# WESTERN DISTRICT HEALTH SERVICE

# REQUEST FOR ADMISSION

Unit Record No. ______________

Surname ______________

Given Names ______________

D.O.B. ______________ Sex ______

Tel. No. ______________

ATTACH HOSPITAL LABEL HERE

## RISK SCREENING / REFERRALS *(To be completed for all patients)*

1. PATIENT LIKELY TO HAVE SELF CARE PROBLEMS? ☐ YES ☐ NO
2. PATIENT LIVES ALONE OR IN AN ISOLATED AREA? ☐ YES ☐ NO
3. CARING RESPONSIBILITIES FOR OTHERS? ☐ YES ☐ NO
4. PATIENT USED SERVICES BEFORE ADMISSION? ☐ YES ☐ NO

PATIENT'S CARER ..............................

Admission Date/Time ..............................

Operation date ..............................

Length of Stay ..............................

Urgency 1 2 3

## ELECTIVE ADMISSION

SURGEON/PROCEDURALIST .............................. REFERRING DOCTOR ..............................

ACCOUNT CLASS ☐ PUBLIC ☐ PRIVATE ☐ V/A ☐ W/C ☐ TAC ☐ Shared Uninsured

REASON FOR ADMISSION / PROCEDURES PLANNED ..............................

..............................

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..............................

SPECIAL ORDERS ..............................

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..............................

☐ ASA SCORE ☐ CONSULTATION WITH CONSULTANT ANAESTHETIST REQUESTED

ASSISTANT BOOKED ..............................

PATIENT NOTIFIED BY VMO ☐ YES ☐ NO PRE-ADMISSION PACK ISSUED ☐ YES ☐ NO

DATE PROCESSED BY ADMISSIONS .............................. DATE PROCESSED BY OPERATING SUITE ..............................

## CONSENT TO OPERATIVE TREATMENT, ADMINISTRATION OF ANAESTHETIC & USE OF TISSUE

I, ..............................
*(given names)* *(family name)*

hereby consent to the following procedure (s) ..............................

..............................

being performed upon .............................. The nature, purpose, effect and risks
*(myself or *name of patient)*

of the above procedure(s) & anaesthetic (s) have been explained to me by Dr/Mr ..............................
to my satisfaction and I have had the opportunity of seeking any futher information I desire. I also consent to the administration of anaesthetics appropriate to and associated with the stated procedure(s) except ..............................
*(details of anaesthetic refused)*

I understand that my tissue may be used for diagnostic and treatment purposes. I understand that it will be kept and may be used for ethically approved research education and laboratory quality procedures.

Signed: .............................. Date: ..............................

## CONSENT FOR

☐ Chemotherapy

☐ Blood Transfusion (the risks, advantages and alternatives have been explained by Dr. ..............................)

☐ Post Acute Care Services

☐ Hospital in the Home Program

☐ District Nursing Services

☐ Palliative Care

☐ Midwifery Model of Care

☐ Other (please specify) ..............................

..............................

Signed: .............................. Date: ..............................

REQUEST FOR ADMISSION

MR 006

May 2010

94250

☐ **Refusal of Treatment**

I, ........................................................................................................ refuse the treatment/procedure stated below
*(whose name appears at the top of this form)*

☐ the administration of a blood transfusion or any other blood products.

☐ other ........................................................................................................
*(Specify)*

Dr ........................................................................has explained to me the risks involved in my decision to refuse the above treatment.
*(Doctor's Name)*

I confirm that I understand the risks involved in my decision to refuse the above treatment. I undertake that I will not pursue legal action against Western District Health Service or its staff in relation to any damage, injury or loss suffered by me and also agree to indemnify Western District Health Service and its staff against any claim made by another person as a result of my refusal of the above treatment.

Signed: ........................................................................................................ Date: ....................................

**Western District Health Service recognises the right of its patients to privacy in Health Care. Western District Health Service may be required by law to disclose some of your health information. If you believe that your privacy has not been respected, a complaints process is available. (Please ask a staff member).**

## Consent to use of and Disclosure of Information

I, (whose name appears at the top of this form) understand that the Western District Health Service may use and disclose any information contained in my medical records to any of its staff members for the purposes of providing treatment to me for my current or any future health condition.

I understand and agree that the information contained in my medical records may also be disclosed to and used by staff members of other public hospitals for the purpose of providing treatment to me for my current or any future health condition.
I consent to the release of any information contained in my medical records to the following:

☐ any private health service provider who requires the information for the purpose of providing treatment for my current condition. I understand that only information which is required for such treatment to occur will be released.

☐ any private health service provider who requires the information for the purpose of providing treatment for any condition I may suffer from in the future. I understand that only information which is required for such treatment to occur will be released.

☐ health or other professionals who will use the information for the purposes of research, teaching or statistical compilation or analysis.

☐ other specified purposes (to be completed) ........................................................................................................

☐ The DHS minimum data collection requirements

Signed: ........................................................................................................ Date: ....................................

## Refusal of Consent to use and Disclosure of Information

I, (whose name appears at the top of this form) refuse to consent to the release by the Western District Health Service of any information contained in my medical record to the following:

........................................................................................................

........................................................................................................

........................................................................................................

Signed: ........................................................................................................ Date: ............../............../..............

**You have the right to review or change any of the above decisions at any time during your hospital stay. (Please ask a staff member)**