

1993—No. 113

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

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

NEW SOUTH WALES



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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

Commencement

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

Amendment

2. The Day Procedure Centres Regulation 1990 is amended by omitting Forms 6, 7 and 8 from Schedule 2 and by inserting instead the following forms:

1993—No. 113

PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988

REGISTER OF PATIENTS FORM 8

TRIPPLICATE
(G. 13)

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. SINGLE 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	ADMISSION WEIGHT (IF OVER ONE DAY)
PERSON FOR NOTIFICATION		RELATIONSHIP	PHONE	NAME OF REFERRING/ LOCAL MEDICAL OFFICER		PHONE
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.
ABDING/ALITY <input type="checkbox"/> 1. ABDING/ALITY <input type="checkbox"/> 2. TORCH ST. AL. <input type="checkbox"/> 3. NEITHER	READMISSION WITHIN 28 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	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. REHAB. CARE 4. MEDICAL CARE 5. PALLIATIVE CARE 6. PSYCHIATRIC CARE 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 CONTRACT 8. OTHER	MODE OF SEPARATION 1. DISCHARGED BY HOSP. 2. DISCHARGED OWN SPEN. 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 ACCLM. 9. TYPE CHANGE SEPARATION 10. DISCHARGE ON LEAVE			
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION) *						
DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR THE LENGTH OF STAY (IF DIFFERENT 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)						E
PLACE OF OCCURRENCE OF INJURY OR POISONING 1. HOME 2. MINE/QUARRY 3. INDUSTRIAL PREMISES 4. RECREATION/SPORTING VENUE 5. STREET/HIGHWAY 6. PUBLIC BUILDING 7. RESIDENTIAL INSTITUTION 8. OTHER SPECIFIED PLACE 9. UNSPECIFIED PLACE						
AMBULANCE CREDIT NUMBER						

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

FORM NO. PR15

1993—No. 113

PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988

ADMISSION FORM 7

ORIGINAL
(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. SINGLE 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	ADMISSION WEIGHT (OR PREVIOUS DAY)	
PERSON FOR NOTIFICATION		RELATIONSHIP	PHONE	NAME OF REFEREING/LEGAL MEDICAL OFFICER			PHONE
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	READMISSION WITHIN 28 DAYS	HOSPITAL INSURANCE <input type="checkbox"/> 1. NOT APPLICABLE <input type="checkbox"/> 2. THIS HOSPITAL <input type="checkbox"/> 3. OTHER HOSPITAL	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. CONVALENT CARE 3. REHABILITATION 4. REHABILITATION 5. PALLIATIVE CARE 6. PSYCHogeriatric 7. ACUTE CARE	PAYMENT STATUS ON SEPARATION <input type="checkbox"/> 1. PRIVATE 2. WORKERS COMP. 3. MOTOR ACCIDENT 4. VETERAN AFFAIRS 5. INELIGIBLE 6. DEFENCE FORCE 7. PUBLIC CONTRACT 8. OTHER	MODE OF SEPARATION 1. DISCHARGE BY HOSP. 2. DISCHARGED OWN RISK 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 ACCUM. 9. TYPE CHANGE SEPARATION 10. DISCHARGE ON LEAVE				
PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION)							
DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR THE LENGTH OF STAY (5 LINES OR 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 6. HOME 7. MARINE/ARMY 8. PUBLIC BUILDING 9. INDUSTRIAL PREMISES 10. STREET/ROADWAY		4. RECREATION/WORKING VENUE 5. STREET/ROADWAY		6. PUBLIC BUILDING 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. PR15							

1993—No. 113

PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988
IN-PATIENT STATISTICS FORM 8DUPLICATE
(CL. 14)

HOSPITAL		HOSPITAL CODE No.	MEDICAL RECORD No.
		SEX	
		<input type="checkbox"/> 1. MALE	<input type="checkbox"/> 1. MARRIED
		<input type="checkbox"/> 2. FEMALE	<input type="checkbox"/> 2. WIDOWED
			3. SEPARATED
			4. DIVORCED
			5. 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 WEIGHT (or residence weight)	
PART A			
ABORIGINALITY		READMISSION WITHIN 28 DAYS	HOSPITAL INSURANCE
<input type="checkbox"/> 1. ABORIGINAL <input type="checkbox"/> 2. TORRES ST. IS. <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. TOP COVER <input type="checkbox"/> 2. BASIC COVER <input type="checkbox"/> 3. NO COVER
EMERGENCY STATUS		SERVICE CATEGORY ON ADMISSION	PAYMENT STATUS ON SEPARATION
<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		<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. PSYCHIATRIC <input type="checkbox"/> 7. ACUTE CARE	<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. INELIGIBLE <input type="checkbox"/> 6. DEFENCE & FORCE <input type="checkbox"/> 7. PUBLIC CONTRACT <input type="checkbox"/> 8. OTHER
CONTRACT STATUS		WAS PATIENT ADMITTED TO A PSYCH. UNIT?	
<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO		<input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO	
DISCHARGE INTENTION		BABY STATUS	
<input type="checkbox"/> 1. TODAY <input type="checkbox"/> 2. OTHER		<input type="checkbox"/> 1. UNQUALIFIED <input type="checkbox"/> 2. QUALIFIED	ADMISSION DATE
		19	
		HOURS IN I.C.U.	
		NO. OF LEAVE DAYS	
		SEPARATION DATE	
		19	
		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 ACQUA. <input type="checkbox"/> 9. TYPE CHANGE SEPARATION <input type="checkbox"/> 10. DISCHARGE ON LEAVE	
		IF THE SEPARATION MODE IS 4 OR 5, 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)			
SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY			
PART B			
PRINCIPAL OPERATION OR MAJOR PROCEDURE			
OTHER OPERATIONS OR PROCEDURES			
EXTERNAL CAUSE OF INJURY OR POISONING (IF APPLICABLE)		E	
PLACE OF OCCURRENCE OF INJURY OR POISONING			
<input type="checkbox"/> 1. HOME <input type="checkbox"/> 2. FARM		<input type="checkbox"/> 3. MINING/QUARRY <input type="checkbox"/> 4. RECREATION/SPORTING VENUE <input type="checkbox"/> 5. STREET/HIGHWAY	
<input type="checkbox"/> 6. INDUSTRIAL PREMISES		<input type="checkbox"/> 7. PUBLIC BUILDING <input type="checkbox"/> 8. RESIDENTIAL INSTITUTION	
<input type="checkbox"/> 9. AMBULANCE CLIENT NUMBER		<input type="checkbox"/> 10. OTHER SPECIFIED PLACE <input type="checkbox"/> 11. UNSPECIFIED PLACE	
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 PO BOX 555 NORTH SYDNEY NSW 2059			

EXPLANATORY NOTE

The object of this Regulation is to amend the Day Procedure Centres 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.