Status:  Aboriginal  Torres Strait Islander  Both Aboriginal & Torres Strait Islander  Neither

Religion/Denomination:

Would you like a religious visit?  Yes  No

### Next of Kin

Relationship to Patient:

Language Spoken:

Last Name: Mr / Mrs / Miss / Ms

First Name:

Address:

Suburb:

Postcode:

Home Phone:

Business Phone:

Mobile Phone:

### Admission Information

Expected admission date: / /

Expected Admission Time:

Name of specialist/doctor admitting you to Castlecrag Private Hospital:

General Practitioner:

Address of GP:

Phone No:

Have you been a patient at Castlecrag Private Hospital before?  Yes  No If Yes, Year

Have you been in any hospital in the last 7 days?  Yes  No

## TO BE COMPLETED BY THE PATIENT

### FINANCIAL DETAILS

#### Private Health Fund Information

Are you a member of a health fund?

Yes  No

Name of fund:

Membership number:

Contributor name:

Table of cover:

Date joined fund:

Has this level of cover changed in the last 12 months  Yes  No

Please contact your health fund to confirm your level of cover for this admission.

Medicare Number:

No. on Medicare card:

Valid to:

Pharmacy Benefits number:

Pension number:

Expiry Date:

#### Veteran's Affairs

Veteran's Affairs card number

Card Colour:  White  Gold

#### Worker's Compensation/Third Party Liability Claims

Are you entitled to Third Party Liability Claim?

Yes  No

Are you entitled to Workers' Compensation (approval required)?

Yes  No

Employer name:

Employer address:

Postcode:

Contact name:

Contact telephone No:

Insurance company:

Contact name:

Address:

Suburb:

Postcode:

Telephone:

Claim No:

Date of injury:

#### Person Responsible for Payment of Account

Self  Next of kin  Other

Last Name: Mr / Mrs / Miss / Ms

First name:

Street number/Property name:

Street name:

Suburb:

Postcode:

Home phone:

Other phone:

Signature:

Date:

#### Room Preference

Single  Shared

Whilst every effort will be made to provide the accommodation you request, this is subject to availability at the time of admission.

Accommodation costs will be billed to the actual accommodation occupied.

Workers Compensation, Third Party and DVA patient are covered for shared room only.

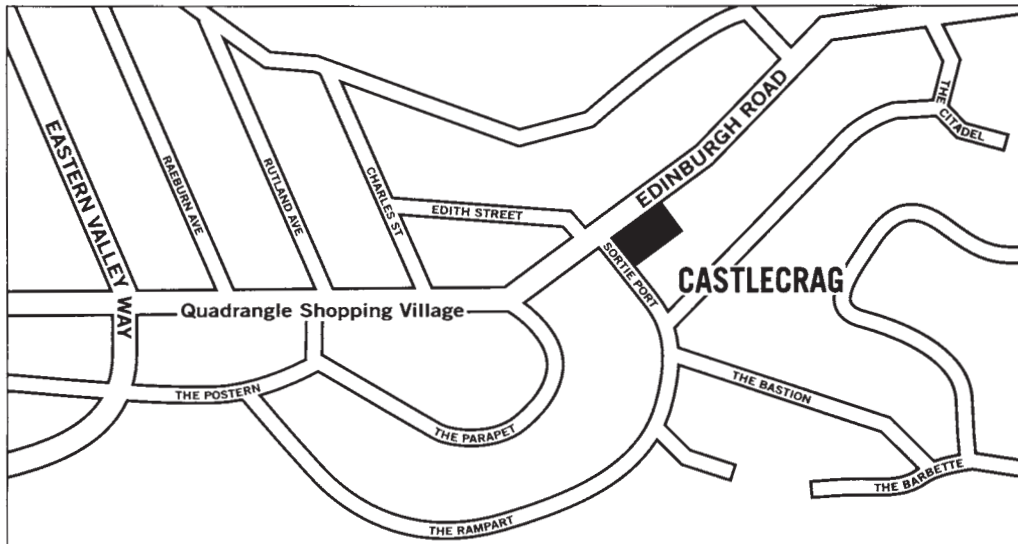
## Privacy Statement

We acknowledge our obligations to you under the Privacy Amendment (Privacy Sector) Act 2000. Personal information collected about you will be used primarily to provide your health care and for a limited number of purposes. For further information, our Privacy Policy is attached.

Please return your completed details as soon as possible to:

Admission Department  
Castlecrag Private Hospital  
PO Box 760  
Willoughby NSW 2068

Telephone: 02 9935 0200 Facsimile: 02 9958 8438



## DVA Authority

Department of Veterans' Affairs patients must also sign below:

### HOSPITAL ADMISSION VOUCHER

DVA Authority Number: \_\_\_\_\_

The information in these forms is required to identify the patient, determine patient eligibility under the Department of Veterans' Affairs and to obtain authorisation from the patient for disclosure of clinical information relating to the patient.

### Patient Declaration

I authorise disclosure of information from my clinical records, to the Repatriation Commission/Military Rehabilitation and Compensation Commission, and the Department of Veterans' Affairs.

Patient or agent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is unable to sign, please state agent's name: \_\_\_\_\_

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