**Unit 3: Hospital admission**

**Background:**

-A patient can be admitted to hospital in one of three ways:

1-as an outpatient (to see a consultant but not needing a bed)

2- as a day patient (needing a hospital bed for tests of minor surgery but not needing to stay overnight)

3- as an inpatient (needing to stay in hospital).

- It is relatively easy to organize beds for inpatients who come through **GP**, but not easy to predict numbers who come through **Accident and Emergency department.**

**-** a hospital has to keep a number of empty beds available, and makes estimates based on past statistics for the time of the year**.**

- **Medical records consist of material such as:**

* handwritten medical notes
* computerized files
* correspondence between health professionals
* laboratory reports
* x-ray films and scans
* photographs
* printouts from monitoring equipment.

**-The form that is filled in for every patient on admission contains:**

* basic personal details
* details of past hospitalizations and surgeries
* the name of a person to contact
* patient's insurance
* any **advance directives.**

**-Advance directives  are** instructions from the patient about what efforts should or should not be made to extend their life and who is to make medical decisions in the event of them being in a coma**.**

-The information is given a code number, and in many hospital it is written on a plastic bracelet and fixed to the patient's wrist.