



**ST VINCENT'S
HEALTH AUSTRALIA**

PATIENT REGISTRATION FORM

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: _____ ADM No: _____
 SURNAME: _____
 GIVEN NAMES: _____ SEX: _____
 DATE OF BIRTH: _____ PHONE No: _____
 ADDRESS: _____

TO BE COMPLETED BY CONSULTING ROOMS

Admission Date: _____ Admission Time: _____ Overnight + Day Stay Only
 Procedure/Operation: _____ Date: _____
 Admitting Doctor : _____ Preferred Accommodation: Shared Private
 Anaesthetist : _____ Other Medical Practitioners: _____

PERSONAL DETAILS TO BE COMPLETED BY PATIENT

PLEASE ENSURE WE RECEIVE THIS PAPERWORK 7 DAYS PRIOR TO YOUR ADMISSION

Have you previously been a patient at St Vincent's Private Hospital, Yes No
 Have you been a patient in any other hospital within the last 28 days: Yes No Which Hospital? _____

Title: Mr Mrs Miss Ms Mstr Sr Fr Br Dr Other _____

Surname: _____ Previous Surname: _____

Given Names: _____

Address: _____ Suburb: _____ Postcode: _____

Phone No (Home): _____ (Work): _____ (Mobile): _____

Are you willing to receive an SMS from the hospital

Sex Male Female Date of Birth: ____/____/____ Age _____ Marital Status: _____

Religion _____ Country of Birth: _____ Which state?: _____

Aboriginal/Torres Strait Islander: Yes No Language Spoken _____

Medicare Number - - Reference number (left of patient name)

Medicare Expiry Date: ____/____/____ Pension/Health Care Card No.: _____

DVA - Veterans Affairs No.: _____ Gold White Safety Net No.: _____

Ambulance Membership Yes No Membership No.: _____

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for your account?

Private Health (see below) Uninsured DVA

Workcover (see over) TAC (see over)

PRIVATE HEALTH INSURANCE

Fund: _____ Membership No.: _____

DOCTOR DETAILS

Name of GP: _____

GP Address: _____

GP Phone No: _____ GP Fax No: _____

PLEASE TURN OVER

PATIENT REGISTRATION

MR1



NEXT OF KIN - FIRST CONTACT

Surname: _____ Given Name: _____ Relationship to patient: _____
 Address: _____ Suburb: _____ Postcode: _____
 Phone No (Home) _____ (Work): _____ (Mobile): _____

ADDITIONAL CONTACT PERSON

Surname: _____ Given Name: _____ Relationship to patient: _____
 Address: _____ Suburb: _____ Postcode: _____
 Phone No (Home): _____ (Work): _____ (Mobile): _____

MEDICAL POWER OF ATTORNEY

Surname: _____ Given Name: _____
 Address _____ Phone No: _____

Do you have an Advanced Care Directive? Yes No

WORKCOVER

Name of Employer _____
 Address: _____ Suburb: _____ Postcode: _____
 Phone No: _____ Date of Accident _____
 Has Employer accepted liability? Yes No If yes, attach acceptance letter
 Has an Insurance Company accepted liability for admission? Yes No
 Name of Insurance Company: _____ Claim Number _____
 Case Manager: _____ Phone No: _____

TAC

Date of accident: _____ TAC Claim No: _____

Support Co-ordinator / Rehabilitation Officer: _____

If you have ticked Work Cover or TAC please note:

Approval of your application is necessary prior to admission. The TAC or Work Cover will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and they have accepted liability for your hospitalisation, treatments and other associated costs.

If TAC or Work Cover do not accept liability for your hospitalisation, treatments and other associated costs, then you may be admitted under your private insurer.

DECLARATION CONCERNING CLAIM (The accurate answers to these questions are an essential part of this claim)

Patient/Guardian to complete (please tick (✓) below)	Yes	No
Do you have entitlement to claim compensation or damages (including previous settlements)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lodged a claim for compensation or damages?	<input type="checkbox"/>	<input type="checkbox"/>
Did the injury or condition occur at work, going to or from work or as a result of being at work?	<input type="checkbox"/>	<input type="checkbox"/>
Did the hospitalisation result from a motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>
Did the hospitalisation result from any other type of accident?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient a full-time student dependant over 17 years and under 25 years?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, name of educational institution:
 Date patient was first aware of symptoms: / / Date patient first consulted a doctor for symptoms: / /

- I hereby declare and warrant that all the above information provided in connection with this claim is true and correct.
- I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.
- I authorise my health fund to pay benefits directly to the hospital.

Patient's/
Guardian's Signature: Date: / /



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TO BE COMPLETED BY PATIENT PRIOR TO YOUR ADMISSION

Interpreter required No Yes Language _____
 Form completed by Patient Parent Relative/Carer, specify _____ Staff member
 I understand that the hospital is a teaching hospital & I have read the section titled "Teaching & Learning" in the Patient Information Booklet

Have you been in hospital in the last 2 months? Yes No
 Reason? _____ How long? _____

Reason for this admission and history or presenting illness:

If reason for admission is the result of an accident, please state:
 When injury occurred: _____ Where injury occurred (eg. Football field): _____
 How injury occurred: _____

Medical/Surgical History: List the medical conditions/operations performed and date (attach list if insufficient space)

CURRENT MEDICATIONS

Current medications – please list ALL medications including complementary medications and bring these to hospital in their original containers (attach a list if insufficient space)

DRUG NAME	DOSE	FREQUENCY / TIME	Staff use

MEDICATIONS

Do you take or have you recently taken blood thinning medication or natural blood thinning medication? Yes No
 Is your admitting doctor aware of this? Yes No
 Have you been told to cease this? Yes No
 Date to cease ____ / ____ / ____ Date last taken ____ / ____ / ____
 Have you been told to start any other treatment eg clexane? Yes No
 Have you taken any steroids or cortisone tablets/injections in the last 6 months? Yes No
 If yes. specify _____ Date last taken ____ / ____ / ____

Staff use

Patient aware of management plan
 Notified required and completed
 Surgeon
 Anaesthetist
 Theatre
 Ward
 DPU



SVPHM
P39
09/16

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

ALLERGIES			Staff use
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes please tick appropriate box and name allergies and give details)			Entered on IBA
<input type="checkbox"/> Drug or Natural Remedy Allergy	<input type="checkbox"/> Latex / Rubber Allergy		<input type="checkbox"/>
<input type="checkbox"/> Adhesive Tapes Allergy	<input type="checkbox"/> Food Allergy		____/____/____
<input type="checkbox"/> Lotions Allergy	<input type="checkbox"/> Other Allergy		
PATHOLOGY / X-RAYS OR OTHER TEST RESULTS			Staff use
Has your surgeon ordered blood tests / pathology / autologous blood for THIS admission <input type="checkbox"/> Yes <input type="checkbox"/> No			Results available?
Name of Pathology Service: _____ Date of test _____			<input type="checkbox"/> In File
Have you had a recent ECG / Echocardiogram? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Online
Have X-rays been taken for this admission? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Not available
If Yes – please make sure you bring them with you			<input type="checkbox"/> With Patient
			<input type="checkbox"/> With Doctor
GENERAL MEDICAL HISTORY	YES (Please Tick)	NO	Comments & Further Information
Heart Disease including Heart Attack / Angina			Details/Date:
(Please Circle) High Blood Pressure High Cholesterol			Details: Name of treating Dr:
(Please Circle) Peripheral Vascular Disease palpitation, irregular heart beat / heart murmur			
(Please Circle) Implanted devices / prosthesis (eg joint / heart valve / lapband / stents / stimulators/ shunts/eye lens/other Pacemaker – last checked ____ / ____ / ____			Type & brand of implant: Is surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No Bring ID information if applicable
Diagnosed Sleep Apnoea CPAP <input type="checkbox"/> Mouth Guard <input type="checkbox"/>			Bring CPAP Machine to hospital Mouth Guard <input type="checkbox"/>
(Please Circle) Asthma / bronchitis / emphysema / shortness of breath / hay fever / pneumonia / TB			Treatment (Please Tick) <input type="checkbox"/> Oral Steroids <input type="checkbox"/> Puffers <small>Please bring all Asthma medications</small> <input type="checkbox"/> Nebulisers <input type="checkbox"/> Home Oxygen
Anaesthetic Reactions			Details
Family history of anaesthetic reactions			
Problems with extending neck fully?			
Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>			Controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin <input type="checkbox"/> Pump
Do you have instructions how to manage your diabetes on the day of surgery?			Specialist details:
(Please Circle) Blood Disorders / bleeding problems / bruise easily / anaemia			Details
Blood clots in legs			Specify
Blood clots in lungs			Is Surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion Blood Transfusion reaction			Date of last transfusion ____ / ____ / ____ Type of reaction
Arthritis			Details:
Infectious diseases: HIV / sexual / hepatitis or other infections			Specify Treatment:
Elimination issues: bowel or bladder problems / incontinence / stoma therapy			Specify
(Please Circle) Skin conditions – existing wounds / fistula / pressure areas / ulcers / broken skin or reddened due to friction or pressure			Details and current treatment:

Name: _____

Date of Birth: ____ / ____ / ____

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO	Comments & Further Information	Staff use
(Please Circle) Epilepsy / fits / seizure			Last Seizure: Treatment:	
(Please Circle) Strokes / mini strokes / MS / Motor Neurone Disease / brain surgery			Any residual weakness or symptoms?	
Parkinson's Disease			Treatment:	
(Please Circle) Short Term Memory loss / confusion / dementia			Details:	
(Please Circle) Mental illness / nervous breakdown / anxiety attacks / depression / psychosis			Details:	
Have you ever experienced drug or alcohol withdrawal?			Specify:	
Have you been diagnosed with chronic pain?			Specify:	
Faints / Black outs / dizzy spells / Migraine			Details:	
Fall in the past 12 months			Details:	Falls Risk Assessment <input type="checkbox"/> By PAC <input type="checkbox"/> On Admission
Physical Disability – Mobility aids			Specify: Please bring to hospital	
Reflux / hiatus hernia / gastric ulcers Renal impairment eg. dialysis				
Cancer			Location: Date diagnosed ____ / ____ / ____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy	
Pregnant N/A			Due date ____ / ____ / ____	If yes, advise anaesthetist
Last menstrual period			Date ____ / ____ / ____	
Breastfeeding N/A				
Impairment <input type="checkbox"/> Vision <input type="checkbox"/> Hearing			Aids used:	
Do you have glaucoma?			Treatment:	
Dental problems			Specify:	
Do you have dentures			Specify:	
Limited jaw movement			<input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Loose teeth	
INFECTION CONTROL ASSESSMENT				Staff use
(Please Circle) Have you had a cough/cold/ chest infection recently?			Currently taking antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No	Infection Control notified <input type="checkbox"/> <input type="checkbox"/> Yes No ____ / ____ / ____
Have you had any illnesses such as gastroenteritis, or been in contact with someone who has had chicken pox within the last 14 days			Specify:	
Do you have a FAMILY HISTORY of Creutzfeldt Jacob Disease (CJD) or progressive neurological disorder of less than 12 months duration?				Staff use Infection Control notified <input type="checkbox"/> <input type="checkbox"/> Yes No ____ / ____ / ____
Do YOU have acute dementia or progressive neurological disorder of less than 12 months duration?				Infection Control to manage <input type="checkbox"/> <input type="checkbox"/> Yes No ____ / ____ / ____
Were you a recipient of a dura mater graft prior to 1990?				____ / ____ / ____
Have you been a recipient of human pituitary-derived hormones for infertility or short stature prior to 1985?				No further action required as per plan <input type="checkbox"/> <input type="checkbox"/> Yes No ____ / ____ / ____
Have you been involved in a "Look Back" study for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD?				

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

LIFESTYLE	YES NO (Please Tick)	Staff use
Do you smoke?	<input type="checkbox"/>	Consider Nicotine patches
Have you ever smoked regularly?	<input type="checkbox"/>	
Have you discussed nicotine replacement therapy or cessation with your Doctor?	<input type="checkbox"/>	
Alcohol intake	<input type="checkbox"/>	Amount: Frequency:
Recreational drug use?	<input type="checkbox"/>	Type:
NUTRITIONAL ASSESSMENT		Staff use
Height _____ cms Weight: _____ kgs		BMI = Hovermat in IBA <input type="checkbox"/> ___ / ___ / ___
Have you lost weight recently without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No = 0 <input type="checkbox"/> Unsure = 2		
If yes to weight loss: <input type="checkbox"/> 1-5kg = 1 <input type="checkbox"/> 6-10kg = 2 <input type="checkbox"/> 11-15kg = 3 <input type="checkbox"/> >15kg = 4		Nutritional Assessment
Have you been eating poorly due to a decrease in appetite? <input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0		
Food intolerance or allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Describe exact food and response		
Special dietary needs <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify:		Score of 2 or above – refer to dietician <input type="checkbox"/> ___ / ___ / ___
Do you require assistance with meals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cut up <input type="checkbox"/> Packets opened <input type="checkbox"/> Special utensils <input type="checkbox"/> Assistance with eating		
Day Surgery Patients Discharge Plan		
ALL PATIENTS UNDERGOING DAY PROCEDURES MUST HAVE AN ESCORT HOME AND A CARER OVERNIGHT		
Who is taking you home? Name: _____ Phone No: _____		
Who is staying with you overnight? Name: _____ Phone No: _____		
Overnight Patient Discharge Plan (NOTE – DISCHARGE TIME IS 9.30AM)		Staff use
Living arrangements <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner with Carer <input type="checkbox"/> With Family <input type="checkbox"/> Other, specify		Issues identified
Home environment <input type="checkbox"/> House/flat/apartment <input type="checkbox"/> SRS <input type="checkbox"/> Nursing Home <input type="checkbox"/> Retirement Village <input type="checkbox"/> Hostel <input type="checkbox"/> Other, specify		
At home there are <input type="checkbox"/> Steps <input type="checkbox"/> Ramps/rails <input type="checkbox"/> External toilet <input type="checkbox"/> Shower chair <input type="checkbox"/> Separate shower <input type="checkbox"/> Shower over bath <input type="checkbox"/> Toilet Frame <input type="checkbox"/> Bathroom handrails <input type="checkbox"/> Toilet handrails <input type="checkbox"/> Stairs Are the stairs available <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Home Health <input type="checkbox"/> Social Work ___ / ___ / ___
Activity assessment – Do you cope independently with daily living activities eg showering, dressing? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify assistance required _____		
Support services <input type="checkbox"/> No services <input type="checkbox"/> Family / Friends <input type="checkbox"/> Personal carer <input type="checkbox"/> Delivered meals at home <input type="checkbox"/> Shopping <input type="checkbox"/> Home Nursing <input type="checkbox"/> Home Help <input type="checkbox"/> Personal alarm <input type="checkbox"/> Care package Case Manager _____ Phone No: _____		<input type="checkbox"/> O.T. <input type="checkbox"/> N/A
Name of GP: _____ Phone No: _____ Fax No: _____		
Do you plan to return to your current accommodation directly from hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, specify plans:		
Are you a carer for others at home? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify:		
Any additional patient information: _____ _____ _____		
Signature _____ Date ___ / ___ / ___ Time _____		
Pre-Admission Form Sighted / Triage <input type="checkbox"/> Green No - Further Action Required <input type="checkbox"/> Orange <input type="checkbox"/> Red <input type="checkbox"/> Refer to MR2B Signed: _____ Date: ___ / ___ / ___		
Unit Nurses Signature: _____ Date: ___ / ___ / ___ Time: _____		