



3 Hospital admissions

LANGUAGE

1 Grammar

Choose the correct option to complete the sentences.

- 1 The patient *is arriving / arrives / arrived* at 9.45 p.m. last night.
- 2 We *didn't called / didn't call / calling* an ambulance, because it wasn't necessary.
- 3 Did you *catch / caught / caught* your cold at school?
- 4 I *walked / am walking / was walking* when the dog attacked me.
- 5 **A** Did she interview the patient? **B** Yes, she *did / interviewed / do*.
- 6 What were you doing *while / when / during* you broke your leg?
- 7 She *didn't / wasn't / were* concentrating *while* she was driving.
- 8 They *were / was / been* in a fight.

2 Key words from the unit

Complete the sentences with the words from the list.

- 1 A triage nurse makes an initial _____.
- 2 A snake bite can be _____.
- 3 Sometimes it is difficult to read _____.
- 4 Receptionists make _____ for patients.
- 5 Arms and legs are called _____.
- 6 The doctor decides on the correct _____.
- 7 The patient is _____ to certain antibiotics.
- 8 Go into the _____ to get undressed.

cubicle
life-threatening
prescriptions
treatment
allergic
assessment
appointments
limbs

READING AND VOCABULARY

There are three ways to admit a patient to hospital: either as an outpatient, a day patient or an inpatient. An outpatient needs treatment but not a bed. A day patient needs a bed for a few hours, but doesn't need to stay overnight. An inpatient needs at least one overnight stay.

Hospitals need to plan for patient admissions. They have to predict how many beds they will need. It is quite easy to predict referrals from doctors like General Practitioners, but a larger number of patients come through A&E, and it is more difficult to plan for them.

It is very important to keep accurate records of patients' treatment, from admission through to discharge and follow-up. These include personal details such as marital status, occupation and next of kin, as well as medical history such as past illnesses and treatments, family history and lifestyle.

Medical staff record all treatments, test results and correspondence. They try to record these things at the time they happen. This is important, and not only to ensure the correct treatment. Medical records are sometimes used for research, or in a court of law.



3 Comprehension

According to the text, are the following statements true (T) or false (F)?

- 1 Admissions to hospital are all inpatients. _____
- 2 There are more emergency admissions than referrals. _____
- 3 Hospital records stop at discharge. _____
- 4 Personal details are part of medical records. _____
- 5 Staff should record treatments at the end of their shift. _____
- 6 Only medical staff can look at medical records. _____

4 Vocabulary

Match the words or phrases 1–7 to a suitable definition a–g.
The first one is done for you.

- | | |
|-------------------------|---|
| 1 <i>overnight stay</i> | a when a patient is sent to hospital |
| 2 admission | b normal, everyday behaviour |
| 3 referral | c treatment after a patient has been discharged from hospital |
| 4 discharge | d <i>time as an inpatient</i> |
| 5 follow-up | e letters, emails and messages |
| 6 correspondence | f the moment when a patient enters hospital |
| 7 lifestyle | g when a patient is told they can leave hospital |

5 Further vocabulary practice

Underline the correct words in italics to complete the sentences.
The first one is done for you.

- 1 We don't need beds for out / in / day patients.
- 2 Who is your *family history* / next of kin / occupation?
- 3 What is your *marital status* / past illnesses / personal details?
- 4 The new patient is a *referral* / admission / discharge from Cardiology.
- 5 We need you to come back to the hospital for *discharge* / follow-up / admission tests.
- 6 If you don't stop smoking and drinking so much, your *lifestyle* / test results / medical history may kill you.
- 7 After you sign the *discharge* / correspondence / record form, you can go home.



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