

1993—No. 112

**PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES  
ACT 1988—REGULATION**

(Relating to register of patients, admission and in-patient statistics forms)

NEW SOUTH WALES



*[Published in Gazette No. 26 of 19 March 1993]*

HIS Excellency the Governor, with the advice of the Executive Council, and in pursuance of the Private Hospitals and Day Procedure Centres Act 1988, has been pleased to make the Regulation set forth hereunder.

RON PHILLIPS, M.P.,  
Minister for Health

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**Commencement**

1. This Regulation commences on 19th March, 1993.

**Amendment**

2. The Private Hospitals Regulation 1990 is amended by omitting Forms 6, 7 and 8 from Schedule 3 and by inserting instead the following forms:
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**PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988**  
**REGISTER OF PATIENTS FORM 5**

TRIPPLICATE  
(Cl.14)

HOSPITAL				HOSPITAL CODE No.		MEDICAL RECORD No.	
SURNAME		GIVEN NAMES (IN FULL)		SEX <input type="checkbox"/> 1. MALE <input type="checkbox"/> 2. FEMALE	MARITAL STATUS <input type="checkbox"/> 1. MARRIED <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> 5. SEPARATED <input type="checkbox"/> 2. SINGLE <input type="checkbox"/> 4. DIVORCED <input type="checkbox"/> 6. NOT KNOWN		
OCCUPATION		STREET No.    STREET NAME		USUAL ADDRESS (PLEASE PRINT)		SUBURB, TOWN OR LOCALITY	
RELIGION		COUNTRY OF BIRTH		BIRTH DATE		AGE	
LANGUAGE USED AT HOME		PERSON FOR NOTIFICATION		RELATIONSHIP		PHONE	
ADDRESS		ADDRESS		NAME OF REFERRING LOCAL MEDICAL OFFICER		PHONE	
DRUGS ON ADMISSION		ATTENDING MEDICAL OFFICER		ADDRESS		PHONE	
ADMITTED FROM		BIRTH STATUS <input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED		ADMISSION DATE		TIME	
ASORIGINITY <input type="checkbox"/> 1. ABORIGINE <input type="checkbox"/> 2. TORRES ISL. <input type="checkbox"/> 3. NEITHER		RE-ADMISSION WITHIN 30 DAYS <input type="checkbox"/> 1. NOT APPLICABLE <input type="checkbox"/> 2. THIS HOSPITAL <input type="checkbox"/> 3. OTHER HOSPITAL		HOSPITAL INSURANCE <input type="checkbox"/> 1. TOP COVER <input type="checkbox"/> 2. BASIC COVER <input type="checkbox"/> 3. NO COVER		WAS PATIENT ADMITTED TO A PSYCH UNIT <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO	
EMERGENCY STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		SERVICE CATEGORY ON ADMISSION <input type="checkbox"/> 1. NURSING HOME TYPE <input type="checkbox"/> 2. CONVALESCENT CARE <input type="checkbox"/> 3. RESPIRE CARE <input type="checkbox"/> 4. REHABILITATION <input type="checkbox"/> 5. PALLIATIVE CARE <input type="checkbox"/> 6. PSYCHOGERIATRIC <input type="checkbox"/> 7. ACUTE CARE		PAYMENT STATUS ON SEPARATION <input type="checkbox"/> 1. PRIVATE <input type="checkbox"/> 2. WORKERS COMP. <input type="checkbox"/> 3. MOTOR ACCIDENT <input type="checkbox"/> 4. VETERAN AFFAIRS <input type="checkbox"/> 5. INDEBTABLE <input type="checkbox"/> 6. DEFENCE FORCE <input type="checkbox"/> 7. PUBLIC CONTRACT <input type="checkbox"/> 8. OTHER		MODE OF SEPARATION <input type="checkbox"/> 1. DISCHARGE BY HOSP. <input type="checkbox"/> 2. DISCHARGE OWN HOME <input type="checkbox"/> 3. TRANSFER TO NURSING HOME <input type="checkbox"/> 4. TRANSFER TO PSYCH. HOSP. <input type="checkbox"/> 5. TRANSFER TO OTHER HOSP. <input type="checkbox"/> 6. DEATH WITH AUTOPSY <input type="checkbox"/> 7. DEATH WITHOUT AUTOPSY <input type="checkbox"/> 8. TRANSFER TO OTHER ACCOM. <input type="checkbox"/> 9. TYPE CHANGE SEPARATION <input type="checkbox"/> 10. DISCHARGE ON LEAVE	
CONTRACT STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		DISCHARGE INTENTION <input type="checkbox"/> 1. TODAY <input type="checkbox"/> 2. OTHER		IF THE SEPARATION MODE IS 4 OR 6, RECORD THE CODE NUMBER OF THE HOSPITAL TO WHICH THE PATIENT WAS TRANSFERRED			
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION)							
DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR THE LENGTH OF STAY (If same as above, write AS ABOVE)							
SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY							
PRINCIPAL OPERATION OR MAJOR PROCEDURE				SURGEON		DATE	
OTHER OPERATIONS OR PROCEDURES				SURGEON		DATE	
EXTERNAL CAUSE OF INJURY OR POISONING (IF APPLICABLE)							
PLACE OF OCCURRENCE OF INJURY OR POISONING 0. HOME    1. IMMEDIARY    4. RECREATION/SPORTING VEHICLE    6. PUBLIC BUILDING    8. OTHER SPECIFIED PLACE 1. FARM    2. INDUSTRIAL PREMISES    5. STREET/HIGHWAY    7. RESIDENTIAL INSTITUTION    9. UNSPECIFIED PLACE							
AMBULANCE CLIENT NUMBER							

THIS FORM SHOULD BE  
 CONSOLIDATED SEQUENTIALLY  
 IN A LOOSE LEAF COVER AS THE  
 HOSPITAL'S REGISTER OF PATIENTS

## PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988

## ADMISSION FORM 7

(Cl. 15)

HOSPITAL		HOSPITAL CODE No.		MEDICAL RECORD No.	
SURNAME		GIVEN NAMES (IN FULL)		SEX 1. MALE 2. FEMALE	MARITAL STATUS 1. MARRIED 3. WIDOWED 5. SEPARATED 2. SINGLE 4. DIVORCED 6. NOT KNOWN
OCCUPATION	STREET No.	STREET NAME			
RELIGION	USUAL ADDRESS (PLEASE PRINT)	SUBURB, TOWN OR LOCALITY		POST CODE	PHONE
LANGUAGE USED AT HOME	COUNTRY OF BIRTH	BIRTH DATE	AGE	ADMISSION WEIGHT (in kilograms only)	
PERSON FOR NOTIFICATION	RELATIONSHIP	PHONE	NAME OF REFERRING LOCAL MEDICAL OFFICER		PHONE
ADDRESS		ADDRESS			
OFFICE ON ADMISSION		ATTENDING MEDICAL OFFICER		PHONE	
		ADDRESS			
ADMITTED FROM		BABY STATUS 1. UNQUALIFIED 2. QUALIFIED	ADMISSION DATE	TIME	HOURS IN I.C.U.
ABNORMALITY 1. ABNORMAL 2. TOPICS BY IL 3. NEITHER	RE-ADMISSION WITHIN 30 DAYS 1. NOT APPLICABLE 2. THIS HOSPITAL 3. OTHER HOSPITAL	HOSPITAL INSURANCE 1. TOP COVER 2. BASIC COVER 3. NO COVER	WAS PATIENT ADMITTED TO A PSYCH. UNIT? 1. YES 2. NO	SEPARATION DATE	TIME
EMERGENCY STATUS 1. YES 2. NO	SERVICE CATEGORY ON ADMISSION 1. NURSING HOME TYPE 2. CONVALESCENT CARE 3. RESPIRE CARE 4. REHABILITATION 5. PALLIATIVE CARE 6. PSYCHOGERIATRIC 7. ACUTE CARE	PAYMENT STATUS ON SEPARATION 1. PRIVATE 2. WORKERS COMP. 3. MOTOR ACCIDENT 4. VETERAN'S AFFAIRS 5. UNEMPLOYED 6. DEFENCE FORCE 7. PUBLIC CONTRACT 8. OTHER		MODE OF SEPARATION 1. DISCHARGE BY HOSP. 2. DISCHARGE OWN HOME 3. TRANSFER TO NURSING HOME 4. TRANSFER TO PSYCH. HOSP. 5. TRANSFER TO OTHER HOSP. 6. DEATH WITH AUTOPTSY 7. DEATH WITHOUT AUTOPTSY 8. TRANSFER TO OTHER ACCOMM. 9. TYPE CHANGE SEPARATION 10. DISCHARGE ON LEAVE	
CONTRACT STATUS 1. YES 2. NO	DISCHARGE INTENTION 1. TODAY 2. OTHER	IF THE SEPARATION MODE IS 1 OR 2, RECORD THE CODE NUMBER OF THE HOSPITAL TO WHICH THE PATIENT WAS TRANSFERRED			
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION)					
DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR THE LENGTH OF STAY (If same as above, write AS ABOVE)					
SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY					
PRINCIPAL OPERATION OR MAJOR PROCEDURE		SURGEON	DATE		
OTHER OPERATIONS OR PROCEDURES		SURGEON	DATE		
EXTERNAL CAUSE OF INJURY OR POISONING (IF APPLICABLE)					
PLACE OF OCCURRENCE OF INJURY OR POISONING 1. HOME 2. MANUFACTORY 3. INDUSTRIAL PREMISES 4. RECREATION/SPORTING VENUE 5. PUBLIC BUILDING 6. RESIDENTIAL INSTITUTION 7. STREET/ROADWAY 8. OTHER SPECIFIED PLACE 9. UNSPECIFIED PLACE					
AMBULANCE CLIFT NUMBER		CHIEF NURSE ON ADMISSION		TO BE ATTACHED TO MEDICAL RECORD OF PATIENT	
		CHIEF NURSE ON SEPARATION			

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## PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988

## IN-PATIENT STATISTICS FORM 8

(Cl. 15)

HOSPITAL		HOSPITAL CODE No.		MEDICAL RECORD No.	
		SEX <input type="checkbox"/> 1. MALE <input type="checkbox"/> 2. FEMALE		MARITAL STATUS <input type="checkbox"/> 1. MARRIED <input type="checkbox"/> 2. SINGLE <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> 4. DIVORCED <input type="checkbox"/> 5. SEPARATED <input type="checkbox"/> 6. NOT KNOWN	
USUAL ADDRESS (PLEASE PRINT)		STREET No. STREET NAME		SUBURB, TOWN OR LOCALITY	
				POST CODE	
LANGUAGE USED AT HOME		COUNTRY OF BIRTH		BIRTH DATE	
				ADMISSION IN CENT (Cl. 15)	
		BASIC STATUS <input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED		ADMISSION DATE 19	
		WAS PATIENT ADMITTED TO A PSYCH UNIT? <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		SEPARATION DATE 19	
ABORIGINALITY <input type="checkbox"/> 1. ABORIGINAL <input type="checkbox"/> 2. TORRES ISL. <input type="checkbox"/> 3. NEITHER		RE-ADMISSION WITHIN 28 DAYS <input type="checkbox"/> 1. NOT APPLICABLE <input type="checkbox"/> 2. THIS HOSPITAL <input type="checkbox"/> 3. OTHER HOSPITAL		HOURS IN C.U.	
EMERGENCY STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		SERVICE CATEGORY ON ADMISSION <input type="checkbox"/> 1. NURSING HOME TYPE <input type="checkbox"/> 2. CONVALESCENT CARE <input type="checkbox"/> 3. RESPIRE CARE <input type="checkbox"/> 4. REHABILITATION <input type="checkbox"/> 5. PALLIATIVE CARE <input type="checkbox"/> 6. PSYCHOGERIATRIC <input type="checkbox"/> 7. ACUTE CARE		MODE OF SEPARATION <input type="checkbox"/> 1. DISCHARGE BY HOUR <input type="checkbox"/> 2. DISCHARGE OWN RISK <input type="checkbox"/> 3. TRANSFER TO NURSING HOME <input type="checkbox"/> 4. TRANSFER TO PSYCH. HOSP. <input type="checkbox"/> 5. TRANSFER TO OTHER HOSP. <input type="checkbox"/> 6. DEATH WITH AUTHORITY <input type="checkbox"/> 7. DEATH WITHOUT AUTHORITY <input type="checkbox"/> 8. TRANSFER TO OTHER ACCOMM. <input type="checkbox"/> 9. TYPE CHANGE SEPARATION <input type="checkbox"/> 10. DISCHARGE ON LEAVE	
CONTRACT STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		PAYMENT STATUS ON SEPARATION <input type="checkbox"/> 1. PRIVATE <input type="checkbox"/> 2. WORKERS COMP. <input type="checkbox"/> 3. MOTOR ACCIDENT <input type="checkbox"/> 4. VETERANS AFFAIRS <input type="checkbox"/> 5. INDEMNITY <input type="checkbox"/> 6. PUBLIC CONTRACT <input type="checkbox"/> 7. DEFENCE FORCE <input type="checkbox"/> 8. OTHER		Nk. OF LEAVE DAYS	
DISCHARGE INTENTION <input type="checkbox"/> 1. TODAY <input type="checkbox"/> 2. OTHER					
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION)					
DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR THE LENGTH OF STAY (8 DAYS OR ABOVE, WITH AS ABOVE)					
SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY					
PRINCIPAL OPERATION OR MAJOR PROCEDURE					
OTHER OPERATIONS OR PROCEDURES					
EXTERNAL CAUSE OF INJURY OR POISONING (IF APPLICABLE)					
PLACE OF OCCURRENCE OF INJURY OR POISONING 1. HOME 2. MINICLINIC 3. INDUSTRIAL PREMISES 4. RECREATION/SPORTS VENUE 5. STREET/ROADWAY 6. PUBLIC BUILDING 7. RESIDENTIAL INSTITUTION 8. OTHER SPECIFIED PLACE 9. UNSPECIFIED PLACE					
AMBULANCE CLIENT NUMBER					

AN IN-PATIENT STATISTICS FORM MUST BE COMPLETED FOR EVERY SEPARATION AND FORWARDED TO:

THE DATA QUALITY COORDINATOR  
HEALTH DATA COLLECTIONS UNIT  
NSW HEALTH DEPARTMENT  
LOCKED MAIL BAG 961  
NORTH SYDNEY NSW 2058

**EXPLANATORY NOTE**

The object of this Regulation is to amend the Private Hospitals Regulation 1990 by substituting Form 6 (register of patients), Form 7 (admission) and Form 8 (in-patient statistics) to provide for the recording of certain additional information (for example, aboriginality, baby status, emergency status, contract status, discharge intention and readmission within 28 days) necessary to comply with the National Minimum Data Set approved by the Australian Health Ministers Advisory Conference.

This Regulation is made under the Private Hospitals and Day Procedure Centres Act 1988, including section 55 (the general regulation-making power, in particular, section 55 (2) (b) (ii)) and section 44.