Calvary

North Adelaide Hospital

CALVARY NORTH ADELAIDE HOSPITAL

Day Patient Admission Package

89 Strangways Terrace
North Adelaide SA 5006
Ph: (08) 8239 9100

Admission Date:.....

Admission Time:.....

Fasting Time:.....

Attention Please

Completed "tear out" forms are to be returned to Calvary North Adelaide Hospital as soon as possible prior to admission.

Admission Information

Thank you for choosing Calvary North Adelaide Hospital (Calvary). It is important that you read this package as it contains:

- the forms you need to complete in order to provide us with the information we need to finalise your booking and let us know about any special care you may require
- information on how to prepare for your stay
- information about your hospital bill and how you can pay your account
- information on how we protect your privacy
- information on your rights and responsibilities whilst in hospital.

COMPLETING THE FORMS

Please complete the following three forms using black ball point pen.

1. Patient Registration Details
2. Day Patient Health Assessment
3. Privacy Consent / Rights and Responsibilities Acknowledgment.

Alternatively you can complete an online version of the forms via out e-admission portal. This is our preferred option.

Tear off the forms along the perforated lines and return them to the hospital at least seven (7) working days before your admission. Retain the rest of the package.

Forms can be delivered to the hospital in the following ways:

INTERNET

E-Admission
Log onto http://calvary.eadmissions.org.au

FAX

(08) 8239 9291

If the forms are faxed please remember to bring the originals with you on the day of your admission.

POST

(no postage stamp required)

Patient Services Department
Reply Paid 64513
Calvary North Adelaide Hospital
89 Strangways Terrace
North Adelaide SA 5006

Note: Postage can take up to 7 days for delivery.

HAND DELIVERED

Calvary North Adelaide Hospital
89 Strangways Terrace
North Adelaide

If for any reason you are not able to submit the forms to us within the required time please ring Patient Services Department as soon as possible on (08) 8239 9100.

MEDICINES

Before your admission to hospital please let your doctor know what medicines you are taking including prescription, non-prescription, and complementary medicines (including creams, eye drops, puffers, vitamins, herbal preparations, etc).

It is important that your Doctor and the hospital staff know exactly what medicines you are taking as medicines can adversely react with one another and your treatment. Your doctor can then tell you which medicines you need to stop before your surgery (if any) and when to stop taking them.

Please bring all your medicines in their original packaging into hospital with you (even if you use a Webster / Blister pack). This ensures the medicines you need are available when you need to take them.

ADMISSION DATE / TIME

Admission times at Calvary vary and are usually arranged by your doctor at the time of booking your hospital stay.

Please contact your doctor's rooms on the last working day before your scheduled procedure to confirm your admission and fasting times, and pre-procedure instructions.

Please advise your doctor and the hospital of any change in your condition, such as a cold or fever, between now and the day of admission.

FASTING INSTRUCTIONS

Please contact your Doctor/Anaesthetist for fasting instructions regarding food and drink.

WHAT TO BRING

On day of admission please bring:

- ☐ all forms, letters, and requests from your doctor
- ☐ all prescription, non-prescription and complementary medicines (in original packaging) you are currently taking unless advised otherwise by hospital staff
- ☐ printed list of current medicines from your GP or pharmacist
- ☐ X-rays and scans related to your admission and/or procedure (your procedure may be cancelled if x-rays or scans needed for your procedure are not available)
- ☐ Medicare card and health fund details
- ☐ Department of Veterans' Affairs (DVA) card, Department of Defence Service Provider advice slip, Pension/Health Care card, Pharmaceutical entitlements card, Ambulance card (if applicable)
- ☐ letter of approval for WorkCover, Third Party or Public Liability claims (if applicable)
- ☐ a copy of your advanced medical directive (if applicable)
- ☐ any other items eg. crutches/abdominal corsets as instructed by your Doctor
- ☐ reading material
- ☐ loose comfortable clothing.

DO NOT BRING

- ☐ valuables
- ☐ webster packages (all medication to be in the package supplied from the pharmacy)
- ☐ large amounts of cash.

MONEY/JEWELLERY/VALUABLES

We advise you to leave valuables such as jewellery, large amounts of cash (unless you are paying an excess or co-payment on admission) and electronic items at home as we cannot accept responsibility for them if they are lost or stolen.

YOUR ADMISSION

On arrival at the hospital please check in at the main reception.

DO NOT

- smoke for 24 hours before admission – please talk to your Doctor if you require nicotine replacement treatment during your stay in hospital (Calvary is a smoke free hospital)
- chew gum or suck lozenges while fasting
- wear jewellery including piercings (a wedding ring is permitted)
- wear make-up or nail polish (false nails are permitted but are discouraged)
- bring children (unless the patient)
- use talcum powder on day of the procedure.

Please shower before you come to the hospital.

ACCOMMODATION

Day patients are usually accommodated in a specialty day procedure area furnished with either beds or recliner chairs. If you are accommodated on a ward it will usually be in a shared room.

DISCHARGE

Please make arrangements in advance for a responsible adult to accompany you when you leave hospital and stay with you overnight. Failure to comply with this may result in the cancellation of your procedure.

YOU MUST NOT DRIVE YOURSELF HOME OR STAY AT HOME ALONE as it is unsafe to do so no matter how well you may feel.

You will be given written post-procedure instructions to take home.

Account Fees and Payments

ESTIMATE OF EXPENSES

- An estimate of the expenses for your hospital stay can be obtained by contacting our Claims Officer during the hours of 9.00am and 4.00pm Monday to Friday on (08) 8239 9138.
- Whilst every effort will be made to provide an accurate estimate of expenses additional costs are sometimes incurred. This may be due to:
  - Variations in proposed treatment, procedure, prosthesis, or length of stay
  - Sundry charges eg. STD phone calls, discharge medicines, take home items.

  Any balance outstanding is payable prior to, or on discharge from the hospital.
- You will need to sign a copy of the estimate of expenses to acknowledge that you have received and understand the estimate and that you agree to pay for any unforeseen charges.
- If responsibility for payment of the claim is not accepted by your health insurer, Department of Veterans' Affairs /Defence or other insurer (WorkCover, Third Party and Public Liability) then you or the person nominated as responsible for the account on the Patient Registration Details form are responsible for payment of the entire account.

COSTS OF OTHER HEALTH CARE PROVIDERS

- Please contact your doctor for an estimate of his/her costs as these are separate to those of the hospital
- You are responsible for accounts which you may receive from other parties including but not limited to anaesthetist, surgical assistants, pathology, pharmacy and x-ray. Please discuss with these providers an estimation of fees and any out of pocket expenses.

PROSTHESIS COSTS AND CONSENT

- Where a prosthesis (an implanted medical device eg. a hip replacement, pacemaker, pins, screws etc) is required there is a possible out of pocket expense. If you have not been informed of the out of pocket expense please discuss this with your doctor immediately.

HEALTH FUND PATIENTS

- Please contact your health fund before admission to check your level of cover and clarify any excesses or co-payments you may have.
- The hospital will also contact your health fund to confirm your cover, including any exclusions, pre-existing illness not covered, excesses or co-payments. These costs will be included in your estimate of expenses.
- Excesses and co-payments are payable prior to or on admission.

UNINSURED PATIENTS

- Uninsured patients are required to pay the total estimated cost of their hospital stay prior to admission.
- Any shortfall in the estimate and other charges will be payable prior to or on discharge.
- Over-payments will be refunded as soon as possible after discharge.

DEPARTMENT OF VETERANS' AFFAIRS (DVA) PATIENTS

- If you are a gold card holder and require a cosmetic procedure your doctor must seek authorisation from DVA prior to admission.
- If you are a white card holder your doctor must seek authorisation from DVA for any admission.
- There is a surcharge for a private room if there is not a clinical need. If you have any queries prior to admission please contact the hospital on 8239 9279.

WORKCOVER, THIRD PARTY AND PUBLIC LIABILITY PATIENTS

- A letter of approval from the relevant insurer must be provided with the Patient Registration Details form prior to admission for WorkCover, Third Party and Public Liability claimants.

ACCOUNT PAYMENTS

- Accounts can be paid by credit card (Visa, Mastercard), cash or EFTPOS.
- Payments by Visa and Mastercard can be made over the phone prior to admission.
- We do not accept Amex or Diners Club Card.
- We do not accept personal cheques.

Calvary

North Adelaide Hospital

Patient Registration Details

PATIENT TO COMPLETE

ROOM NUMBER

PATIENT ADMISSION DETAILS

Admission Date: Admission Time: Admitting Specialist:

Referring Doctor (Name): Phone:

PATIENT DETAILS

Title: Surname: Given Names:

Gender: Date of Birth: Country of Birth:

Marital Status: ☐ Married ☐ De facto ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Spoken language: Interpreter required: ☐ Yes ☐ No

Address:

Postcode:

Phone: (Home) (Bus) (Mobile)

Email:

Indigenous Group: ☐ Non Indigenous ☐ Aboriginal & TSI ☐ Aboriginal ☐ Torres Strait Islander

Religion: Occupation: Preferred Name:

Have you ever been admitted to Calvary North Adelaide Hospital? ☐ Yes ☐ No

If your name has changed since last admission, name previously admitted under:

CONCESSION/PENSION CARD INFORMATION

(Relevant cards to be presented prior to or on admission or concession cannot be given)

Pension / Concession No: _ _ _ _ _ _ _ _ _ _ Expiry Date: _ _ / _ _

Safety Net No: _ _ _ _ _ _ _ _ _ _ _

Department of Veterans' Affairs patients, refer DVA section overleaf.

SA AMBULANCE MEMBERSHIP

Ambulance Membership No:

PERSON FOR NOTIFICATION

Next of Kin:

Title: Surname: Given Name:

Relationship: Address:

Phone: (Home) (Bus) (Mobile) Email:

Alternative Emergency Contact:

Title: Surname: Given Name:

Phone: (Home) (Bus) (Mobile) Relationship:

PERSON RESPONSIBLE FOR ACCOUNT *(if other than patient)*

Title: Surname: Given Name: Relationship:

Address:

Phone: (Home) (Bus) (Mobile) Email:

HOSPITAL INFORMATION

Have you been or will you be discharged from a hospital in the seven (7) days prior to this admission? ☐ Yes ☐ No

If yes, name of hospital: Admission date: Discharge Date:

OFFICE USE ONLY

Booked:	Cards sighted:	Excess: Co-payment:	Claim Form Signed:
URN:	☐ Full cover ☐ Other:	Quote Sent: Sent by:	Admit Time:
PAC Date:	Exclusions:	Quote/IFC Signed:	Admit Officer:
PAC Time:	Length of Cover:	Amt pd: Date:	Discharge Date:
Adm Forms (7) Signed:	Financial: ☐ Yes ☐ No	Apprvd WC/TP/PL:	Discharge Time:
Diagnosis:		Pre-admitted:	Discharge Officer:

PATIENT REGISTRATION DETAILS

HEALTH INSURANCE DETAILS *(Relevant cards to be presented prior to or on admission)*

Private Health Fund Name: Table:

Name of Policy Holder: Membership No: Patient Reference No:

Date of Joining Fund: Current Table Membership: ☐ Less than 12 months ☐ Over 12 months

If current table membership is less than 1 year, name of fund and table transferred from:

Do you have an excess: ☐ Yes (Amt: $) ☐ No Do you have a co-payment: ☐ Yes (Amt: $) ☐ No

It is recommended that you contact your fund to confirm your level of cover. Please Note: All excesses and co-payments are payable prior to or on admission.

DEPARTMENT OF VETERANS' AFFAIRS AND DEPARTMENT OF DEFENCE PATIENTS

(Relevant cards to be presented prior to or on admission)

DVA File/Card No:__ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ Card Colour:

For Veterans with a Gold Card admitted for cosmetic surgery, or White Card holders admitted for any treatment, the admitting doctor must seek authorisation prior to admission.

Auth'n No: __ __ __ __ __ __ __ __

Defence Personnel Service No: __ __ __ __ __ __ __ __ Ref No: Rank:

MEDICARE CARD INFORMATION AND GENERAL PRACTITIONER *(Medicare Card to be presented prior to or on admission)*

Medicare No: __ __ __ __ __ __ __ __ __ __ Patient Reference No: __ Expiry Date: __ __ / __ __

GENERAL PRACTITIONER

General Practitioner (Name): Practice Name/Suburb: Phone:

WORKCOVER, THIRD PARTY AND PUBLIC LIABILITY CLAIMS *(Letter of Approval must accompany this form)*

Date of Accident: Nature of Claim: ☐ WorkCover ☐ Third Party ☐ Public Liability ☐ Other

WorkCover: Employer's Name: Contact:

Address: Phone: Claim No:

Employer's Insurance Company: Contact: Phone:

Third Party / Public Liability / Other (please specify):

Patient's Solicitor / Insurance Company: Contact:

Address: Phone: Claim No:

Please Note: If responsibility is not accepted through compensation the person responsible for the account (refer previous page) is personally responsible for payment.

DECLARATION *(To be completed by patient or parent / guardian if the patient is a minor)*

I have read and understand the information contained in the Patient Registration Details form. I certify that to the best of my knowledge the particulars set out on this form are correct. I understand the conditions relating to payment as set out below*. I understand that total costs cannot be quoted, only estimated in advance. My obligation to pay for the hospitalisation is independent of any benefits claimable from Medicare or Private Health Insurance.

I release Calvary North Adelaide Hospital (the Hospital) from any claim for whatever loss, theft or damage of any property or valuables.

Signature: Date:

Print Name:

*** Conditions of Payment**

1. I accept personal responsibility for full payment of the Hospital's account, or balance remaining in the event that my claim is rejected in full or partly paid as applicable.
2. In the event that I am uninsured while an inpatient of the Hospital, I accept personal responsibility for full payment of the Hospital's account.
3. I accept personal responsibility for full payment of the Hospital's account in the event that my compensation claim (if applicable) is not settled within 90 days of being an inpatient of the Hospital.
4. In the event that the whole or any part of the account shall be unpaid after my discharge from the Hospital and the Hospital appoints an agent for the purpose of recovering any such amount from me, I acknowledge that I am personally responsible for any fees, charges and/or commission which the Hospital may pay to such an agent for the collection of such an account.

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Privacy Consent / Rights & Responsibilities Acknowledgement

Surname: _____

Given Names: _____

D.O.B: _____

Sex: M / F

Attach **PATIENT ID LABEL** on admission

PATIENT TO COMPLETE

* PLEASE FILL IN THIS FORM USING **BLACK** BALL POINT PEN
* PLEASE ENSURE YOUR NAME AND DATE OF BIRTH ARE WRITTEN ON EACH PAGE.

By signing and dating in the space below you are acknowledging that you have read and understood the Privacy Policy on page 13 and Rights and Responsibilities on page 14. You are also giving consent to the collection and use of your personal information as described in the policy.

If you do not consent to your information being used in the manner described below, please cross out the choice, for example ~~cross out the choice~~.

- I consent to **Calvary North Adelaide Hospital** providing information about my condition and treatment to my nominated next of kin.
- I consent to **Calvary North Adelaide Hospital** providing my name and religion/denomination to visiting chaplains accredited with the facility.
- I consent to **Calvary North Adelaide Hospital** providing my name to members of Returned Services organisations (if appropriate).
- I consent to **Calvary North Adelaide Hospital** sending me confidential surveys to obtain my feedback as to the quality of care I received during my stay.
- To support **Calvary North Adelaide Hospital** in providing practical training and education I consent to undergraduate and post-graduate health care students being involved in my clinical care under the supervision of a health care professional.

Irrespective of any request received, I direct you NOT TO PROVIDE my personal information to (please specify name / details or leave blank if not applicable):

*Signature of Patient / Person Responsible**: Date:

Print Full Name:

* Strike out what is not applicable.

** "Person Responsible" means a person defined as a "person responsible" under the Privacy Act 1988 (Amended) including the patient's partner, family member, carer, guardian, close friend, and a person exercising power under an Enduring Power of Attorney.

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Day Patient Health Assessment

Surname: _____

Given Names: _____

D.O.B: _____

Sex: M / F

Attach **PATIENT ID LABEL** on admission

PATIENT TO COMPLETE

* PLEASE FILL IN THIS FORM USING **BLACK** BALL POINT PEN
* PLEASE ENSURE YOUR NAME AND DATE OF BIRTH ARE WRITTEN ON EACH PAGE.

Surgeon: **Planned Admission Date:** / / **Height:** **Weight:**

In your own words please tell us why you are being admitted to hospital:

If caused by an injury please describe, including where it occurred:

PLEASE TICK BOX				Staff Use Only Initial actions
Do you require an interpreter?	☐ No	☐ Yes	Specify language / type:	
Allergies: Are you sensitive or allergic to medicines, foods, tapes, metals, latex/rubber, antiseptics, other?	☐ No	☐ Yes	Specify allergy and reaction *(attach a list if there is not enough room)*	
Have blood tests or other pathology tests been taken for this admission?	☐ No	☐ Yes	If Yes, when and where?	
Have X-rays / CT scan / MRI / Ultrasound been taken for this admission?	☐ No	☐ Yes	Please bring your x-rays/scans to hospital with you.	
Are you receiving treatment from other specialists/doctors?	☐ No	☐ Yes	If Yes, please list name(s):	
Female patients – could you be pregnant?	☐ No	☐ Yes	If Yes, when was your last period? / /	
Do you have any physical disabilities? If yes please contact Patient Services Office on (08) 8239 9100 so we can meet your needs	☐ No	☐ Yes	Please specify	
Do you have specific dietary requirements?	☐ No	☐ Yes	Please specify	
Do you or have you ever smoked?	☐ No	☐ Yes	Number per day: Date stopped: / /	
Do you drink alcohol?	☐ No	☐ Yes	Amount per day: Amount per week:	
Do you use recreational drugs (other than alcohol or tobacco)?	☐ No	☐ Yes	Type: Daily amount:	
Are you currently receiving community nurse visits?	☐ No	☐ Yes	Please specify	
Do you require a Doctor's Certificate?	☐ No	☐ Yes	If yes please discuss with your Doctor	

MEDICINES *If you do not have a current printed list of your medicines from your GP please list all medicines including vitamins, herbal preparations and alternative medicines below (please attach a list if there is not enough room.) Please bring to hospital any medicines / insulin / puffers in their labeled packages that you are currently taking.*

Do you take or have you recently taken blood-thinning medicines ie. Aspirin (Astrix, Cartia, Aspro, Disprin etc), Warfarin (Marevan, Coumadin), Clopidogrel (Iscover, Plavix), or drugs for arthritis?	☐ No	☐ Yes	Name of medicine: Date last taken / / or still taking ☐ Yes	

Current Medicines	Dose/Frequency	Current Medicines	Dose/Frequency	

PAST MEDICAL AND SURGICAL HISTORY

Please list previous illnesses, operations and the years you had them (Please attach a list if there is not enough room.)

Surname: _____

Given Names: _____

D.O.B: _____

Sex: M / F

Attach **PATIENT ID LABEL** on admission

DO YOU HAVE/HAD ANY OF THE FOLLOWING?

Side effects / reactions to an anaesthetic such as nausea, confusion, aggression or poor recovery	☐ No	☐ Yes	Gastric band / surgical weight loss aid	☐ No	☐ Yes
An immediate blood relative who has had side effects or reactions to an anaesthetic	☐ No	☐ Yes	Hiatus hernia / reflux / indigestion	☐ No	☐ Yes
Asthma/ shortness of breath/ hayfever/ sleep apnoea/ tuberculosis/ persistent cough *(please circle condition) (please bring your CPAP machine to hospital with you if you use one)*	☐ No	☐ Yes	Mental illness / nervous breakdown / PTSD / anxiety attacks / depression *(please circle condition)*	☐ No	☐ Yes
Chest pain / angina / heart attack/ heart surgery / pacemaker / implantable defibrillator/ palpitations / irregular heart beat / heart murmur/ rheumatic fever *(please circle condition)*	☐ No	☐ Yes	Dementia / short term memory loss	☐ No	☐ Yes
Ankle / leg swelling	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
High or Low blood pressure	☐ No	☐ Yes	Are you immunocompromised? *please specify why*	☐ No	☐ Yes
Stroke / mini strokes	☐ No	☐ Yes	Lymphoedema *please specify*	☐ No	☐ Yes
Diabetes *please specify type*	☐ No	☐ Yes	Arthritis / osteoporosis	☐ No	☐ Yes
Thyroid problems	☐ No	☐ Yes	Kidney trouble *please specify*	☐ No	☐ Yes
Epilepsy / fits / seizures / faints *(please circle condition)*	☐ No	☐ Yes	Do you wear glasses/contact lens?	☐ No	☐ Yes
Migraines	☐ No	☐ Yes	Do you have any piercings? *please specify*	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes	Do you have dentures? ☐ Upper ☐ Lower ☐ Partial ☐ Full	☐ No	☐ Yes
Blood clot in legs (DVT) or lungs	☐ No	☐ Yes	Do you have dental problems? ☐ Caps ☐ Crowns ☐ Loose teeth	☐ No	☐ Yes
Anaemia	☐ No	☐ Yes	Do you have any prostheses? *please specify*	☐ No	☐ Yes
Blood transfusion	☐ No	☐ Yes	Do you have any difficulties with mobility? *e.g back or hip problems*	☐ No	☐ Yes
Hepatitis / jaundice / liver disease	☐ No	☐ Yes	Do you have a history of a multi-resistant organism (MRSA / Clostridium difficile/ VRE / other)?	☐ No	☐ Yes

Creutzfeldt-Jakob Disease (CJD)

Have you had a dura mater graft prior to 1990?	☐ No	☐ Yes
Do you have a family history of two or more first degree relatives with classical Creutzfeldt- Jacob (CJD) disease or other unspecified progressive neurological disorder?	☐ No	☐ Yes
Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?	☐ No	☐ Yes
Have you received human pituitary hormones prior to 1986?	☐ No	☐ Yes
Have you been involved in "look back" for CJD or do you have a "medical confidence letter" regarding your risk of CJD?	☐ No	☐ Yes

PATIENT COMPLIANCE STATEMENT

I certify that I have a responsible adult to both accompany me home and stay with me overnight.
I understand that surgery may be cancelled if I do not have a responsible adult to accompany me home and stay overnight.

Name of responsible adult: **Contact number:**

I understand the importance of and agree to follow instructions regarding my post-operative care.
I undertake not to drive, operate machinery, drink alcohol, sign legal documents or make significant decisions following my anaesthetic, until the next day or as advised by my doctor.

Patient Signature: **Date:**

STAFF USE ONLY *Information on this Day Patient Health Assessment has been discussed and confirmed with the patient*

Name of Pre-admission Nurse:	Signature:	Designation:	Date:
Name of Admitting Nurse:	Signature:	Designation:	Date:

Privacy Policy

Calvary North Adelaide Hospital is committed to conducting its health care services in compliance with all applicable laws and regulations and in accordance with the highest ethical standards. Calvary North Adelaide Hospital complies with the Commonwealth Privacy Act and all other state/territory legislative requirements in relation to the management of personal information. We believe that our patients can feel safe in the knowledge that we safeguard their personal health information ensuring that confidentiality is respected and information is stored securely.

In order to provide you with the health care services you have requested, we need to collect and use your personal health information. If you provide incomplete or inaccurate information or withhold personal health information from us we may not be able to provide you with the services you are seeking.

WHAT INFORMATION DO WE COLLECT?

We collect information that is necessary for the provision of your health care. This may include collecting information about your health history, family history, your ethnic background or your current lifestyle to assist the health care team in diagnosing and treating your condition. Our staff will always endeavour to be sensitive to your needs when obtaining personal health information. However, they are also committed to acting in your best interests by making a thorough assessment of your condition and medical history before recommending treatment.

HOW DO WE USE YOUR INFORMATION?

Modern health care practices mean that your treatment will be provided by a team of health professionals working together. You may be referred for diagnostic tests such as pathology or radiology and our staff may consult with senior medical experts when determining your diagnosis or treatment. These health professionals will share your health information as part of the process of providing your treatment. Of course, we will only do this while maintaining confidentiality of all this information. Information will only be disclosed to those health care workers involved in your treatment. This will include such activities as providing a discharge summary to your referring medical practitioner or nominated general practitioner.

However, if in the future you are treated by a medical practitioner who requires access to the health record of your treatment in our hospital we will require an authorisation from you to provide a copy of your record. The only time we would provide information about your health records to another medical practitioner without your consent is in the event of an emergency where your life is at risk and you are not able to provide consent.

In order to provide the best possible environment in which to treat you, we shall also use your information where necessary for the management of our hospital or health service, to liaise with your health fund, and Medicare as necessary, and for activities such as quality assurance processes, accreditation, audits, risk and claims management, and education of health care workers and health care students.

We may share your health information between Calvary Health Care Adelaide facilities to coordinate your care and to minimise bad debts.

Where we outsource any of our services or hire contractors to perform services within our hospital or health service we require them to also comply with the Privacy Act and our Privacy Policy.

We may provide your de-identified health information to State and/or Commonwealth Government agencies to assist in research and future prevention/management of disease, in accordance with legislative requirements.

With your consent we can also use your information for other purposes such as including you on a survey mailing list. You can provide your additional consent to this use of your information on the attached privacy consent form.

ACCESS TO YOUR HEALTH INFORMATION

You have a right to access your health record and to request an amendment to your health record should you believe that it contains inaccurate information. Should you wish to access your health record ask for our Privacy Officer who can give you more detailed information about how to access your health record.

IF YOU HAVE A COMPLAINT ABOUT PRIVACY ISSUES

If you have a complaint about our information handling practices or feel that the privacy of your health information has been interfered with, you can lodge a complaint with our Privacy Officer or directly with the Office of the Privacy Commissioner, an independent Office which has responsibilities under the Privacy Act 1988. All complaints will be dealt with fairly and as quickly as possible.

Privacy Officer
Calvary North Adelaide Hospital
89 Strangways Tce
North Adelaide SA 5006

Office of the Privacy Commissioner
GPO Box 5218
Sydney NSW 2001
Phone: 1300 363 992 (local call)
Email: privacy@privacy.gov.au

If you have any questions in relation to our **Privacy Policy**, please ask to see our Privacy Officer.

Rights & Responsibilities

Based on our values of hospitality, healing, stewardship and respect, the management and staff of Calvary support the Australian Charter of Healthcare Rights developed by the Australian Commission on Safety and Quality in Healthcare. The Charter 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 healthcare 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.

IF YOU HAVE A COMMENT OR COMPLAINT ABOUT OUR SERVICE

- Talk to the person in charge or any health worker at the time of the problem
- You can write to, phone or see the person in charge at any time during your care or afterwards
- If you are not satisfied with the results of your complaint you can contact the:
  Chief Executive Officer
  Calvary North Adelaide Hospital
  89 Strangways Tce
  North Adelaide SA 5006
- If you have not been able to resolve the problem, you can write to the appropriate State or Federal independent complaints organisations:

Health and Community Services Complaints Commissioner
PO Box 199
Rundle Mall
Adelaide SA 5001
Phone: 1800 232 007 (local call)

Medical Board of South Australia
PO Box 791
North Adelaide SA 5006
Phone: (08) 8219 9800
(For complaints against Medical Practitioners)

Private Health Insurance Ombudsman
Phone: 1800 640 695 (free call)
(For matters relating to health insurance)

WHAT CAN I EXPECT FROM THE LCM HEALTH CARE SYSTEM?	
MY RIGHTS	**WHAT THIS MEANS**
Access I have a 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.

WHAT CAN THE LCM HEALTH CARE SYSTEM EXPECT FROM YOU?	
MY RESPONSIBILITIES	**WHAT THIS MEANS**
Honesty and openness I have a responsibility to answer questions about my health openly and completely	I will disclose all information about my health
Compliance I have a responsibility to comply with prescribed treatments or to inform my health carers if I do not intend to do so.	If I wish to refuse treatment I will discuss with my health carers .
Respect I have a responsibility to show respect to my health carers.	I will be courteous, considerate and respectful towards others

Little Company of Mary Health Care

Calvary North Adelaide Hospital is part of the Little Company of Mary Health Care, a national Catholic health care organisation providing high quality values-based care and support for people who are sick, dying and in need.

Little Company of Mary Health Care operates in New South Wales, Victoria, Tasmania, South Australia, the Northern Territory and the Australian Capital Territory. Services include public and private hospital care, acute and sub-acute care, and home, community, retirement and aged care services.

Our vision as a Catholic Health, Community and Aged Care provider, is to excel and be recognised as a continuing source of healing, hope and nurturing to the people and communities we serve.

CALVARY NORTH ADELAIDE HOSPITAL