



Pre-Admission Information

This form is available for completion on-line, go to www.matertsv.org.au

This form should be returned as soon as possible and no later than one week prior to your date of admission.

Maternity Patients

Please return this form to the Women's Unit by 20 – 25 weeks.

Pre-Admission Team Contact Details

Pimlico Campus

25 Fulham Road, Pimlico QLD 4812 | Locked Bag 1000, Aitkenvale BC, QLD 4814
Ph +61 7 4727 4444 | Fax: +61 7 4725 1034
Email: info@matertsv.org.au

Hyde Park Campus

12 – 14 Oxford Street, Hyde Park QLD 4812 | Locked Bag 1000, Aitkenvale BC, QLD 4814
Ph: +61 7 4727 4444 | Fax: +61 7 4725 1034
Email: info@matertsv.org.au

Mater Private Hospital Townsville is a smoke free zone.

**Thank you for choosing Mater Private Hospital Townsville for your hospital care.
It is our privilege to welcome you as our patient and guest.
Staff at the hospital understand that coming to hospital can be an unsettling experience,
this information has been compiled to help answer some of your questions.**

PREPARING FOR YOUR ADMISSION

Prior to your hospital admission you are required to complete the Pre-Admission Form at the back of this booklet and return it to the Mater Hospital as soon as possible and no later than one week prior to your date of admission, therefore enabling us to prepare for your hospitalisation. Please complete to the best of your ability, providing as much detail as possible.

Maternity Patients: please return this form to the Women's Unit, Hyde Park Campus at 20-25 weeks.

If you have any questions please contact the Mater on 4727 4444 and ask for our Patient Services Department.

Please bring a list of all medications (including natural therapies) and any medicine you will need to take during your stay (refer to the Medication Summary Form within this booklet). Report all medication you are taking. Please ensure you have your medications with you in their original containers/packaging and any current prescriptions you may have. Webster packs and dosettes that have already been prepared cannot be used by our staff.

A copy of the Australian Charter of Healthcare Rights is available on our website, or within the waiting rooms of the hospital for your perusal.

Information for your visitors

Please refer to your hospital ward for visiting hours. We do request that you advise your loved ones that a rest period is scheduled daily as this is an important aspect of your recovery. You may also visit our website or contact us on 4727 4444 to confirm the visiting hours for your ward.

Your visitors may like to know that they are able to order meals from our Food Services Department which will be delivered along with your meal. If you wish to take advantage of this service please see your nursing staff. Meals provided by the hospital to your visitor will incur a charge that is payable on discharge.

Accommodation is also available for patients and relatives who are from out of town. Please contact us on 4727 4444 and ask for our Patient Services Department for further information.

Day Procedures

Please arrange for a responsible person to transport you home following your procedure and stay with you overnight – it is unsafe and you may not be covered legally or by insurance to drive for 24 hours after your anaesthetic.

You must not sign any contracts or make important decisions for 24 hours following your procedure – these may not be legally binding.

You must follow any post-procedural instructions given to you and contact your doctor or present to an Emergency Department should you have any post-procedural complications.

Fasting

If you are having surgery you will need to "fast". This means that you will not be able to have any food or fluids (including water) for a specified period of time. You will be advised by your doctor if you are required to fast and how long you would need to fast.

You must not drink alcohol or smoke for 24 hours prior to your surgery. You must not drink alcohol for 24 hours after your anaesthetic.

Valuables

Please do not bring valuables to the hospital including large amounts of cash or jewellery. The Mater Hospital will not accept any liability from loss or damage, however caused, for any items of value retained in your responsibility whilst a patient in the hospital. However, please note that the Mater will require payment of any expected out of pocket expenses prior to or on admission.

Electrical Testing

In the interests of patient safety, all electrical equipment, eg. shavers, hairdryers, phone chargers and computers must be checked by our technical staff prior to use. Please arrange this with our Patient Services staff.

Power of Attorney and Advanced Healthcare Directions

If you have an Advanced Healthcare Directive or Power of Attorney, please ensure you discuss this with your treating specialist/doctor and bring a copy of the documents with you to hospital. We will keep a photocopy in your chart with your consent.

Dietary Requirements

Should you have any special requirements please contact our Food Services Manager on 4727 4535 prior to your admission.

Smoking

The Mater Hospitals are committed to good health for everyone therefore smoking will not be permitted on hospital grounds (including car parks and outbuildings). If you are a patient coming into hospital you will not be able to smoke within the hospital premises and grounds (Tobacco & Other Smoking Products Act 1998 Qld).

WHAT TO DO ON THE DAY OF ADMISSION

On the day of your admission, please present to the hospital's main reception area at the time requested by your doctor. Please note that the requested time is your admission time only, this is not your operation or procedure time. You have been asked to arrive at this time by your doctor to allow for any necessary preoperative requirements.

Your doctor sets the order of the operating list and makes the decision about what time you are needed in the operating theatre. As a result, you may have to wait between two and six hours before your surgery or procedure. The staff will aim to make your wait as comfortable and pleasant as possible.

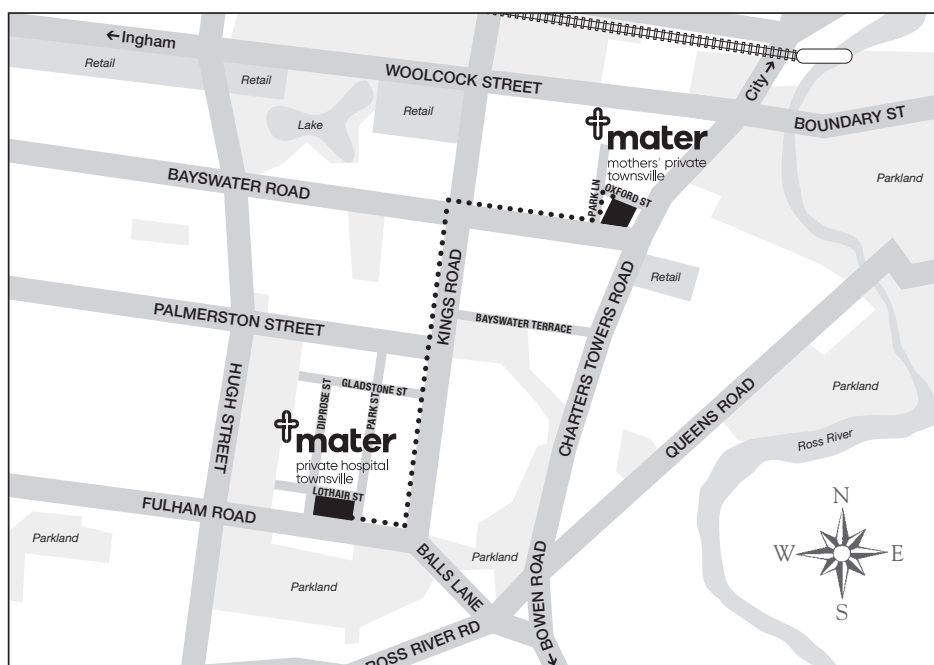
Your admission checklist:

- ☐ Any letters from your doctor including your consent form
- ☐ Any appropriate x-rays, scans and medical reports
- ☐ All medication that you are currently taking (in original packaging) and all prescriptions
- ☐ A list of any known allergies
- ☐ Your EFTPOS, credit card or other means of payment for any out of pocket expenses (all charges are payable on or prior to admission)
- ☐ If you are having day surgery please shower and wear loose, comfortable and appropriate clothing
- ☐ Do not wear any chemicals, eg. perfume, makeup, nail polish or deodorant
- ☐ If you are staying overnight, for your comfort we suggest you bring a small bag containing slippers, dressing gown, personal toiletries, night attire and contact lenses/glasses
- ☐ Please bring any item of a personal nature you may require (eg. sanitary products)
- ☐ If you are an insulin dependent diabetic, please bring your pens/needles with you
- ☐ A book or reading material

If your relative or friend will be waiting at the hospital our friendly staff will provide directions for them to relax in the café or one of the lounges within the hospital. We will ensure our staff have a mobile number for your relative or friend to ensure they can be contacted.

LOCATION OF OUR HOSPITALS

Distance between hospitals 2.25kms



PRIVACY STATEMENT

Our hospital is committed to protecting your privacy. We comply with the Commonwealth Privacy Act 1988, acknowledging the Privacy Amendment (Private Sector) Act 2000 and the Australian Privacy Principles as updated in March 2014. Further information is available on our website or contact our Health Information Manager on (07) 4727 4337.

To access a copy of your health information record, see further information on our website or contact our Health Information Manager on (07) 4727 4337.

Identification

You will wear an identification band which will state your name, date of birth and unique hospital identification number and other relevant information. At various times staff will check the details on this band and ask you to tell them information such as your name and date of birth. This is not because they don't know who you are - they are taking precautions to ensure you are the correct patient to receive the medication or treatment.

The staff are taking these steps to ensure that everything goes as planned for your procedure.

Ensuring Correct Surgery

Before you are transferred to the operating theatre your doctor may need to make a mark with a pen on the part of your body which requires surgery.

It is important that this mark does not rub off. It is essential for the doctor and nursing staff to see the mark before your surgery commences. If for any reason the mark is removed, please advise the staff as soon as possible.

When you arrive in the operating theatre, the nurse will ask you to state your name, date of birth and the type of operation you are having. This is done to ensure that your surgery is performed correctly.

Just prior to the commencement of your surgery, the surgical team will undertake a 'Final Team Check' to verify your identification and procedure you are to undergo.

Stop the clot

As a result of your admission to hospital you may be at increased risk of developing a blood clot in your legs or lungs.

As part of your care your doctor will assess you on admission to determine your level of risk and if necessary implement treatment options to reduce the risk of developing a clot.

These treatment options may include:

- Wearing compression stockings
- Using a compression pump on your lower legs
- Taking tablets or injections to help prevent blood clots
- Gently exercising your feet or legs in bed
- Getting out of bed and walking as soon as possible.

Some of these treatments are not suitable for all patients. Your doctor will decide the correct treatment option for you.

Falls Prevention

For a number of reasons, people of all ages are at increased risk of falling whilst in hospital. These reasons include unfamiliar surroundings, poor balance, poor eyesight, unsafe footwear, their medical/surgical condition and some medications.

While only a small number of these falls cause serious injury, they often result in a loss of confidence which can interfere with independence and prolong the time spent in hospital.

Everyone has a role to play in helping reduce the risk of falls, while in hospital.

On your admission, staff will show you around the ward to ensure you are familiar with your surroundings. You may also have a Falls Risk Assessment completed which staff will discuss with you and put in place a plan that suits your needs.

This may involve seeing a range of Allied Health Practitioners (eg. physiotherapist, dietitian) to provide you with information and support.

Please ensure you have appropriate clothing and footwear when you come into hospital. Footwear should fit securely; have a flat or low heel and a non-slip grip.

Many patients are fitted with anti-embolism stockings while in hospital. These stockings increase the risk of slipping or falling when walking. It is therefore important to wear slippers or other footwear if you are using these stockings.

Preventing Pressure Ulcers

To reduce the risk of developing a pressure ulcer –

- Ensure good posture when sitting in a chair. Change your body position frequently if lying in bed for a prolonged time. At least every 1-2 hours if you are in bed, or every 15 minutes to 1 hour if you are in a chair. If you cannot move easily yourself, ask for assistance.
- Staff may use special equipment like air mattresses and heel elevators, to help relieve the pressure.
- Inspect your skin for early warnings of redness that does not go away, broken or blistered skin, or numbness. If you cannot see all your body ask a nurse, a family member or a friend to check regularly for you.
- Use moisturising lotion to prevent your skin drying out. Avoid vigorous massage or rubbing of the skin, as this can damage the underlying tissue.
- Keep your skin clean and dry at all times. If you use a continence device to control your bowel or bladder, it is important that you change it regularly to keep the skin clean and dry to reduce skin irritation from any urine or faeces.

YOUR SAFETY IN HOSPITAL

10 TIPS FOR SAFER HEALTH CARE (Australian Council for Safety and Quality in Health Care)

1. Be actively involved in your own health care

Take part in every decision to help prevent things from going wrong and get the best possible care for your needs.

2. Speak up if you have any questions or concerns

Ask questions.

Expect answers that you can understand.

Ask a family member, carer or interpreter to be there with you, if you want.

3. Learn more about your condition or treatments

Collect as much reliable information as you can.

Ask your health care professional:

- what should I look out for?
- please tell me more about my condition, tests and treatment?
- how will the test or treatments help me and what is involved?
- what are the risks and what is likely to happen if I don't have this treatment?

4. Keep a list of all the medicines you are taking

Include:

- prescriptions, over-the-counter and complementary medicines (eg vitamins and herbs); and
- information about drug allergies you may have.

5. Make sure you understand the medicines you are taking

Read the label, including the warnings.

Make sure it is what your doctor ordered for you.

Ask about:

- directions for use;
- possible side effects or interactions; and
- how long you'll need to take it for.

6. Get the results of any test or procedure

Call your doctor to find out your results.

Ask what they mean for your care.

7. Talk about your options if you need to go into hospital

Ask:

- how quickly does this need to happen?
- is there an option to have surgery/procedure done as a day patient.

8. Make sure you understand what will happen if you need surgery or a procedure

Ask:

- what will the surgery or procedure involve and are there any risks?
- are there other possible treatments?
- how much will it cost?

Tell your health care professionals if you have allergies or if you have ever had a bad reaction to an anaesthetic or any other drug.

9. Make sure you, your doctor and your surgeon all agree on exactly what will be done

Confirm which operation will be performed and where, as close as possible to it happening.

10. Before you leave hospital, ask your health care professional to explain the treatment plan you will use at home

Make sure you understand your continuing treatment, medicines and follow-up care.

Visit your GP as soon as possible after you are discharged.

For further information contact the Australian Commission on Safety and Quality in Health Care.

Ph: (02) 9126 3600 Website: www.safetyandquality.gov.au Email: mail@safetyandquality.gov.au

PLEASE RETAIN FOR YOUR RECORDS

My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights**.

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access

- Healthcare services and treatment that meets my needs

Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services



PUBLISHED JULY 2019

RIGHTS AND RESPONSIBILITIES

The information provided reflects our commitment to providing you with exceptional care. It explains your rights and responsibilities relating to the care and treatment you will receive as our patient.

As a patient you have a right:

- To be treated with respect, dignity, care, consideration, courtesy and understanding of your individual, spiritual, emotional, social, physical and cultural needs.
- To be involved in the planning of your continuing health care needs, from admission through to discharge from our hospital.
- To be informed of services available at the Mater or in the community that you can access.
- To have a family member or nominated person present when you receive information about your condition. To ask for a second opinion and extra information on any diagnosis or treatment.
- To withdraw consent and refuse treatment after discussion about the outcomes of your decision with the health care professionals caring for you.
- To be informed of the names and roles of key health care providers and be able to refuse a particular health care provider at any time.
- To have access (with advanced notice) to a confidential interpreter service.
- To refuse to take part in clinical training or medical research without reason.
- To have your medical history and personal information kept confidential to the extent allowed by the law.
- To choose who is able to visit you and the right to refuse to see visitors.
- To receive an itemised final account for services within the hospital's control.
- To express an opinion or make reasonable verbal or written complaints regarding your treatment or any facilities or services which you feel are below your reasonable expectations. If you have concerns with any aspect of your care please discuss this with the staff looking after you. If you would like to voice a concern or make a complaint, you may wish to speak to the nurse in charge of that particular shift. The Executive Director of Nursing is also available on telephone 07 4727 4570.

As a patient at the Hospital you or your authorised representative have a responsibility:

- To give staff as much information as you can about your health and any ethnic, cultural or religious beliefs that may affect your care.
- To give the hospital accurate information about your personal and health details including current treatment and medications including recreational drugs and natural remedies.
- To be well informed about your condition and proposed treatment, before giving consent to any procedure. Feel free to ask for more information.
- To keep to the agreed treatment plan and discuss any desired change.
- To consider the consequences of refusing to comply with instructions and recommendations.
- To inform staff if you are having any problems or reactions to the treatment or the medicines being taken.
- To inform staff if you have any concerns about your discharge from hospital and the instructions you need to follow at home.
- To inform staff if you have an Advance Health Directive/Enduring Power of Attorney which includes health care instructions before or at the time of the admission or when consenting to treatment which might be relevant to the directives.
- To understand that there may be a reason why a service is not available at a particular time.
- To tell staff if you change your contact details.
- To be on time for appointments and let staff know in advance if you want to cancel.
- To finalise any accounts relating to your hospitalisation.
- To be considerate and respectful of the confidentiality, privacy and wellbeing of others including staff, volunteers, patients and visitors and ask your visitors to be considerate.
- To show respect for hospital property as well as the property of other persons. To take responsibility for your personal belongings.

Providing Feedback or Making a Complaint

If you have any issues or problems that relate to your admission to hospital please let us know.

At the time of your discharge you may receive a patient feedback form or a phone call which we use to obtain information about our care and service delivery. We would appreciate your assistance with this survey.

The Mater Hospital has a formal compliments and complaints management process and we value feedback.

If you wish to provide us with additional feedback or make a complaint about any aspect of your hospital experience, you may either:

- Speak to the Nurse Manager of your ward. After hours, request to speak to the Hospital Co-Coordinator;
- Complete a Patient Feedback Form (located on each ward and at Patient Services on discharge);
- Write to the Chief Executive Officer or Executive Director of Nursing,
Mater Private Hospital Townsville, Locked Bag 1000, Aitkenvale BC, QLD, 4814;
- Send an email to info@matertsv.org.au.

Issues that are not resolved to your satisfaction can be taken to the Office of the Health Ombudsman:

Telephone: 133 OHO (133 646) Fax: (07) 3319 6350 Email: info@phio.gov.au Web Address: www.oho.qld.gov.au

Postal Address: PO Box 13281 George Street, Brisbane QLD 4003

Health Insurance Complaints may be directed to your health fund or to the Commonwealth Ombudsman:

Telephone: 1300 362 072 Fax: 02 6276 0123 Email: ombudsman@ombudsman.gov.au

Web Address: www.ombudsman.gov.au

HOSPITAL FEES AND CHARGES

Hospital charges can include accommodation, use of theatre, prostheses and essential pharmacy items for your care.

Charges can vary depending on treatment required, length of stay, prostheses (implants) provided, accommodation category and individual private health insurance contracts.

Hospital costs do not include non-hospital or medical provider costs, such as your doctor, anaesthetist, assisting doctor, pathology, x-ray or STD, ISD and mobile phone charges from your room. Additional charges may also include allied health providers, eg physiotherapy and the hire of physical aids.

Listed below are the different forms of cover patients may use when they are admitted to hospital.

(Please read the one applicable to you.)

If you have any questions about your hospital account prior to admission please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Pre-Admission Team. Payment methods available at the Mater are cash, Visa/Mastercard, cheque, EFTPOS or direct deposit (Amex and Diners facilities are unavailable).

All hospital estimates and out of pocket expenses are required to be paid prior to or on admission. Any additional costs that may arise during your hospital stay (eg. co-payments, pharmacy, phone call charges, visitors meals or unforeseen circumstances), are required to be paid on discharge.

After you have been discharged from the Mater, our Patient Accounts Team will finalise your hospital account. Please note that this process **may take up to three weeks**. Once complete you may receive an invoice if there are any outstanding charges. If you have any questions regarding your invoice please contact the Mater on 4727 4444 between 8am and 4pm weekdays (excluding Public Holidays) and ask for our Patient Accounts Team.

Private Health Insurance

If you have private health insurance please speak to your health fund prior to your admission into hospital, to ensure you understand your level of cover.

Important questions to ask your health fund are:

- Am I covered for the procedure at the Mater? (Do I have any exclusions or restrictions?)
- What level of cover do I have?
- Does my health fund cover all medication expenses?
- Do I have to contribute to the hospital costs? (Do I have an excess or co-payments?)
- Have I served all waiting periods? (Did I join less than 12 months ago or is this a pre-existing ailment?)

The Mater will require payment of any health insurance policy excess or co-payment prior to or on admission. If any additional costs arise because of your stay (eg. co-payments, pharmacy, phone call charges, visitors meals or unforeseen circumstances), you are required to pay these on discharge.

The Mater has agreements with most major health funds in Australia. Under those agreements, subject to your membership, your insurer will meet the costs of your hospital fees. An account for your hospital stay will be sent directly to your Private Health Insurer for assessment in accordance with our contract. If your hospital claim requires any further documentation prior to submission or assessment by your health insurer, we ask that you comply and return to us as soon as possible.

If you have any questions about your hospital fees and charges, including medication, please contact your health fund insurer directly to discuss any out of pocket expenses prior to your admission.

HOSPITAL FEES AND CHARGES

Cosmetic Surgery

Private Health Funds do not cover cosmetic surgery and the estimate of all costs related to cosmetic surgery needs to be paid prior to or on admission. For an estimate please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Pre-Admission Team.

Department of Veterans' Affairs (DVA)

If you have Department of Veterans' Affairs (DVA) cover

- Gold Card Holders – No approval necessary
- White Card Holders – You must provide your approval letter from DVA prior to admission

Overseas Travel Insurance

If you have travel insurance, the hospital requires you to pay for your hospital stay prior to admission unless approval has been given by a recognised insurer and proof of the approval and billing details are provided prior to admission.

For an estimate please contact the Mater on 4727 4444 between 8am and 5pm weekdays (excluding public holidays) and ask for our Pre-Admission Team.

Self Insured

If you are self insured (paying the hospital account yourself), you will need to contact the Mater to discuss hospital costs once you have discussed your hospital admission with your doctor. To assist in providing an accurate estimate you are required to provide as much information as possible about your stay. This would include the procedure item numbers for your proposed theatre procedure/s, prostheses (implants) items to be used (such as screws or mesh) and proposed length of stay.

You will be required to pay all estimated hospital costs prior to or on admission. Estimates provided are based on the information available at the time and are subject to change. If any aspect of your stay changes due to medical necessity, for example your doctor performs a different or modified procedure, the doctor uses additional or different prostheses or the length of stay changes, this will affect the cost. Any additional costs that arise during your hospital stay are required to be paid on discharge.

Workers Compensation and Third Party

If you have Workers Compensation Cover or Third Party Compensation we will require the approval letter from your employer or related Third Party Insurer provider prior to admission.

Defence Force

If you are covered under the Defence Force we will require your defence approval and EP identification number prior to admission.

Please Note

If your hospitalisation is not covered by private health insurance or if it is related to a Workcover or Third Party claim that has not been approved for payment, then you are fully responsible for the costs and an estimate of fees needs to be paid prior to or on admission, with any balance on discharge.

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**OFFICE USE ONLY**

Surname: _____

Given Names: _____

UR: _____

Ward: _____ Bed: _____

Please affix patient's identification label

OFFICE USE ONLY

Medical Consent	Date	Staff

ADMISSION DETAILS

Admission Date:	Time: _____ AM / PM	Admitting Hospital: <input type="checkbox"/> Pimlico <input type="checkbox"/> Hyde Park
Operation Date:	Admission Type: <input type="checkbox"/> Day <input type="checkbox"/> Overnight	MATERNITY Admission: Dr _____
Admitting Doctor: Dr _____	Expected Date of Delivery: _____	

PREVIOUS ADMISSION

Have you been a patient in the last 3 months? ☐ Yes ☐ No
IF YES, ONLY COMPLETE NAME, DOB, DETAILS THAT HAVE CHANGED & SIGN THE DECLARATION ON THE PATIENT REGISTRATION FORM (All remaining pages must be completed)
IF NO, PLEASE COMPLETE ALL SECTIONS

PATIENT DETAILS

Title:	Surname:	Previous Name (if applicable)		
First Name:	Middle name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	
Residential Address (Not Postal Address):				
Suburb:			State:	Postcode:
Home Phone:	Work Phone:	Mobile:		
Email:				
Marital Status:	<input type="checkbox"/> Married/Defacto <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Religion:	Country of Birth:	Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you of Aboriginal, Torres Strait or South Sea Islander Origin (QLD Health requirement)?				
Tick all that apply: <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, South Sea Islander				
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is your Preferred Language:			
Medicare Card No.:		Number beside Patient on Card:	Valid to:	
Occupation:				
DVA Number:	DVA Card Colour: <input type="checkbox"/> Gold <input type="checkbox"/> White			
Referring GP:	Practice:			
Usual/Local GP:	Practice:			

HOSPITAL ACCOUNT (Please select one of the Options Below)

<input type="checkbox"/> Private Health Fund	Fund Name:	Member No.:
Have you confirmed that you are covered for this procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you been with your health fund for 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Australian Defence Force	<input type="checkbox"/> Army <input type="checkbox"/> RAAF <input type="checkbox"/> Navy	Rank: _____ Unit: _____ EP ID: _____ Defence Approval no. _____
<input type="checkbox"/> Workcover / Third Party Liability	Have you lodged a claim yet? <input type="checkbox"/> Yes <input type="checkbox"/> No Claim no. _____	
Date of Accident:	Accident Location:	
<input type="checkbox"/> DVA (Department of Veteran's Affairs)		
<input type="checkbox"/> Self Insured / Overseas	Have you been given an estimate of hospital fees? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please contact the Mater on (4727 4444) for an estimate of hospital fees & charges</i>	
<input type="checkbox"/> Other		

CONCESSION CARDS

Without the provision of correct and complete details the patient is advised that they will be billed the full amount and must take responsibility for later claiming from Medicare and / or the appropriate provider.

Pension Card:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Valid to: ____/____/____
Health Care Card:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Valid to: ____/____/____
Commonwealth Seniors Health Card:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Valid to: ____/____/____
Pharmacy Safety Net:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Valid to: 31 / 12 / ____

POSTAL ADDRESS

Address:		
Suburb:	State:	Postcode:

NEXT OF KIN

Title:	Surname:	Given Name:
Address:		
Suburb:	State:	Postcode:
Relationship to Patient:		
Home Phone:	Work Phone:	Mobile:
Email:		

EMERGENCY CONTACT (Other than Next of Kin)

Title:	Surname:	Given Name:
Address:		
Suburb:	State:	Postcode:
Relationship to Patient		
Home Phone:	Work Phone:	Mobile:
Email:		

PAST HOSPITAL DETAILS

Have you been in hospital in the last 28 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been in hospital in the last 7 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please name the hospital/s:	
Dates of hospitalisation: _____ to _____	Public or Private patient: <input type="checkbox"/> Public <input type="checkbox"/> Private
Reason for hospitalisation:	

DECLARATION

I certify that the above information is true to the best of my knowledge and agree to its release in support of my insurance claim.

Signature: _____ Date: _____

NURSING STAFF USE ONLY

Ward:	Bed:	Admission Time:
Admitting Diagnosis:		
Has patient presented at another hospital in the last 7 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, name of Hospital:	Date of Admission from: ____ / ____ / ____ to ____ / ____ / ____	
Was the patient transferred in? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> A&E <input type="checkbox"/> Admitted		

ADMINISTRATIVE STAFF USE ONLY

Visit no:	Pre-admission clerk:	Date: ____ / ____ / ____
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Consent to Use and Disclose Information

OFFICE USE ONLY

Surname: _____

Given Names: _____

UR: _____

Ward: _____ Bed: _____

Please affix patient's identification label

Mater Private Hospital Townsville (MPHT) acknowledges its privacy obligations to patients under the Privacy Act 1988 (Clth) and handles the personal information, including health information, that we collect in accordance with the Australian Privacy Principles.

We collect information about your health condition and other personal information (eg. Name, date of birth, address, billing information etc.) to provide health services to you.

To understand our privacy principles in more detail and your rights concerning accessing and correcting your personal information please refer to the Privacy Policy on our website or contact the Privacy Manager on 07 4727 4337.

Please indicate if you consent to the use of your personal information for the purposes described below, by ticking the relevant boxes.

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I consent to a visit from a hospital-accredited representative of my religion while I am a patient in this hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | I consent to a visit from a member of the Returned Services Organisation while I am a patient in this hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | I consent for my health information to be provided to other hospitals, doctors or health institutions who may treat me in the future and who may request my information for continuum of care |
| <input type="checkbox"/> | <input type="checkbox"/> | I consent to allowing a student with supervision, (this may include medical, nursing, midwifery, allied health) to be part of my care while I am a patient in this hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | I consent to being contacted by MPHT for marketing or quality activities and planning activities to improve patient care (such as Patient Focus Groups, Surveys etc) |
| <input type="checkbox"/> | <input type="checkbox"/> | I consent for MPHT to access My Health Record for clinical care |

- To the best of my knowledge, the answers I have provided on the admission forms are true and correct.
- I hereby acknowledge that I have read, understood and agree with the way my personal information will be used while I am a patient of this hospital.
- I hereby acknowledge that I have read and understood all the admission information provided by MPHT.

Patient Name: _____

Signature: _____ Date: _____

CONSENT TO USE AND DISCLOSE INFORMATION

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY



Medication Summary Form

OFFICE USE ONLY

Surname: _____

Given Names: _____

UR: _____

Ward: _____ Bed: _____

Please affix patient's identification label

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS AND RETURN WITH YOUR ADMISSION PAPERWORK TO THE HOSPITAL WHERE YOU WILL BE ADMITTED AT LEAST 7 DAYS BEFORE ADMISSION OR AS SOON AS POSSIBLE.

Whilst you are a patient at the Mater Hospital we will endeavour to ensure all medicines prescribed for you are safe and appropriate. An important part of this process is to have an accurate record of all medicines you are already taking. Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products. If you have any problems completing the list please contact your GP or Community Pharmacy for assistance. If you have a printed medicine list (from a pharmacy) that is up to date, complete and accurate a copy can be attached to this form.

Medication	Strength	Number to Take & Time of Administration				Reason for Taking	Taking for how long
		Morning	Midday	Evening	Bedtime		
<i>For Example - metoprolol</i>	<i>50mg</i>	<i>Half</i>			<i>Half</i>	<i>Blood Pressure</i>	<i>2 Years</i>
<i>For Example - Aspirin</i>	<i>100mg</i>	<i>1</i>				<i>Thin Blood</i>	<i>2 Years</i>

Medications STOPPED in the last 2 weeks

Medication	Strength	Dose	Reason for Taking	Date Stopped & Reason
<i>For Example - Warfarin</i>	<i>5mg</i>	<i>1 daily</i>	<i>Heart Valve</i>	<i>1 Dec - Dr told me to stop</i>

Staff of the Mater Hospital may need to contact your local health care providers to obtain or provide information (eg Safety Net number or values, pre-admission medicines, discharge medicine summary). Please provide contact details for the following healthcare providers.

Retail/Community Pharmacy: _____

Respite or home nursing service: _____

In order to ensure an uninterrupted supply of your regular medicines during your stay in hospital, please remember to bring in ALL your medicines in their original labelled containers and/or repeat prescriptions with you upon admission. Please include all eye drops, patches, puffers, natural/complementary medicines and cream or ointment products.

Charges for medicines provided during your stay in hospital may be billed to you depending on the agreement between your Private Health Fund and the Mater Hospital. Not all pharmacy items may be covered by your health fund. In this case payment is to be made to the pharmacy prior to discharge.

The information I have provided here is accurate and complete to the best of my knowledge.

Patient/Carer Signature: _____ Date: _____

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY



Patient History & Nursing Assessment

OFFICE USE ONLY

Surname: _____

Given Names: _____

UR: _____

Ward: _____ Bed: _____

Please affix patient's identification label

PLEASE READ QUESTIONS CAREFULLY & PLACE TICK IN THE APPROPRIATE BOX.
USE SPACE PROVIDED FOR ANY FURTHER INFORMATION.

NB SHADED AREAS FOR STAFF ONLY
If yes response, follow prompts

PATIENTS TO COMPLETE THE WHITE AREA ONLY

Reason for admission: _____

Next of Kin contact no: _____

Has information been provided to patient on (refer to Patient Information folder located in patient room):

- Rights and Responsibilities ☐ initial: _____
- Compliment/Complaint process ☐ initial: _____

ENDURING POWER OF ATTORNEY / ADVANCED HEALTH DIRECTIVE

Do you have an Advanced Health Directive? ☐ N ☐ Y Please provide copy

Do you have Enduring Power of Attorney? ☐ N ☐ Y Please provide copy

Name of Attorney: _____ Phone No: _____

Do you have a Guardian? ☐ N ☐ Y
If yes, Guardian must be present during pre-procedure checks.

File copy in medical record

ALLERGIES & REACTIONS

☐ N ☐ Y

Please document any known allergies or reactions eg. medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit.

Have you ever been allergic to latex? ☐ N ☐ Y

Reaction: _____

Food Allergy ☐ N ☐ Y

Reaction: _____

Allergy / Sensitivity

Reaction

Refer to MHSNQ Latex Policy 227

Apply ALLERGY ID band

PAST SURGICAL / MEDICAL HISTORY

Surgery & medical conditions to be listed below

Year	Surgery / Medical Condition	Year	Surgery / Medical Condition	Year	Surgery / Medical Condition

Previous anaesthetic problem (self/family) ☐ N ☐ Y if Yes, specify: _____

Advise Anaesthetist

GENERAL HEALTH & WELLBEING

What is your height? _____ cm

How much do you weigh? _____ kg

If >120kg refer to Bariatric Management Plan

Do you smoke? ☐ N ☐ Y _____ per day

If no, have you smoked in the past? ☐ N ☐ Y Date ceased: ____ / ____ / ____

Do you drink alcohol? ☐ N ☐ Y _____ standard drinks/day

Do you have pain? ☐ N ☐ Y Where: _____

Disturbed sleep patterns / sleep apnoea? ☐ N ☐ Y ☐ Sedation ☐ CPAP

Immunisations? ☐ N ☐ Y

Patient Advised to update ☐ N ☐ Y

Female patients: Are you pregnant? ☐ N ☐ Y _____ weeks

Consider Obstetric review

Do you have, or have you in the past, had a problem with?

CANCER

Name of Specialist/s _____

Do you have or have you had cancer? ☐ N ☐ Y Site: _____

If yes, Year diagnosed? _____ Treatment: ☐ Surgery ☐ Last Chemo ____ / ____ / ____ ☐ Radium

Do you have a family history of cancer? ☐ N ☐ Y Explain: _____

DERMATOLOGY

Name of Specialist/s _____

Skin Condition? ☐ N ☐ Y Specify: _____

Pressure Ulcer? ☐ N ☐ Y Where: _____ When: _____

RESPIRATORY	Name of Specialist/s	
Bronchitis/Asthma/Emphysema/COPD/Shortness of breath/bronchiectasis/asbestosis	<input type="checkbox"/> N <input type="checkbox"/> Y Do you use: <input type="checkbox"/> Nebulisers <input type="checkbox"/> Home oxygen <input type="checkbox"/> Puffers	Document on Medication Chart 21H
Breathing Problems	<input type="checkbox"/> N <input type="checkbox"/> Y	
Other Chest Problems	<input type="checkbox"/> N <input type="checkbox"/> Y Explain:	
CARDIOVASCULAR	Name of Specialist/s	
High Blood Pressure	<input type="checkbox"/> N <input type="checkbox"/> Y	
Chest Pain, angina	<input type="checkbox"/> N <input type="checkbox"/> Y Year/s:	
Heart attack/s	<input type="checkbox"/> N <input type="checkbox"/> Y	
Heart failure/congestive heart failure	<input type="checkbox"/> N <input type="checkbox"/> Y	
Rheumatic fever/valve disease	<input type="checkbox"/> N <input type="checkbox"/> Y	
Palpitations/heart murmur/irregular heart beat	<input type="checkbox"/> N <input type="checkbox"/> Y	
Previous blood clots	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:	
Family history of cardiac disease	<input type="checkbox"/> N <input type="checkbox"/> Y	
Other related problems: eg arterial/venous ulcers	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:	
NEUROLOGY	Name of Specialist/s	
Stroke/TIA (Transient Ischaemic Attack) Any residual weakness?	<input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y Where:	Initiate Discharge Planning
Fits/faints/"funny turns"	<input type="checkbox"/> N <input type="checkbox"/> Y When:	
Limb paralysis/weakness	<input type="checkbox"/> N <input type="checkbox"/> Y Where:	
Speech problems	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:	
Epilepsy	<input type="checkbox"/> N <input type="checkbox"/> Y Last seizure:	
Parkinson's Disease	<input type="checkbox"/> N <input type="checkbox"/> Y Diagnosed:	
Polio/meningitis	<input type="checkbox"/> N <input type="checkbox"/> Y When:	If yes, high falls risk - implement fall prevention strategies. Initiate Discharge Planning
A fall or falls within the last 6 months	<input type="checkbox"/> N <input type="checkbox"/> Y How often:	
Difficulty walking/unsteady on feet	<input type="checkbox"/> N <input type="checkbox"/> Y	
Short term memory loss/dementia	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:	
Migraines/headaches	<input type="checkbox"/> N <input type="checkbox"/> Y	
GASTROINTESTINAL	Name of Specialist/s	
Gastric ulcer/reflux/hiatus hernia	<input type="checkbox"/> N <input type="checkbox"/> Y	
Hepatitis/Liver Disease	<input type="checkbox"/> N <input type="checkbox"/> Y Type: Jaundice <input type="checkbox"/> N <input type="checkbox"/> Y	
Diarrhoea	<input type="checkbox"/> N <input type="checkbox"/> Y	
Constipation	<input type="checkbox"/> N <input type="checkbox"/> Y	
Stoma	<input type="checkbox"/> N <input type="checkbox"/> Y	
Nausea/Vomiting	<input type="checkbox"/> N <input type="checkbox"/> Y	
GENITOURINARY	Name of Specialist/s	
Dialysis	<input type="checkbox"/> N <input type="checkbox"/> Y	
Renal impairment/'kidney trouble'	<input type="checkbox"/> N <input type="checkbox"/> Y	
Bladder problems	<input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Pain	
Stoma	<input type="checkbox"/> N <input type="checkbox"/> Y	
MUSCULOSKETAL SYSTEM	Name of Specialist/s	
Arthritis	<input type="checkbox"/> N <input type="checkbox"/> Y	Note: Cytotoxic precautions may need to be implemented depending on type of medication eg methotrexate
Back or neck injury or problems	<input type="checkbox"/> N <input type="checkbox"/> Y	
Pins, plates, implants or devices	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:	



Patient History & Nursing Assessment

OFFICE USE ONLY

Surname: _____

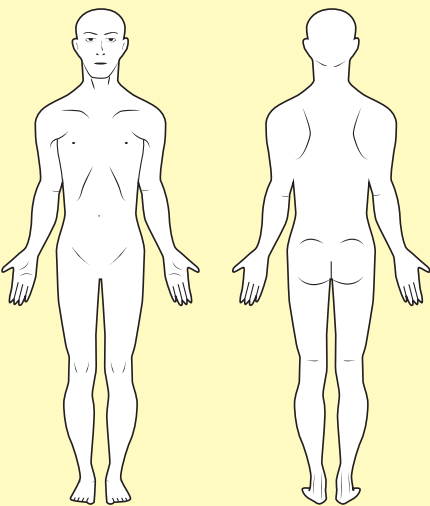
Given Names: _____

UR: _____

Ward: _____ Bed: _____

Please affix patient's identification label

ENDOCRINE		Name of Specialist/s		
Do you have diabetes?	<input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet	Educator to see is answer is >8 Educator to see is answer is >8 Educator to see is answer is yes		
If yes, what is your usual blood glucose in the morning?				
If yes, what was your last HbA1c?	Date: <input type="checkbox"/> Unknown			
Have you had a HYPO (very low blood sugar) in the last 3 months?	<input type="checkbox"/> N <input type="checkbox"/> Y			
Thyroid problems	<input type="checkbox"/> N <input type="checkbox"/> Y			
NUTRITION		SCORE	If score is >1 refer to MUS tool	
Have you lost any weight recently without trying?	<input type="checkbox"/> No <input type="checkbox"/> Unsure	0 2		
If yes, how much weight have you lost?	<input type="checkbox"/> 0.5 - 5 kg <input type="checkbox"/> 5.1 - 10 kg <input type="checkbox"/> 10.1 - 15 kg <input type="checkbox"/> Over 15 kg <input type="checkbox"/> Unsure	1 2 3 4 2		
Has your appetite decreased recently?	<input type="checkbox"/> N <input type="checkbox"/> Y	0 1		Total Score
Do you need a special or modified diet?	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:			
				If yes notify Food Services.
HAEMATOLOGY		Name of Specialist/s		
Blood disorders/bleeding problems/clotting disorders	<input type="checkbox"/> N <input type="checkbox"/> Y			
Anemia	<input type="checkbox"/> N <input type="checkbox"/> Y			
Previous blood transfusions	<input type="checkbox"/> N <input type="checkbox"/> Y When:	Adverse reaction: <input type="checkbox"/> N <input type="checkbox"/> Y Document on Progress Notes		
Do you take blood thinning/arthritis or aspirin based medication?	<input type="checkbox"/> N <input type="checkbox"/> Y Specify:			
If yes, have you ceased this medicine?	<input type="checkbox"/> N <input type="checkbox"/> Y Date last taken: / /	Consider notifying medical officer		
INFECTION CONTROL				
Have you been a patient, in another hospital/nursing home in the past 24 hours?	<input type="checkbox"/> N <input type="checkbox"/> Y	If yes, obtain swabs from: <input type="checkbox"/> Nose <input type="checkbox"/> Groin <input type="checkbox"/> Axilla <input type="checkbox"/> Wound		
Do you have a wound/infection?	<input type="checkbox"/> N <input type="checkbox"/> Y	Commence Wound Assessment Chart 15V		
Have you ever had an infection with any multi resistant bacteria eg. "golden staph"?	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> MRSA <input type="checkbox"/> Nose & Groin <input type="checkbox"/> ESBL/VRE <input type="checkbox"/> Rectal Swab/Faecal Spec		
Have you had neurosurgery prior to 1990?	<input type="checkbox"/> N <input type="checkbox"/> Y			
Have you travelled overseas in the past fourteen days?	<input type="checkbox"/> N <input type="checkbox"/> Y If yes where:			
Have you taken human pituitary hormone (growth hormone, gonadotrophin) prior to 1986?	<input type="checkbox"/> N <input type="checkbox"/> Y	If yes notify Infection Control Officer or Hospital Coordinator if required		
Does anyone in your family have CJD (Creutzfeldt-Jacob Disease)?	<input type="checkbox"/> N <input type="checkbox"/> Y			
Has the patient been identified as potentially CJD after a surgical procedure or shown you a medical letter regarding their risk for CJD?	<input type="checkbox"/> N <input type="checkbox"/> Y			
PSYCHOSOCIAL				
Depression/Anxiety	<input type="checkbox"/> N <input type="checkbox"/> Y	Details		
Diagnosed Mental Illness	<input type="checkbox"/> N <input type="checkbox"/> Y			
PTSD	<input type="checkbox"/> N <input type="checkbox"/> Y			

SPECIAL NEEDS			
Primary Language: _____ Cultural considerations: _____			
Interpreter Required: <input type="checkbox"/> N <input type="checkbox"/> Y Specify: _____			
<p align="center">We encourage you to leave valuables at home.</p> <p align="center">The hospital will take no responsibility for valuables kept with patients.</p>		<input type="checkbox"/> Kept at own risk <input type="checkbox"/> Taken home by _____ <input type="checkbox"/> Placed in safe Receipt No.: _____	
Visual Aids	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Eye Prosthesis	
Walking Aids	<input type="checkbox"/> N <input type="checkbox"/> Y	Specify: _____	
Hearing Aids	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Dentures	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Upper: <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/> Lower: <input type="checkbox"/> Partial <input type="checkbox"/> Full	
Valuables	<input type="checkbox"/> N <input type="checkbox"/> Y	If yes, document in Progress Notes.	
Patient History Form reviewed/completed by: <input type="checkbox"/> (Pre-Admission Clinic Staff) <input type="checkbox"/> Unit Staff <input type="checkbox"/> SAU Signature: _____ Name (Print) _____ Designation _____ Date: ____/____/____			
DISCHARGE PLANNING		Discuss possible post discharge needs with patient/carer. Refer to Discharge Planning Guidelines. Discuss Discharge Time of 10am with Patient/Carer. Transport required - documented in notes.	
Do you live alone? <input type="checkbox"/> N <input type="checkbox"/> Y			
Do you live in a: <input type="checkbox"/> House <input type="checkbox"/> Unit/flat <input type="checkbox"/> Retirement Village <input type="checkbox"/> Hostel <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other _____ Do you have stairs? <input type="checkbox"/> N <input type="checkbox"/> Y			
Do you have problems caring for yourself at home? If yes, who will care for you on discharge?			
<input type="checkbox"/> N <input type="checkbox"/> Y Name: _____			
Is this person in good health and able to assist? <input type="checkbox"/> N <input type="checkbox"/> Y			
Are you the carer for someone else? <input type="checkbox"/> N <input type="checkbox"/> Y			
Do you currently use any community services? If yes, which service?			
Proposed length of stay? _____ days			
Discharge time is 10am for inpatients. Can someone collect you by this time? If not, how do you plan to get home?			
<input type="checkbox"/> N <input type="checkbox"/> Y Name: _____ Phone: _____ <input type="checkbox"/> N <input type="checkbox"/> Y Explain: _____			
Post procedure patients only			
Who will care for / collect you on discharge?		Name: _____ Phone: _____ Relationship: _____	
Transport arrangements?		<input type="checkbox"/> N <input type="checkbox"/> Y Explain: _____	
Patient or Carer Signature		I have read the above and certify that the information given is correct to the best of my knowledge. Name: (Print) _____ Signature: _____ Relationship to Patient: _____ Date: ____/____/____ <i>If not completed by Patient</i>	
PRESENTATION ON ADMISSION: initiate appropriate nursing interventions/s; document issue action and outcome in notes			
Physical Appearance: Assessment Attended: <input type="checkbox"/> Yes			
 <p align="center"><i>Identify Observations with the use of Symbols on the above illustrations eg. P (for pain)</i></p>		Symbol	Observation
		P	Pain <input type="checkbox"/> N <input type="checkbox"/> Y
		#	Fracture
		PA	Pressure Area
		U	Ulcer
		ST	Skin Tears
		W	Wound
		S	Swelling / oedema
		R	Rash
		B	Bruise
		D	Drains
		IV	Intravascular device including IVT, port-a-cath, CVC etc.
		SC	Subcutaneous line
		IDC	Indwelling catheter: Type: _____ Date last changed: _____
		E	Enteral feeding eg. N/G/peg feeds
		O	Ostomy - Type: _____
LA	Limb amputation - Prosthesis <input type="checkbox"/> N <input type="checkbox"/> Y		
Oth	Other: _____		
Mental Status: <input type="checkbox"/> Orientated <input type="checkbox"/> Vague <input type="checkbox"/> Confused <input type="checkbox"/> Other Emotional Status: <input type="checkbox"/> Calm <input type="checkbox"/> Anxious <input type="checkbox"/> Distressed <input type="checkbox"/> Other Medications: <input type="checkbox"/> N/A <input type="checkbox"/> Yes - Documented on 21H Medication Chart (Refer to Medication Management Policy 539 V1)			