AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian Health System. These rights are essential to make sure that wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving health care rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system.

A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

	MY RIGHTS	WHAT THIS MEANS
ACCESS	I have the right to health care	I can access services to address my healthcare needs
SAFETY	I have a right to receive safe and high quality care	I receive safe and high quality health services, provided with professional care, skill and competence
RESPECT	I have a right to be shown respect, dignity and consideration	The care provided shows respect to me and my culture, beliefs, values and personal characteristics
COMMUNICATION	I have a right to be informed about services, treatment, options and costs in a clear and open way	I receive open, timely and appropriate communication about my health care in a way I can understand
PARTICIPATION	I have a right to be included in decisions and choices about my care	I may join in making decisions and choices about my care and about health service planning
PRIVACY	I have a right to privacy and confidentiality of my personal information	My personal privacy is maintained and proper handling of my personal health and other information is assured
COMMENT	I have a right to comment on my care and to have my concerns addressed	I can comment on or complain about my care and have my concerns dealt with properly and promptly

AESTHETIC DAY SURGERY

A.C.N. 147 561 975 A.B.N. 29 834 680 521

14 Kensington Street
KOGARAH 2217
TEL: 9553 9905 FAX: 9553 9924

Patient Label

To Be Completed In Full

Please complete using a Black Pen
If you make a mistake just draw a line through the error

Date of Admission: Admitting Doctor:

Has the patient been admitted to Aesthetic Day Surgery before? YES ❑ or NO ❑

PERSONAL DETAILS

SURNAME: TITLE:

GIVEN NAME(S): PREFERRED NAME:

D.O.B.: GENDER: Male ❑ or Female ❑

RESIDENTIAL ADDRESS:

SUBURB: POSTCODE:

HOME TELEPHONE: WORK TELEPHONE:

MOBILE TELEPHONE:

EMAIL ADDRESS:

DEMOGRAPHICS

COUNTRY OF BIRTH: LANGUAGE SPOKEN AT HOME:

RELIGION (or NIL): Aboriginal ❑ Torres Strait Islander ❑

MARITAL STATUS: Single ❑ Married ❑ De facto ❑ Separated ❑ Divorced ❑ Widowed ❑

MEDICARE NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Reference No: Expiry Date: /

LOCAL DOCTOR'S NAME (GP): TELEPHONE:

PERSON TO CONTACT (if we need to contact someone else about your admission)

SURNAME: FIRST NAME:

ADDRESS:

RELATIONSHIP TO PATIENT:

HOME TELEPHONE: MOBILE TELEPHONE:

PATIENT DETAILS FORM 001A

ENTITLEMENTS

DVA CARD NUMBER: Gold ❑ White ❑

PENSION CARD NUMBER:

PRIVATE HEALTH FUND DETAILS

Are you self-insured? ❑ (please tick if you are not in a Health Fund, and contact us for an estimate of fees)

NAME OF HEALTH FUND: LEVEL OF COVER:

MEMBERSHIP NUMBER: YEARS OF MEMBERSHIP:

CONTRIBUTOR'S NAME: CONTRIBUTOR'S DATE OF BIRTH:

DO YOU HAVE AN EXCESS? NO ❑ YES ❑ AMOUNT $

HAVE YOU PAID YOUR EXCESS THIS YEAR? NO ❑ YES ❑

HAVE YOU CHANGED YOUR LEVEL OF COVER IN THE LAST 12 MONTHS? NO ❑ YES ❑

WORKERS' COMPENSATION / THIRD PARTY CLAIMS / INSURANCE CLAIMS ONLY

NAME OF INSURANCE COMPANY:

ADDRESS:

TELEPHONE NUMBER: DATE OF ACCIDENT:

CLAIM NO: AUTHORISED BY:

Worker's Compensation only: EMPLOYER'S NAME:

EMPLOYER'S ADDRESS:

EMPLOYER'S TELEPHONE NUMBER:

PATIENT ACKNOWLEDGEMENT

We acknowledge our obligations to you under the Privacy Act 1988 (as amended). Personal information we collect will be used primarily to ensure that patients receive optimal care but may be used for a limited number of other purposes according to the Privacy Act (1988) and Aesthetic Day Surgery's Privacy Policy. Personal information is released under legislation to the State Health Authority, Health Funds, including DVA, and the Private Hospital Data Bureau.

❑ I hereby consent to the collection and use of my personal information to enable Aesthetic Day Surgery to provide appropriate treatment and care, fulfil legislative requirements and to enable payment of benefits for my hospitalisation

❑ I have read and understood the Australian Charter of Healthcare Rights – available on page 8 of this booklet, at the day surgery in multiple languages or on the Aesthetic Day Surgery website www.aestheticdaysurgery.com.au

.....
Name of Patient / Guardian / Person Responsible

.....
Signature of Patient / Guardian / Responsible Person

Date: .....

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14 Kensington Street
KOGARAH 2217

TEL: 9553 9905 FAX: 9553 9924

Patient Name: .....

Date of Birth: .....

Surgeon: .....

Admission Date: .....

Please answer all questions on both sides of the questionnaire (use a ✓ or X as appropriate)

Are you suffering from, or have you ever had:	N	Y	
Diabetes Type 1 ❑ Type 2 ❑			Managed by: Diet ❑ Tablets ❑ Insulin ❑
High blood pressure			
Stroke			Date:
Cardiac conditions			Heart Attack ❑ Chest Pain ❑ Angina ❑
Cardiac irregularities			Palpitations ❑ Irregular heart beat ❑ Murmur ❑
Cardiac surgery			Pacemaker/Defib ❑ Heart valve ❑ Stents ❑
Blood clots in your lung or leg, or bleeding disorder			
Neuromuscular disease (e.g. MS, Parkinson's disease)			
Arthritis			Osteoarthritis ❑ Rheumatoid ❑
Thyroid problems			
Liver disease or Hepatitis (A, B, C, D, E)			
Kidney / bladder problems / renal failure			
Hiatus hernia / gastrointestinal ulcers / bowel disorder / reflux			
Epilepsy / fits / seizures / blackouts			
Dementia / confusion or depression / anxiety / mental illness			
Migraines			
Respiratory problems			Asthma ❑ Other:
Sleep apnoea			Treatment:
Shortness of breath			Walking > 50 metres ❑ Stairs ❑ Lying flat ❑
Lymphoedema (excess fluid / swelling e.g. arm)			Side:
Have you ever had MRSA, VRE, HIV			
Do you or a member of your family have a history of cCJD			(Creutzfeldt-Jakob disease)
Do you have any breaks in your skin			
Back / hip / jaw problems			
Any other serious health problems not mentioned above			
Have you ever had a problem with a general anaesthetic			Details:
Have you ever had a problem with a local anaesthetic			Details:
Is there a family history of anaesthetic problems			Details:
Do you have dentures / caps / crowns / loose teeth			Details:

Please list previous operations (including date):

PATIENT HEALTH QUESTIONNAIRE

001F

PATIENT HEALTH QUESTIONNAIRE

ALLERGIES / ADVERSE DRUG REACTIONS	N	Y	
Do you have any allergies to food, sticking plaster, latex / rubber, chlorhexidine or other substances Have you had an adverse reaction to any medications			List (include details and reactions)

Medications	N	Y	
Do you take any anti-coagulant or blood thinning therapy (Aspirin, Astrix, Cardiprin, Cartia, Coumadin, Iscover, Pradaxa, Plavix, Warfarin)			Date last taken:
Do you take steroids (Prednisone, Cortisone)			Date last taken:
Do you take anti-inflammatory medications (Voltaren, Mobic, Nurofen)			Date last taken:
Do you take fish oil, krill oil or glucosamine			Date last taken:

Please list all medications you take (including herbal / over the counter remedies)		
MEDICATION	HOW MUCH (DOSE)?	HOW OFTEN?

YOUR HEIGHT:	YOUR WEIGHT:

Lifestyle	N	Y	
Could you be pregnant			Number of weeks:
Do you smoke			Daily amount:
Do you drink alcohol			Daily amount:
Take recreational drugs			Details:
Have you had a fall in the last 12 months			
Do you use a mobility aid			Walking stick ❑ Frame ❑ Wheelchair ❑
Have you experienced fainting or dizziness in the last 12 months			Details:
Do you have an enduring power of health attorney / guardian			Name:
Do you require any interpreter			Language:
For patients undergoing general or sedation anaesthesia: Have you arranged for someone to take you home			Name: Relationship: Contact Number:
For patients undergoing general or sedation anaesthesia: Have you arranged for someone to stay with you overnight			Name: Relationship: Contact Number:

Please return your completed forms as soon as possible to:
Aesthetic Day Surgery, 14 Kensington Street, Kogarah 2217

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