NSW GOVERNMENT Health
South Eastern Sydney Local Health District
Illawarra Shoalhaven Local Health District
Sydney Children's Network

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

Facility:

D.O.B. ____/____/____ | M.O.

ADDRESS

RECOMMENDATION FOR PAEDIATRIC ADMISSION for patients less than 16 years

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SE1030005

Pages 1 & 2 to be completed by referring doctor, pages 3, 4 & 5 to be completed by patient

Street Address (not PO Box) _____

Suburb | Postcode | State | Country

Mailing Address (if different from street address) _____

Suburb | Postcode | State | Country

Phone _____

(Please indicate hospital)
☐ Sydney Children's
☐ Shoalhaven
☐ St George
☐ Sutherland
☐ Wollongong

Other staff to be advised of admission
Clinician name _____
Clinician phone _____ Fax _____

Does the patient have unrestricted medicare?
☐ Yes ☐ No

PROCEDURE DETAILS

Planned admission date	Planned procedure date	Admitting Medical Officer	Referring Doctor

Admitting diagnosis	Investigations required on or prior to admission

Planned procedure	All CMBS codes IPC	Approx. time in theatre hrs mins

Significant medical history / Co morbidities (if prem baby provide gestational age)
Special instructions / requirements:

Potential "risk of cross infection" to other patients or staff?
If **yes**, please specify: Airborne _____ Other _____

ADMISSION DETAILS

Interpreter required ☐ No ☐ Yes Preferred language _____

◆ **DAY ONLY** ☐ Medical ☐ Surgical

OR

◆ **OVERNIGHT** ☐ DAY OF SURGERY ☐ FULL ADMISSION ☐ 23 HOUR

Estimated length of stay _____ (day/s)
Estimated length of stay _____ (day/s)

Preferred ward _____

◆ **OTHER SPECIAL BED REQUIREMENTS** ☐ HDU ☐ ICU ☐ ISOLATION

ANTICIPATED ELECTION STATUS / INSURANCE COVERAGE

Does the patient have health insurance or will they be self insured?
☐ Yes, health insurance ☐ Yes, self-insured ☐ No

SOURCE OF BOOKING

☐ OPD (3) ☐ SES/ISLHN Hospital (4) ☐ Other Hospital (5) Specify _____
☐ Medical Practitioner rooms (7) ☐ Other Agency (8)

CLINICAL PRIORITY

☐ Ready for admission within ☐ Category 1 ☐ Category 2 ☐ Category 3
OR ☐ Staged procedure
Admission recommended in _____ months or on approx. date ____/____/____ Clinical review date____/____/____
Can attend at short notice ☐ No ☐ Yes

Admitting AMO _____ **Signature** _____

Name (if not admitting AMO) _____ **Date** ____/____/20____

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BINDING MARGIN - NO WRITING

NO WRITING

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

REQUEST / CONSENT FOR MEDICAL PROCEDURE TREATMENT

(For parents/guardians of patients less than 16 years of age)

SMR020003

Provision of information to patient

To be completed by Medical Practitioner

I, Dr ..... have discussed with this patient's parent/guardian the
INSERT NAME OF MEDICAL PRACTITIONER

various ways of treating the patient's present condition including the following proposed procedure/treatment:

.....
INSERT SITE AND NAME AND REASONS FOR PROCEDURE OR TREATMENT

.....
DO NOT USE ABBREVIATIONS

.....

I have informed this **parent/guardian*** of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

..../...../20..... .....
SIGNATURE OF PERSON RESPONSIBLE DATE TIME

Interpreter present * ..../...../20..... .....
SIGNATURE OF INTERPRETER DATE TIME

Patient consent

To be completed by Parent/Guardian

Dr ..... and I have discussed the present condition of .....
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF MINOR

and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
**I have been told that another doctor may perform the procedure/treatment.*
I **request and consent** to the procedure/treatment described above for .....
INSERT NAME OF MINOR

DELETE IF NOT REQUIRED **This part must be countersigned by your doctor if retained**

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent for my child to have the following aspects of the recommended procedure or treatment.

.....
INSERT OBJECTION

....
PRACTITIONER'S ACKNOWLEDGEMENT

I note that the Children and Young Person's (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.
I **consent/do not consent*** to a blood transfusion if needed.

..../...../20..... .....
SIGNATURE OF PARENT/GUARDIAN DATE PRINT NAME OF PARENT/GUARDIAN

.....
ADDRESS

.....

Use of removed tissue – (See Section 33 of Circular)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of .....'s condition.
INSERT NAME OF MINOR

I **consent/do not consent*** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of .....'s condition.
INSERT NAME OF MINOR

My consent is conditional on the following terms:

.....
(INSERT TERMS, IF ANY)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

..../...../20.....
SIGNATURE OF PARENT/GUARDIAN DATE

*Delete where not applicable

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SMR020.003

NO WRITING

NSW GOVERNMENT Health

Facility:

CLIENT REGISTRATION FORM

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR005001

CLIENT DETAILS

Have you ever been admitted or attended an outpatient service at a Hospital, Emergency Department or Community Health in this Area Health Service? ☐ Yes ☐ No

Title	Surname	Given Names (in full)

Have you ever been known by another name? ☐ No ☐ Yes (list please)	Mother's maiden name	Father's surname

Sex ☐ Male ☐ Female	Your Date of Birth / /	What country were you born in?	What hospital were you born in?

Marital Status: ☐ Married/de facto ☐ Never Married ☐ Widowed ☐ Separated ☐ Divorced

Your Home Address Property Name/House No. Street Name

Suburb, Town or Locality	Postcode	State/Country (if not Australia)

Home Phone No.	Work Phone No.	Mobile Phone No.

Your Postal Address if different to home address: ***(Home address MUST also be filled in please)***

What language do you speak at home?	Do you need an interpreter? ☐Yes ☐No

Are you of Aboriginal or Torres Strait Islander Descent? ☐No ☐Yes *if yes→* ☐Aboriginal ☐Torres Strait Islander ☐Both

What is your Religion? Withhold religion information from Chaplain Services? ☐ YES	What is your occupation?

PERSON FOR NOTIFICATION DETAILS

Who is your contact person	Relationship to patient

Address of contact person: ☐ same as client	Contact Phone Numbers

FINANCIAL DETAILS

Do you have Private Health Insurance? ☐ **No** ☐ **Yes** (please complete following details) Type of Cover: ☐ Single Room

Fund Name Fund Number ☐ Shared Room ☐ Basic ☐ Extras

If you are not in a Private Health Fund, do you choose to be a self-funded Private patient? ☐ **Yes** ☐ **No**

Is your health care covered by Veteran's Affairs? ☐ No ☐ Yes If YES, please complete details

Card Colour: ☐ Gold ☐ Orange ☐ White DVA Card No.: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Single Digit next to patients name ☐ **Exp Date:**_____

Are you covered by Workers Compensation: ☐ No ☐ Yes	Solicitor/Employer's Name:
Are you covered by Third Party: ☐ No ☐ Yes	Solicitor/Employer's Address:
Are you an overseas Visitor? ☐ No ☐ Yes	Solicitor/Employer's Phone Number:

Who is your local GP?	Address of GP	Phone No

Who is your referring Doctor?	Address of Referring Doctor	Phone No

The facility you are attending may have an active programme which gives patients and other interested persons an opportunity to be kept informed about its new developments, learn of progress in clinical areas and to receive information of fundraising activities.

☐ **Please tick this box if you wish to receive this information.**

Clerical Staff Name: | Date:___/___/____ Arrival Time:_____

NH606529

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NSW GOVERNMENT **Health**
South Eastern Sydney Local Health District
Illawarra Shoalhaven Local Health District
Sydney Children's Network

Facility:

ANAESTHETIC QUESTIONNAIRE

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

The following questions will be reviewed by an Anaesthetist prior to your child's admission.
For assistance completing this form see your family doctor.

Tick the appropriate box, add details in the space provided. Use extra paper if required.
Does your child have at present, or has ever had in the past, any of the following

	NO	YES	
Born prematurely	☐	☐	If yes, how many weeks early? _____
Does you child have any health problems other than the planned procedure / surgery?	☐	☐	If yes, what are they? _____
Does you child have any condition that may increase the risk of anaesthetic?	☐	☐	If yes, please specify? _____
Has your child been in hospital for any health problems including pervious surgery?	☐	☐	If yes, what were they? When were they? *Use extra paper if required* _____
Has any family member had a problem with an anaesthetic (eg. bad reaction)?	☐	☐	If yes, what happened? _____
Has your child had an anaesthetic at any time?	☐	☐	If yes, where there any problems? _____
Asthma	☐	☐	If yes, how often? _____
Chest trouble, lung disease or breathing problems	☐	☐	If yes, please give details? _____
Snoring, breathing difficulties or stops breathing during sleep?	☐	☐	If yes, please explain? _____
Has you child had a sleep study?	☐	☐	If yes, where? _____
Any heart condition	☐	☐	If yes, please specify? _____
Is child overweight?	☐	☐	Specify weight and height? _____
Diabetes	☐	☐	If yes, specify? _____
Previous exposure to or treatment with cortisone or other similar steroids	☐	☐	If yes, when and what type? _____
Fits / Epilepsy / Severe development delay	☐	☐	If yes, how often? _____
Kidney condition	☐	☐	If yes, what type? _____
Has you child had exposure to measles, chicken pox or any other **infectious disease** in the last 3 weeks?	☐	☐	If yes, when and what disease? _____
Bleeding / bruising problems	☐	☐	If yes, please specify? _____

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Facility:

D.O.B. _____/_____/_____ | M.O.

ADDRESS

ANAESTHETIC QUESTIONNAIRE

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR005001

Family history of bleeding disorders ☐ ☐ If yes, please specify? _____

Any health problems which run in the family? ☐ ☐ If yes, please specify? _____

Are any other specialists involved in the care of your child **YES** ☐ **NO** ☐

Name _____ Telephone _____

Does your child use regular medication (eg. tablets, syrups, injections, puffers)? **YES** ☐ **NO** ☐

If yes, please list them below. *Use extra paper if required.*

Name of medicine: _____ Name of medicine: _____

How much (dose)? _____ How much (dose)? _____

How often? _____ How often? _____

Does your child have any allergies? (especially to medicines or sticking plaster) ☐ ☐

If yes – what are they? _____

– what reaction did your child have? _____

Are you able to bring your child in for surgery at short notice (ie. 48 hours)? ☐ ☐

Form completed by _____ Date _____

(full name)

The Hospital has an active programme which gives patients and other interested persons an opportunity to be kept informed about its new developments, learn of progress in clinical areas and to receive information of fundraising activities.

If you DO NOT wish to receive this information, please tick box ☐

Please select the hospital your doctor has chosen for admission and return the form as follows:

Sydney Children's Hospital, Randwick

Personal delivery
Admissions Office Level 0 North
(High Street Entrance)
Fax 9382 1451

▶ *or post form to*
Admissions Office
Sydney Children's Hospital
High Street Randwick NSW 2031

St George Hospital

Personal delivery
The Admisssions Office
St George Hospital (Public)
Kogarah

▶ *or post form to*
St George Hospital
Admissions Office
Gray Street
Kogarah NSW 2217

Sutherland Hospital

Personal delivery
Admissions Office
Caringbah

▶ *or post form to*
Admissions Office,
Sutherland Hospital
Locked Bag 21
Taren Point NSW 2229

Shoalhaven Hospital

Personal delivery
Admissions Office

▶ *or post form to*
Admissions Office,
Shoalhaven Hospital
PO Box 246
Nowra NSW 2541

Wollongong Hospital

Personal delivery
Admissions Office
Level 1

▶ *or post form to*
Wollongong Hospital
Admissions Office,
Locked Bag 8808
South Coast Mail
Wollongong NSW 2521

OFFICE USE ONLY

☐ Clerk – received by _____ Date _____

☐ Booked by _____ Date _____

☐ Approved by Anaesthetic Service ☐ Entered into IPM ☐ Entered into ORMIS

Patient for:

Day Only	Day of Surgery	Pre Admission Clinic	Full Admission

Comments _____

Anaesthetic Evaluator _____ Date _____

NAME

SIGNATURE

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NH606529

St George Public Hospital MRI Request

Radiology Department
St George Hospital
Gray St Kogarah 2217
Telephone: 9113-3500
Fax: 9113-3980
Results: 9113-3927
Appointments: 9113-3570

Appointment Details

Appointment Date:

Appointment Time:

Patient Details

Name: MRN: Date of Birth:

Address: Telephone (H):

Telephone (B):

Medicare No.: ☐☐☐☐☐☐☐☐☐☐☐

Examination Required :

Clinical History :

Referring Doctor Details :

Name:

Provider No:

Phone No:

Fax No:

Address:

Media Required :

☐ Compact Disc (CD)

☐ Faxed Report

☐ E-mail Report to: _____

Doctor Signature :

Date :

Patient Questionnaire :

	Yes	No
Have you had a previous MRI?	☐	☐
Are you pregnant?	☐	☐
Have you had previous surgery ? Please specify on back of form.	☐	☐
Do you have or have had -		
A cardiac pacemaker inserted?	☐	☐
Brain aneurysm clips	☐	☐
Implanted programmable mechanical/magnetic device	☐	☐
Body piercing	☐	☐
Neurostimulator wires	☐	☐
Vascular implants (Stents etc.)	☐	☐
Cochlear/stapedial implants/hearing aid	☐	☐
Artificial heart valves	☐	☐
Artificial joints or metallic orthopaedic hardware	☐	☐
A sharpnel injury	☐	☐
Metal in the eye or been employed as a metal worker	☐	☐
Do you have any allergies ? Please specify on back of form	☐	☐
Do you have any kidney disease ?	☐	☐

Is the patient covered by:

☐ Veteran Affairs (DVA)

☐ Workers Comp

☐ Third Party

☐ Clinical Trial / Research

☐ Outpatient Fee from $200
(Partial Medicare License covers some cancer staging and screening)

Radiologists

Dr. S Abeywickrema
Dr. C Chu
Dr. D Glenn
Dr. S Kariappa
Dr. J Lim
Dr. I Lovett
Dr. A Palmer
Dr. M Power
Dr. J Rouse
Dr. J Rusli
Dr. C Shearman
Dr. J Stevenson

PLEASE BRING WITH YOU
THIS REQUEST FORM, ALL PREVIOUS X-RAYS/REPORTS, YOUR MEDICARE CARD & LIST OF MEDICATIONS

"Your doctor has recommended that you use St George Hospital Medical Imaging. You may choose another provider but please discuss this first with your doctor first."