PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, or no later than 72 hours prior to admission.

TO BE COMPLETED BY PATIENT

Attach patient identification label

Patient Details

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

ADMISSION DETAILS

Admission Date:	☐ Day Stay or ☐ Overnight Stay
Operation Date (if different from admission date):	Preferred Accommodation: ☐ Private room (subject to availability) ☐ Shared room
Procedure / Reason for Admission:	
Admitting Doctor:	Have you been to this hospital before? ☐ Yes ☐ No

How did you find out about this hospital? ☐ Specialist ☐ GP ☐ Newspaper ☐ Internet ☐ Social Media ☐ Other ______

Have you been in ANY hospital within the past 28 days? ☐ Yes ☐ No If yes, which hospital? ______

Is this admission related? ☐ Yes ☐ No Date of hospitalisation: From ______ To ______

METHOD OF PAYMENT FOR THIS ADMISSION

☐ Private Health Insurance ☐ Self Funded ☐ Workcover ☐ TAC / Motor Vehicle ☐ DVA ☐ Public Patient ☐ Other ______

PATIENT DETAILS

Title:	Residential Address:
Surname:	
Given Name:	Suburb:
Middle Name:	State: Postcode:
Previous Surname / Maiden Name:	Home Ph: Work Ph:
Preferred Name (if different from above):	Mobile Ph:
DOB: Sex: ☐ Male ☐ Female Gender:	Email:
Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Widowed ☐ Separated ☐ Divorced	☐ I do NOT wish to receive SMS reminders ☐ I do NOT wish to receive a patient satisfaction survey
Religion: Religious Visit: ☐ Yes ☐ No	☐ Australian Resident ☐ Non Resident
Country of Birth:	Preferred Language: Interpreter: ☐ Yes ☐ No
Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Not Applicable ☐ ASSI (QLD Only)	Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Pensioner ☐ Retired ☐ Child ☐ Other: ______

GENERAL PRACTITIONER DETAILS

General Practitioner:	Phone: Fax:
Name of Practice:	☐ I do NOT wish for my GP to be notified of my admission & discharge
Address:	☐ I do NOT wish for my admission information to be uploaded to the My Health Record
Suburb: State: Postcode:	

REFERRING DOCTOR DETAILS

Is the doctor that referred you to your Admitting Doctor the same as the GP above? ☐ Yes ☐ No If no please complete the below details:

Referring Doctor:	Address:
Name of Practice:	Suburb: State: Postcode:
Phone:	Fax:

MEDICARE / CONCESSION CARD DETAILS

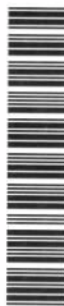
These cards may entitle patients to medicines at the concession rate & may be requested as proof of eligibility for subsidised medicine

Medicare Card No.: ☐☐☐☐☐☐☐☐☐☐	Healthcare Card No.: Expiry
Medicare Reference No.: ☐ Expiry:	Safety Net Card No.: Expiry
DVA Card No.:	Pension Card No.: Expiry
DVA Card Colour: ☐ Gold ☐ White ☐ Orange	Ambulance Membership No.: Expiry

PRIVATE HEALTH INSURANCE

Health Fund:	Level of Cover / Table:
Membership No.:	Have you confirmed your level of cover with your fund? ☐ Yes ☐ No

BINDING MARGIN – DO NOT WRITE IN THIS AREA



HS000540

PATIENT REGISTRATION FORM

HMR 1.0F

Print Media Group HSHGXBKS0011 12/19

PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, or no later than 72 hours prior to admission.

Attach patient identification label

Patient Details

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

TO BE COMPLETED BY PATIENT

NEXT OF KIN / EMERGENCY CONTACT 1		EMERGENCY CONTACT 2	
Title:	Relationship:	Title:	Relationship:
Surname:		Surname:	
Given Name:		Given Name:	
Address:		Address:	
Suburb:		Suburb:	
State:	Postcode:	State:	Postcode:
Home Ph:	Work Ph:	Home Ph:	Work Ph:
Mobile Ph:		Mobile Ph:	

POSTAL ADDRESS

☐ Same as residential address *If different please complete the details below:*

Postal Address:	Suburb:	
	State:	Postcode:

PERSON RESPONSIBLE FOR ACCOUNT *For any out of pocket expenses not covered by your insurer / fund*

☐ Self ☐ Emergency contact 1 ☐ Emergency contact 2 ☐ Other *If other please complete the details below:*

Surname:		Given Name:	
Address:		Relationship:	
Suburb:		Home Ph:	Work Ph:
State:	Postcode:	Mobile Ph:	

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY DETAILS *Written approval will be required prior to admission*

☐ Workcover ☐ Third Party ☐ Motor Vehicle ☐ Public Liability	Employer:	
Name of Insurer:	Contact Person:	
Date of Accident:	Employer Address:	
Location of Accident:		
Cause of Injury:	Suburb:	
Claim Number:	State:	Postcode:
Claim Approved? ☐ Yes ☐ No	Ph:	Fax:

COLLECTION, MANAGEMENT AND RELEASE OF INFORMATION

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our hospital (e.g. to your health fund, DVA, third party insurers such as Workcover, TAC, State Governments for public contract patients, the supplier / manufacturer of your prosthesis, to our insurer, to an external company contracted to evaluate customer satisfaction, your local doctor).
It may also be necessary for Healthscope to collect information about you from third party health care providers about your health. If you do not wish for us to collect certain information about you please tell us and we will discuss any consequences that this may have on your health care.
I authorise the release and collection of information about this admission. I certify that the information provided on this form is true and accurate to the best of my knowledge and I have read and understand the Admission Information brochure available on the hospital website, or provided with these forms.
I also consent to the collection, management and use of my personal and health information in accordance with Healthscope's Privacy Policy.

Patient or Guardians Signature ____________ Patient or Guardians full name ____________ Date ____________

BINDING MARGIN – DO NOT WRITE IN THIS AREA

PATIENT HEALTH HISTORY

Attach patient identification label

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

Patient Details

Please complete this form and forward to your admitting hospital at least 3 days prior to admission

Admission Date:........../........../..............

State reason for admission: ....

Previous operations and procedures: (Please list dates performed. Attach list if insufficient space).

....

....

....

....

....

....

....

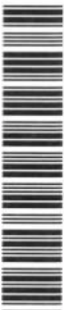
What is your: Height........................cm Weight........................kg

MEDICATION MANAGEMENT	NO	YES	DETAILS
Do you take or have you recently taken blood thinning medications (eg. aspirin / warfarin / clopidogrel)?	☐	☐	Specify: ....
If yes, and attending for surgery have you been told to stop this?	☐	☐	When were they ceased?....................
Have you had any steroid or cortisone injections in the last 12 months?	☐	☐	Specify: ....
Do you require assistance with taking medications? ie. dosette / crushed / webster packs	☐	☐	Specify: ....
Are you taking any prescription / non prescription or complimentary medicines?	☐	☐	***If YES, please bring these with you in original packaging***

Please list all medications below, or provide your Pharmacy card or a Medication list from your doctor.

Medication Name	Dose	Frequency	If known, I'm taking this for... (eg. blood pressure, Diabetes, etc)

BINDING MARGIN – DO NOT WRITE IN THIS AREA



HS000013

Print Media Group HSHGXFMR0045 12/19

PATIENT HEALTH HISTORY

Attach patient identification label

Patient Details

UR Number: ....
Surname: ....
Name: ....
Date of Birth: .... Gender: ....
Dr: ....

Please tick (✓) No or Yes to all of the following questions			*Provide details if requested below*
GENERAL HEALTH / PRE-SURGICAL INFORMATION	**NO**	**YES**	**DETAILS**
Do you have any allergies / sensitivities? ☐ Medication ☐ Tapes ☐ Latex ☐ Food ☐ Other....................	☐	☐	Please identify:.................... ....
Have you had any recent blood or urine tests / pathology?	☐	☐	Specify: .... Which pathology company?....................
Have x-rays / CT Scans / MRI been taken for this admission?	☐	☐	***Please bring with you.***
Females – are you pregnant or are you breastfeeding?	☐	☐	Due date if pregnant: ....
Have you, or a blood relative, had a problem with an anaesthetic?	☐	☐	Please describe: ....
Do you have sleep apnoea? Do you use a CPAP machine?	☐ ☐	☐ ☐	***Please bring your machine in with you.***
Special diet / Cultural Needs	☐	☐	Specify:....................
Do you drink alcohol?	☐	☐	How many standard drinks a week? ....
Have you smoked in the past month?	☐	☐	Ex smoker ☐ Date ceased:......./......../.........
Have you ever used recreational drugs?	☐	☐	Specify:....................
Prosthesis / artificial joints / metal pins or plates / stent or valve / Pacemaker / Defibrillator?	☐	☐	Specify: ....
Broken / loose / chipped teeth / dentures / crowns / plates or caps?	☐	☐	Specify:....................
Mobility issues	☐	☐	☐ Stick ☐ Walking Frame ☐ Wheelchair ☐ Bed bound ☐ Other ....
Fainting or dizzy spells / recent falls?	☐	☐	Specify:....................
DO YOU HAVE / HAVE YOU HAD ANY OF THE FOLLOWING?	**NO**	**YES**	**DETAILS**
Frequent headaches / migraines / neurological issues	☐	☐	Specify:....................
Stroke / TIAs / Head Injury	☐	☐	Specify:....................
Epilepsy / seizures	☐	☐	Specify:....................
Parkinson's / Multiple Sclerosis / Motor Neurone Disease	☐	☐	Mobility issues: ....
Short term memory loss / confusion / Alzheimer's / Dementia	☐	☐	Specify:....................
Had or having treatment for mental health condition	☐	☐	Current treatment: ☐ Yes ☐ No Specify:....................
Previous Suicide attempt or Suicidal / Self Harm Ideation	☐	☐	Specify:....................
Aggressive tendency or behaviour	☐	☐	Specify:....................

BINDING MARGIN – DO NOT WRITE IN THIS AREA

PATIENT HEALTH HISTORY

Attach patient identification label

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

Patient Details

DO YOU HAVE / HAVE YOU HAD ANY OF THE FOLLOWING?	NO	YES	DETAILS
Thyroid problems	☐	☐	Specify: ....
Difficulty swallowing / eating / speech impairment	☐	☐	Specify: ....
High or Low Blood Pressure	☐	☐	Specify: ....
Heart disease / rheumatic fever / palpitations / irregular heartbeat / heart murmur / angina / heart attack	☐	☐	Specify: ....
Lung disease / Asthma / bronchitis / emphysema / shortness of breath / pneumonia	☐	☐	Specify: .... Do you use: ☐ Nebulisers ☐ Inhalers ☐ Home oxygen
Blood disorder / blood clot / DVT / PE	☐	☐	Specify: ....
Blood transfusion and/or blood products	☐	☐	Specify: ....
Cancer / Leukaemia	☐	☐	Specify: ....
Diabetes ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes	☐	☐	Managed by: ☐ Diet ☐ Tablets ☐ Insulin Complications: ....
Reflux / stomach ulcer / hernia	☐	☐	Specify: ....
Kidney or bladder problems / Stoma / Incontinence	☐	☐	Specify: ....
Bowel disease (eg. Crohns, diverticulitis) / Stoma / Incontinence	☐	☐	Specify: ....
Skin issues / Wound / Broken skin / Pressure sores	☐	☐	Specify: ....
Arthritis	☐	☐	Specify: ....

OTHER MEDICAL CONDITIONS: ....

....

....

INFECTION CONTROL	NO	YES	DETAILS
Have you ever had a Multi Resistant Organism or been in household contact with someone who has? eg. MRSA, VRE, CPE, ESBL or Candida Auris	☐ ☐	☐ ☐	**Site:** Date identified: ..../......../........ ☐ Nose ☐ Groin ☐ Wound ☐ Rectal swab ☐ Faeces ☐ Other: .... Hospital where identified: ....
Do you have a current infection?	☐	☐	If Yes, where? ....
Do you have a cough, fever or acute respiratory illness?	☐	☐	Specify: ....

CJD RISK SCREENING	NO	YES
Do you have a family history of two or more first or second-degree relatives with CJD (Creutzfeldt-Jakob disease)?	☐	☐
Have you had an unexplained progressive neurological illness of less than 12 months?	☐	☐
Have you ever received human pituitary hormone for infertility or human growth hormone for short stature prior to 1986?	☐	☐
Have you had surgery on the brain or spinal cord that included a dura mater graft (prior to 1990)?	☐	☐
Have you been involved in a 'look-back' for CJD or shown a 'medical in confidence letter' regarding your risk for CJD?	☐	☐

If the patient answers YES to CJD questions, clarification / advice must be sought from the Infection Control Manager

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PATIENT HEALTH HISTORY

Attach patient identification label

UR Number: ....

Surname: ....

Name: ....

Date of Birth: .... Gender: ....

Dr: ....

Patient Details

HOME SITUATION	NO	YES	DETAILS
Do you live: ☐ with Family ☐ Alone ☐ High Care ☐ Low Care	☐	☐	Care Facility details: ....
Do you anticipate any difficulties returning to your place of residence?	☐	☐	Specify: ....
Are you already receiving assistance at home?	☐	☐	Specify: ....

Please be aware on discharge it is in your best interest to:

1. Have a responsible adult to accompany you home.
2. Understand the importance of following the instructions regarding your ongoing care.
3. Be aware of the danger to yourself / others and not drive a motor vehicle or operate machinery for 24 hours following any sedation, Anaesthetic or strong pain medication.

Patient / carer / relative / guardian signature: ✕ Date:

Pre Admission Nurse signature / Print: Date:

NURSES TO COMPLETE ON ADMISSION

HANDOVER OF CARE: *Nursing staff to check and complete this form and initiate referrals if considered appropriate*

All alerts / allergies documented and communicated on Alert Sheet HMR 000	☐ YES		☐ N/A
ID Band/s and identity confirmed (as per Site policy)	☐ YES		
Valuables stored according to local policy / sent home with relatives / carers?	☐ YES	☐ NO	☐ N/A
The VMO, Surgeon and Anaethetist have been notified of any clinical or medication issues.	☐ YES	☐ NO	☐ N/A

INFECTION SCREENING

General health questions to be asked of the patient on admission:

- Have you had a fever and either a cough or sore throat in the past 2 days? ☐ YES ☐ NO
- Have you had a fever associated with a rash in the last week? ☐ YES ☐ NO
- Have you had a sudden onset of vomiting and/or diarrhea in the past 2 days? ☐ YES ☐ NO

Overseas Healthcare

- Have you been admitted to, transferred from or stayed overnight in any overseas healthcare facility in the past 12 months? ☐ YES ☐ NO
- Have you resided in an overseas Residential Aged Care Facility in the past 12 months? ☐ YES ☐ NO

If YES to any of these questions, staff must contact the Bed Manager, Hospital Coordinator or Infection Control Manager to report this information and gain advice on their care in the clinical area.

I have reviewed the Patient Health History and taken necessary actions

Admitting nurse Signature / Print name: Designation: Date: Time:

BINDING MARGIN – DO NOT WRITE IN THIS AREA