

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	MARITAL STATUS		
				<input type="checkbox"/> 1. MALE <input type="checkbox"/> 2. FEMALE	1. MARRIED 2. SINGLED 3. WIDOWED 4. DIVORCED 5. SEPARATED 6. NOT KNOWN		
OCCUPATION		USUAL ADDRESS (PLEASE PRINT)	STREET NO.	STREET NAME			
RELIGION		SUBURB, TOWN OR LOCALITY		POST CODE	PHONE		
LANGUAGE USED AT HOME		COUNTRY OF BIRTH		BIRTH DATE	AGE		
PERSON FOR NOTIFICATION		RELATIONSHIP	PHONE	NAME OF REFERRING/ LOCAL MEDICAL OFFICER			
ADDRESS		ADDRESS					
DRUGS ON ADMISSION		ATTENDING MEDICAL OFFICER		PHONE			
ADDRESS							
ADMITTED FROM			BABY STATUS <input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED	ADMISSION DATE 19	TIME	HOURS IN I.C.U.	
ABORIGINITY <input type="checkbox"/> 1. ABORIGINAL <input type="checkbox"/> 2. TORRES STR. IS. <input type="checkbox"/> 3. NEITHER		READMISSION 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	WAN PATIENT ADMITTED TO A PSYCH. UNIT <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO	SEPARATION DATE 19	TIME	NO. OF LEAVE DAYS
EMERGENCY STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		SERVICE CATEGORY ON ADMISSION <input type="checkbox"/> 1. NURSING HOME TYPE 2. CONVALESCENT CARE 3. REHABILITATION 4. REHABILITATION 5. PALLIATIVE CARE 6. PSYCHIATRIC 7. ACUTE CARE	PAYMENT STATUS ON SEPARATION <input type="checkbox"/> 1. PRIVATE 2. WORKERS COMP. 3. MOTOR ACCIDENT 4. VETERANS AFFAIRS 5. INELIGIBLE 6. DEFENCE FORCE 7. PUBLIC CONTACT 8. OTHER	MODE OF SEPARATION <input type="checkbox"/> 1. DISCHARGED BY HOSP. 2. DISCHARGED OWN FREE 3. TRANSFER TO NURSING HOME 4. TRANSFER TO PSYCH. HOSP. 5. TRANSFER TO OTHER HOSP. 6. DEATH WITH AUTOPSY 7. DEATH WITHOUT AUTOPSY 8. TRANSFER TO OTHER ACCOMM. 9. TYPE CHANGE SEPARATION 10. DISCHARGE ON LEAVE			
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHERLY RESPONSIBLE FOR THE ADMISSION)							
DIAGNOSIS WHICH WAS CHERLY RESPONSIBLE FOR THE LENGTH OF STAY (IF MORE THAN ONE, 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)							E
PLACE OF OCCURRENCE OF INJURY OR POISONING		4. RECREATION/SPORTING VENUE 5. STREET/NUMBER		6. PUBLIC BUILDING 7. RESIDENTIAL INSTITUTION		8. OTHER SPECIFIED PLACE 9. UNSPECIFIED PLACE	
9. HOME 10. FARM 11. INDUSTRIAL PREMISES AMBULANCE CLIENT NUMBER							

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

FORM NO. PR15

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## 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	MARITAL STATUS		
				<input type="checkbox"/> 1. MALE	1. MARRIED 2. SINGLED 3. WIDOWED 4. DIVORCED 5. NOT KNOWN		
OCCUPATION		USUAL ADDRESS (PLEASE PRINT)	STREET NO. STREET NAME				
RELIGION		SUBURB/TOWN OR LOCALITY		POST CODE	PHONE		
LANGUAGE USED AT HOME		COUNTRY OF BIRTH		BIRTH DATE	AGE		
PERSON FOR NOTIFICATION		RELATIONSHIP	PHONE	NAME OF REFERRING/LOCAL MEDICAL OFFICER			
ADDRESS		ADDRESS					
DRUGS ON ADMISSION		ATTENDING MEDICAL OFFICER		PHONE			
ADDRESS							
ADMITTED FROM		BABY STATUS <input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED	ADMISSION DATE 19		TIME	HOURS IN I.C.U.	
ABORIGINALITY <input type="checkbox"/> 1. ABORIGINAL <input type="checkbox"/> 2. TORRES ST. IS. <input type="checkbox"/> 3. MELTING	READMISSION WITHIN 30 DAYS <input type="checkbox"/> 1. NOT APPLICABLE <input type="checkbox"/> 2. IN 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	SEPARATION DATE 19		TIME	NO. OF LEAVE DAYS
EMERGENCY STATUS <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO	SERVICE CATEGORY ON ADMISSION <input type="checkbox"/> 1. NURSING HOME TYPE 2. HOMELESS 3. RESIDENT CARE 4. REHABILITATION 5. PALLIATIVE CARE 6. PSYCHOSURGICAL 7. ACUTE CARE		PAYMENT STATUS ON SEPARATION <input type="checkbox"/> 1. PRIVATE 2. WORKERS COMP. 3. MOTOR ACCIDENT 4. VETERAN AFFAIRS 5. INDEMNITY 6. DEFENCE FORCE 7. PUBLIC CONTRACT 8. OTHER		MODE OF SEPARATION 1. DISCHARGE BY HOSP. 2. DISCHARGE OWN RES. 3. TRANSFER TO NURSING HOME 4. TRANSFER TO PSYCH. HOSP. 5. TRANSFER TO OTHER HOSP. 6. DEATH WITH AUTOPSY 7. DEATH WITHOUT AUTOPSY 8. TRANSFER TO OTHER ACCOMM. 9. TYPE CHANGE SEPARATION 10. DISCHARGE ON LEAVE		
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHEIRLY RESPONSIBLE FOR THE ADMISSION) *							
DIAGNOSIS WHICH WAS CHEIRLY RESPONSIBLE FOR THE LENGTH OF STAY (IF MORE THAN ONE, WRITE AS ABOVE) *							
SECONDARY DIAGNOSIS AFFECTING TREATMENT OR LENGTH OF STAY *							
SECONDARY DIAGNOSIS 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)				E			
PLACE OF OCCURRENCE OF INJURY OR POISONING 1. HOME 2. MANSIONARY 4. RECREATIONAL VENUE 6. PUBLIC BUILDING 1. FAIR 2. INDUSTRIAL PREMISES 3. STREET/ROADWAY 5. RESIDENTIAL INSTITUTION 7. RESIDENTIAL INSTITUTION 8. OTHER SPECIFIED PLACE 9. UNSPECIFIED PLACE							
AMBULANCE CLIENT NUMBER						TO BE ATTACHED TO MEDICAL RECORD OF PATIENT	
		CHIEF NURSE ON ADMISSION					
		CHIEF NURSE ON SEPARATION					

FORM NO. PR16

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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		MARITAL STATUS	
		<input type="checkbox"/> 1. MALE	<input type="checkbox"/> 2. FEMALE	<input type="checkbox"/> 1. MARRIED	<input type="checkbox"/> 3. SEPARATED
				<input type="checkbox"/> 2. SINGLE	<input type="checkbox"/> 4. DIVORCED
				<input type="checkbox"/> 5. NOT KNOWN	
LEGAL ADDRESS (PLEASE PRINT)		STREET No. STREET NAME		POST CODE	
LANGUAGE USED AT HOME		COUNTRY OF BIRTH		BIRTH DATE	
				ADMISSION WEIGHT (kg) (RECORD 100)	
ABORIGINALITY		READMISSION WITHIN 28 DAYS		BABY STATUS	
<input type="checkbox"/> 1. ABORIGINAL <input type="checkbox"/> 2. TORRES STR. ISL. <input type="checkbox"/> 3. NEITHER		<input type="checkbox"/> 1. NOT APPLICABLE <input type="checkbox"/> 2. THIS HOSPITAL <input type="checkbox"/> 3. OTHER HOSPITAL		<input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED	
EMERGENCY STATUS		HOSPITAL INSURANCE		ADMISSION DATE	
<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		<input type="checkbox"/> 1. TOP COVER <input type="checkbox"/> 2. BASIC COVER <input type="checkbox"/> 3. NO COVER		19	
CONTRACT STATUS		WAS PATIENT ADMITTED TO A PSYCH. UNIT?		SEPARATION DATE	
<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		19	
DISCHARGE INTENTION		SERVICE CATEGORY OR ADMISSION		HOURS IN I.C.U.	
<input type="checkbox"/> 1. TODAY <input type="checkbox"/> 2. OTHER		<input type="checkbox"/> 1. NURSING HOME TYPE <input type="checkbox"/> 2. CONVALESCENT CARE <input type="checkbox"/> 3. REHAB CARE <input type="checkbox"/> 4. REHABILITATION <input type="checkbox"/> 5. PALLIATIVE CARE <input type="checkbox"/> 6. PSYCHIATRIC <input type="checkbox"/> 7. ACUTE CARE		NO. OF LEAVE DAYS	
PAYMENT STATUS ON SEPARATION					
<input type="checkbox"/> 1. PRIVATE <input type="checkbox"/> 2. GOVERNMENT COMP. <input type="checkbox"/> 3. MOTOR ACCIDENT <input type="checkbox"/> 4. VETERANS AFFAIRS <input type="checkbox"/> 5. INDIGENOUS <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. DISCHARGED 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 AUTOPSY <input type="checkbox"/> 7. DEATH WITHOUT AUTOPSY <input type="checkbox"/> 8. TRANSFER TO OTHER ACROSS TYPE CHANGE SEPARATION <input type="checkbox"/> 9. DISCHARGE ON LEAVE					
IF THE SEPARATION MEETS 1 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 MEETS 1 OR 6, WITH 11 ABOVE) *					
SECONDARY DIAGNOSSES 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					
<input type="checkbox"/> 1. HOME <input type="checkbox"/> 2. FARM		<input type="checkbox"/> 3. MEDICAL/PHARMACY <input type="checkbox"/> 4. RECREATION/SPORTS VENUE <input type="checkbox"/> 5. STREET/HIGHWAY		<input type="checkbox"/> 6. PUBLIC BUILDING <input type="checkbox"/> 7. RESIDENTIAL INSTITUTION	
<input type="checkbox"/> 8. OTHER SPECIFIED PLACE <input type="checkbox"/> 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 981 NORTH SYDNEY NSW 2056					

**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.