Dalcross Wellness Hospital

Pre-Admission Package

Complete Your Pre-Admission

Your pre-admission can also be done online. Follow the link provided via SMS from webPAS to access the online pre-admission form.

If you have any questions, please contact the administration team by email at dwhadmin@machealth.com.au or by phone on (02) 7228 6700.

Mission Statement

Macquarie Hospital Services has a philosophy which focuses on wellness and well-being for our customers and a commitment to providing a service of quality and value. Macquarie Hospital Services will provide comprehensive and profitable health care service and valued partners in an environment of growth and development.

Patient information

Please complete your pre-admission using the secure link sent to you via SMS. Alternatively, completed pre-admission forms may be submitted to DWHAdmin@machealth.com.au, if instructed by the hospital.

Pre-Admission Information

Pre-admission is an important part of your hospital care. To ensure we can confirm your admission, financial and other arrangements, **we ask that you:**

- Complete the Pre-Admission and Patient History forms (enclosed) or follow link provided via SMS from webPAS to access online pre-admission form.

- If you are not online, please remove the completed forms from the booklet and **forward immediately** to the hospital in one of the following ways:
  a. **In person to Reception** (open 8 a.m.- 4 p.m. Monday to Friday)
  b. **Fax** (02) 7228 6710 please remember to bring the original forms on the day of admission.
  c. **Post at least two weeks before admission** or as soon as completed to Dalcross Wellness Private Hospital, 28 Stanhope Road KILLARA NSW, 2071.

- If you are unable to deliver, fax or post the forms, please telephone the hospital as soon as possible on (02) 7228-6701 (Bus. Hours) 8 a.m. to 4 p.m. to confirm your admission.

- Please ensure that you bring the following documentation either **when you bring your forms to the hospital or on the day of admission**.
  - Health Fund card.
  - Medicarecard
  - Pharmaceutical entitlements card
  - Pension card / Health Care card
  - Repatriation / Veterans' Affairs card
  - Credit card or alternative form of payment

- If your account is subject to Workers' Compensation or a Third Party claim, forward full details of the claim, including a letter from your insurance company accepting liability for this admission, to our Pre-Admission Office.

Your doctor will notify the hospital of the date of your procedure/operation and inform you of the day of admission. The doctor will also explain your procedure or operation and complete the consent form with you.

Prior to admission, check with your doctor as to which, **if any**, regular medications are to be taken on the morning of your surgery.

If you have any questions about hospital procedures, completion of forms, cost or health insurance status, our staff will be happy to assist you.

The day prior to Admission

The hospital will contact you after **12 p.m**, on the working day prior to your operation regarding fasting instructions and arrival time.

What to bring into hospital on the day of Admission

- Any medications (in original packaging) you are currently taking
- if you currently use a blister pack for your medications, please contact your pharmacist and request original packaging.
- any current x-rays
- reading material
- crutches / walking aids if required.

Do not (unless instructed by your doctor):

- Eat or drink anything after 6 a.m. for afternoon surgery – (a light breakfast prior to 6.30 a.m. is acceptable i.e. tea and toast)
- Smoke cigarettes or chew gum
- Wear jewellery (wedding ring and watch are permitted)
- Wear make-up or nail polish.

On arrival report to:

Main Reception Desk.

Day Procedure Patients (additional information):

- Wear garments that are comfortable and easy to remove.
- Check with your nurse before informing relatives/friends regarding the time that you should be picked up.

Valuables

Do not bring jewellery or large amounts of money to hospital, as provision for safe custody is not available. Dalcross Wellness Hospital does not accept liability for any items brought into the hospital.

Meals

Dalcross Wellness Hospital will provide light refreshments. Food or alcoholic drinks should not be brought to you by visitors, without the permission of your Nurse.

Smoking

Please be aware that Dalcross Wellness Private Hospital is a **NO SMOKING** hospital.

Accounts/Fees

If you are a member of a , it is important prior to your admission to check with them regarding the following:

1. That your level of Health Fund Cover adequately covers the cost of the procedure and accommodation outlined in the Pre-Admission Form.
2. If an excess is payable for this admission.
3. **If you have been a member of your Health Fund for less than 12 months, your fund may not accept liability for the costs of this admission – e.g. if your condition or any symptoms of your condition existed prior to your joining. If there is a question regarding pre-existing symptoms your Health Fund has the option to obtain details in this regard from your GP or Specialist.**

Payment Procedure

- Private patients: the portion of your estimated hospital account not covered by your Health Fund, e.g. an excess, must be paid on admission. Any additional costs incurred during your stay e.g. Pharmacy Costs and some investigations as outlined above, are payable prior to discharge.

- Repatriation (DVA) patients: the hospital will lodge a claim on your behalf. Any personal item purchased on your behalf must be paid for by you.

- Workers' Compensation patients: total payment (aside from any ancillary charges) must be made on admission unless approval for admission has been confirmed.

- Third-party patients: total payment (aside from any ancillary charges) must be made on admission unless approval for your hospitalisation has been authorised.

- Self Insured patients: total payment (aside from any ancillary charges) must be made on admission.

- Payment may be made by cash, bank cheque, MasterCard, Visa/Eftpos or American Express.

PLEASE NOTE: Dalcross Welllness Hospital does not accept personal cheques.

Medical Records and Privacy

Records of your illness and treatment will be kept for a limited time. They are confidential. The contents will be divulged only with your consent, or where justified by law. Dalcross complies with the Privacy Act 1988, and Health Records and Information Privacy Act 2002 including the way we collect, store, use and disclose health information.

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our hospital (*e.g. to your Health Fund, DVA, the supplier / manufacturer of your prosthesis, to our insurer, or to an external company contracted by Dalcross to evaluate customer satisfaction*).

Discharge Information

- You should arrange for someone to escort you home.

- You must not drive a car until 24 hours after your procedure or anaesthetic, or until advised by your doctor. (your motor vehicle insurance may not cover you).

- Before you leave the hospital, make sure that you or your relatives / friends know how to care for you at home.

- Check with your nurse / doctor about continuing medication, follow-up appointments, etc.

- Please do not forget to collect any medications brought with you on admission.

- Please complete a Patient Questionnaire Form to assist us improve our service.

Please contact your nurse, if you have any concerns, problems or suggestions during your stay.

Dalcross Wellness Hospital

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	GENDER M F
WARD	DOCTOR
UNIT NUMBER	

PRE-ADMISSION FORM

To be completed by Patient
Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Details

Date of Admission: ____/____/____ Date of Operation: ____/____/____ ADMISSION TYPE:

Admission Time: _____ 23-hour observation Day only

ADMITTING DOCTOR: _____

Admission Diagnosis / Procedure: _____

Personal Details

Title: _____ Surname: _____ Previous Surname *(if applicable)* _____

Given Names: _____ Preferred Name: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: (Home) _____ (Business): _____ (Mobile): _____

Email: _____ Are you interested in receiving the hospital newsletter __ YES __ NO

Sex: Male Female Date of Birth: ____/____/____ Age: _____

Marital Status: __ Single __ Married __ De facto __ Separated Divorced Widowed

Occupation: _____

Are you an Australian Resident: Yes No Country of Birth: _____ If Australia, specify state: _____

Are you of Aboriginal / Torres Strait Islander (TSI) descent? __ No Yes, Aboriginal Yes, TSI __ Yes, both Aboriginal and TSI

Religion: _____ Do you wish to be visited by a member of your clergy? __ Yes No

Person to Contact (Next of Kin)

Name: _____ Relationship to patient: _____

Address: _____ State: _____ Postcode: _____

Telephone: (Home) _____ (Business): _____ (Mobile): _____

Second Contact / Power of Attorney: _____ Telephone: _____

Section A: Private Health Insurance

Fund Name: _____ Membership Number: _____ Date Joined: ____/____/____

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

Type of cover: __ Single Family __ Other: _____ Level of cover (if known) _____

Do you have an excess? __ No __ Yes Amount $_____ Have you paid an excess this year? __ No __ Yes Amount $ _____

Section B: Workers' Compensation/Third Party

☐ Workers' Compensation __ Third Party *(Please tick one box)*

The approval letter for this admission *(from your insurance company)* must accompany this form.

Insurance Company Details: Name of Insurance Company: _____

Address: _____ State: _____ Postcode: _____

Telephone: _____ Claim No: _____ Authorised by: _____

Has your insurance company accepted liability: Yes No Please specify reason *(if no)* _____

Workers' Compensation Patients Only - Employer Details: Name of Employer: _____

Address: _____ State: _____ Postcode: _____

Telephone: _____ Date of Accident: ____/____/____ Has your employer completed a Report of Injury Form? __ Yes __ No

BINDING MARGIN – DO NOT WRITE

PRE-ADMISSION FORM

MR 007

MSO132182/08/26 - Version 1

Dalcross Wellness Hospital

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	GENDER M F
WARD	DOCTOR
UNIT NUMBER	

PRE-ADMISSION FORM

ENTITLEMENTS

Medicare Card No: ☐☐☐☐☐☐☐☐☐☐ Medicare Reference No: Medicare Exp. Date: ____/____/____

Pension / Health Care Card No: ☐☐☐☐☐☐☐☐☐☐ Exp. Date: ____/____/____

Safety Net No: ☐☐☐☐☐☐☐☐☐☐

Repatriation No: ☐☐☐☐☐☐☐☐☐☐ Card colour: ☐ White ☐ Gold ☐ Other

Do you wish to be visited by a member of an Ex-Service Organisation? *Please indicate:*

☐ No ☐ Yes, I will organise it ☐ Yes, please organise it for me

PLANNED 23-HOUR OBSERVATION

This section applies only to patients who have been clinically scheduled for 23-hour observation.
Accommodation will be allocated by Dalcross Wellness Hospital according to clinical requirements and availability.
Patient preference does not determine admission or room allocation.

Planned 23-hour observation: ☐ No ☐ Yes

Authorised by: _____

Clinical reason: _____

GP / LOCAL DOCTOR

Full name of GP: _____

GP Address: _____

GP Telephone: _____ GP Facsimile: _____ GP E-mail: _____

PREVIOUS HOSPITALISATION

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year: _____

Is this admission for a child? ☐ No ☐ Yes

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes

Which Hospital? _____ Dates: _____

HOW WILL THIS ADMISSION BE CLAIMED? (Please ✔ tick)

☐ Private Health Insurance - please complete Section A

☐ Repat / Veterans Affairs - please complete Entitlements

☐ Workers' Compensation / Third Party - please complete Section B

☐ Self Insured

FINANCIAL CONSENT / VALUABLES

I understand the portion of my estimated hospital fees not covered by a health fund must be paid on admission and any additional fees incurred during my stay are payable on discharge.

I agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables brought to the hospital.

Signature of patient / parent / guardian: _____ Date: ____/____/____

Name of patient / parent / guardian (print): _____

PRE-ADMISSION FORM

MR 007

BINDING MARGIN – DO NOT WRITE

Dalcross Wellness Hospital

PRE-ADMISSION FORM

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	GENDER M F
WARD	DOCTOR
UNIT NUMBER	

To be completed by Patient Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Date: ____/____/____

Please specify the reason for your admission? _____

	YES	NO	COMMENTS OR FURTHER INFORMATION
Do you need an interpreter?			Language spoken at home:
What is your goal of this procedure?			
Have ECG, Urine or blood tests been performed?			Pathologist/Company:
MEDICATIONS	**YES**	**NO**	
ALLERGIES Do you have any allergies to medications, food, intravenous dyes, sticking plaster, latex / rubber (e.g. balloons, gloves) or other substances?			Specify:
Have you recently taken blood thinning/arthritis medication (Aspirin Based) Clopidogrel (Plavix/Iscover) Anti-inflammatories, Dipyridamole (Asasantin / Persantin), Warfarin?			Name of medication:
Have you been instructed to cease this medication?			Date last taken / / or still taking ☐ Yes
Have you taken any steroids or cortisone tablets/injections in the last 6 months?			Name of medication: Date last taken / / or still taking ☐ Yes
Are you taking any other prescription or non-prescription medication? If so, list the medications you currently take. **Please bring current medications to hospital on admission, in the original packaging.** *Please obtain advice from your Doctor on taking medications on the morning of your operation.*			
MEDICAL HISTORY	**YES**	**NO**	**SPECIFY DETAILS:**
Diabetes			Managed by: ☐ Diet ☐ tablets ☐ Insulin
Cancer year diagnosed:_____			Site:
Stroke Date: ____/____/____			Residual problems ☐ Yes ☐ No
Infectious diseases / recent infections			
High blood pressure			
Heart attack / chest pain / angina, especially heart failure or changed chest pain.			Date: / / Specify:
Cardiac Surgery or Ste			Specify:
Prosthetic heart valve			Type:
Palpitations / irregular heart beat / heart murmur			
Pacemaker			Make _____ Model _____ last checked / /
Rheumatic Fever			
Tendency to bleed / bruise easily			
Arthritis			
Asthma / bronchitis / pneumonia / hay fever			
Liver disease / hepatitis (Specify type A,B,C)			
Kidney / bladder problems			
Hiatus hernia / gastro-intestinal ulcers / bowel disorder			
Thyroid problems			
Epilepsy / fits / febrile convulsions			If yes, discuss medication with your Doctor while 'nil by mouth'
Depression / other mental illness			

BINDING MARGIN – DO NOT WRITE

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BINDING MARGIN – DO NOT WRITE

PRINT NAME:

MEDICAL HISTORY:	YES	NO	SPECIFY DETAILS:
Dementia/confusion			
Migraines			
Recent cold or flu			
Female patients - could you be pregnant?			Number of weeks:
Impairment e.g. vision, hearing, mobility			Specify:
Leg or lung clots			
Any cuts or abrasions near operative site			
Other health problems			

PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations - if so, please list the year/s and operation/s performed:

	YES	NO	SPECIFY DETAILS:
Have you or anyone in your immediate family ever had a reaction to an anaesthetic?			Details of any reaction
Have you ever had a blood transfusion?			Details of any reaction

PROSTHESIS / AIDS / OTHERS			
Glasses / contact lenses / eye problems			
Hearing aid or other hearing appliance			
Body piercing			
Dentures / caps / crowns / loose teeth			
Artificial joints or limbs			
Metal plates / pins			

LIFESTYLE			
Have you ever smoked?			Daily amount _____ or date ceased / /
Do you drink alcohol?			Daily amount _____
Do you use recreational drugs?			Type _____ Daily amount _____
Do you require a special diet?			Type of diet
Have you a fear of falling or have fallen within the last 12 months?			
SLEEP APNOEA Have you ever suffered from sleep apnoea?			
If so, do you have a CPAP machine at home?			**If yes, bring your machine with you.**

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE			
Have you had a dura mater graft between 1972-1989?			
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?			
Have you received human pituitary hormones *(growth hormones, gonadotrophins)* prior to 1985?			
Has the patient suffered from a recent progressive dementia *(physical or mental),* the cause of which has not been diagnosed?			

DISCHARGE PLANNING *(this information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete)*

	YES	NO	SPECIFY DETAILS:
Are you over 75 years of age?			
Do you live alone?			
Are you solely responsible for the care of another person at home?			
Do you currently receive community support services?			
Do you require assistance with any aspect of day-to-day living?			
Do you have multiple health problems?			
Do you have more than 1-2 external or internal stairs in your home?			

DISCHARGE PLAN (patients to complete)

Who will care for you after discharge from hospital?

Name of Person:	Relationship:
Contact No.:	How will you get there?

Admission Nurse Signature: _____ Date: _____ Time: _____

Name (print): _____ Designation: _____

Dalcross Wellness Hospital

Location & Travel

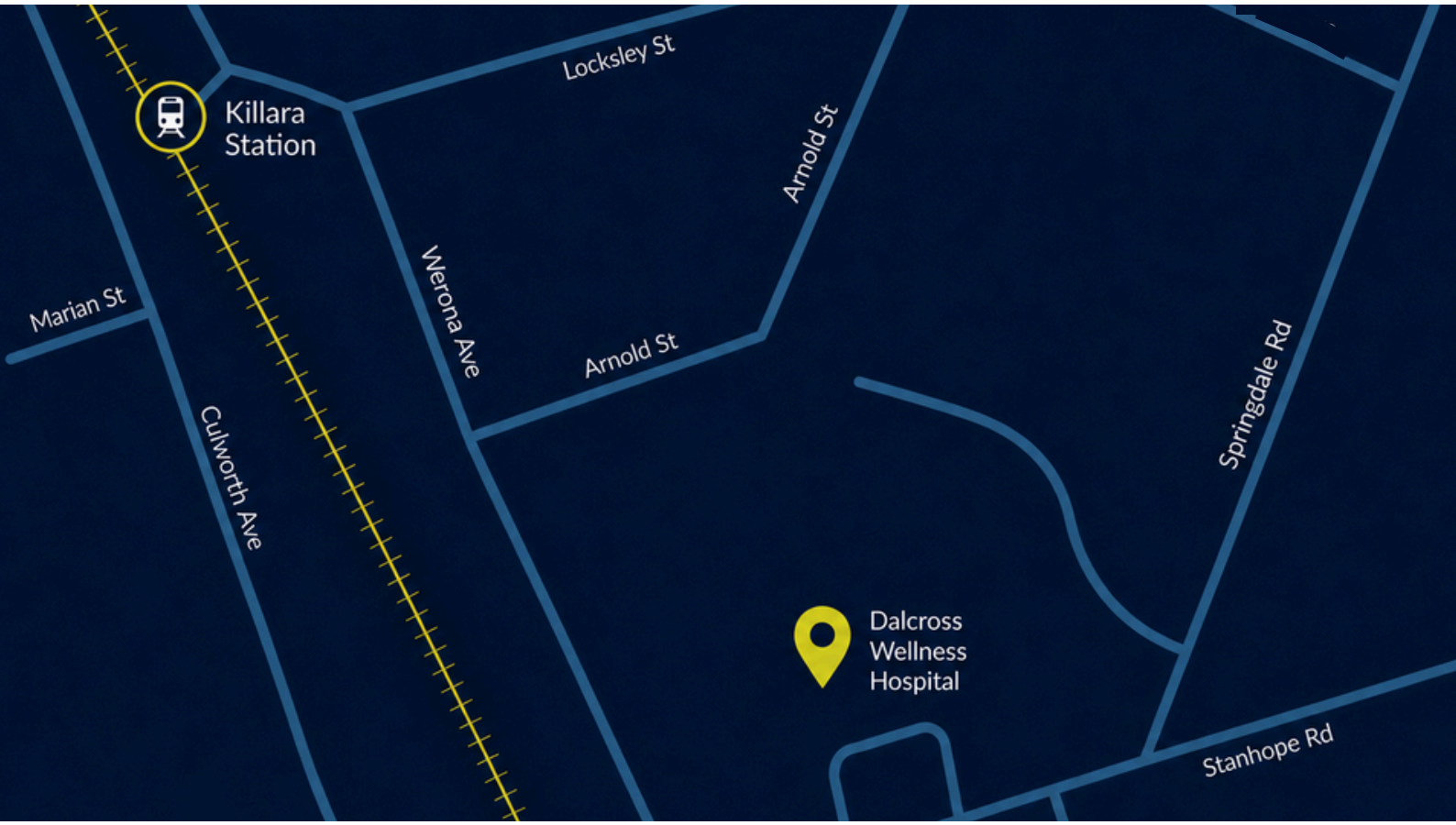
Car Parking

Free on-site parking is available for patients and visitors. Please allow enough time before your admission to park, check in at reception and complete any required paperwork.

If you are being admitted for a procedure, please arrange for a responsible adult to take you home after discharge. You must not drive yourself home after your procedure unless your doctor has specifically advised that you may do so.

Arrival at the Hospital

Patients attending Dalcross Wellness Hospital should enter via the main entrance and report to reception on arrival. If you are unsure where to go, please contact the hospital before your admission and our team will assist you.



For further information or assistance, please contact our administration team.

www.dalcrosswellness.com.au · dwhadmin@machealth.com.au

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