ST VINCENT'S PRIVATE COMMUNITY HOSPITAL
GRIFFITH

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) ☐ Third Party(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

SVPHM
P32A
09/16

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:_____

THIRD PARTY

Date of accident: _____ Third Party Claim No:_____

Support Co-ordinator / Rehabilitation Officer:_____

If you have ticked Work Cover or Third Party please note:

Approval of your application is necessary prior to admission. The Third Party 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 Third Party 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)?	☐	☐
Have you lodged a claim for compensation or damages?	☐	☐
Did the injury or condition occur at work, going to or from work or as a result of being at work?	☐	☐
Did the hospitalisation result from a motor vehicle accident?	☐	☐
Did the hospitalisation result from any other type of accident?	☐	☐
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	☐	☐
Is the patient a full-time student dependant over 17 years and under 25 years?	☐	☐

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:** / /

ST VINCENT'S HEALTH AUSTRALIA

PATIENT REGISTRATION FORM

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UR No: _____ ADM No: _____

SURNAME: _____

GIVEN NAMES: _____ SEX: _____

DATE OF BIRTH: _____ _____ PHONE No: _____

ADDRESS: _____

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 occured: _____ Where injury occured (eg. Football field): _____

How injury occured: _____

_____

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

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

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PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

ALLERGIES

Staff use

Do you have any allergies? ☐ Yes ☐ No (If yes please tick appropriate box and name allergies and give details)

Entered on IBA ☐ ___/___/___

☐ Drug or Natural Remedy Allergy	☐ Latex / Rubber Allergy
☐ Adhesive Tapes Allergy	☐ Food Allergy
☐ Lotions Allergy	☐ Other Allergy

PATHOLOGY / X-RAYS OR OTHER TEST RESULTS

Staff use

Has your surgeon ordered blood tests / pathology / autologous blood for **THIS admission** ☐ Yes ☐ No

Name of Pathology Service: _____ Date of test _____

Have you had a recent ECG / Echocardiogram? ☐ Yes ☐ No

Have X-rays been taken for this admission? ☐ Yes ☐ No
If Yes – please make sure you bring them with you

Results available?
☐ In File
☐ Online
☐ Not available
☐ With Patient
☐ With Doctor

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO (Please Tick)	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? ☐ Yes ☐ No Bring ID information if applicable	Ward / Theatre Notified ☐ __ / __ / __
Diagnosed Sleep Apnoea CPAP ☐ Mouth Guard ☐			Bring CPAP Machine to hospital Mouth Guard ☐	
(Please Circle) Asthma / bronchitis / emphysema / shortness of breath / hay fever / pneumonia / TB			Treatment (Please Tick) ☐ Oral Steroids ☐ Puffers ☐ Nebulisers ☐ Home Oxygen Please bring all Asthma medications	
Anaesthetic Reactions			Details	Anaesthetic referral ☐ __ / __ / __
Family history of anaesthetic reactions				
Problems with extending neck fully?				
Diabetes Type 1 ☐ Type 2 ☐			Controlled by ☐ Diet ☐ Tablet ☐ Insulin ☐ 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	VTE Assessment ☐ PAC ☐ On Admission
Blood clots in lungs			Is Surgeon aware? ☐ Yes ☐ 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:	Infection Control ☐ __ / __ / __
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:	Pressure Ulcer Assessment ☐ By PAC ☐ On Admission

Name: _____

Date of Birth: _____ / _____ / _____

GENERAL MEDICAL HISTORY	YES	NO (Please Tick)	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 withdrawl?			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 ☐ By PAC ☐ On Admission
Physical Disability – Mobility aids			Specify: Please bring to hospital	
Reflux / hiatus hernia / gastric ulcers Renal impairment eg. dialysis				
Cancer			Location: Date diagnosed ___ / ___ / ___ ☐ Chemotherapy ☐ Radiotherapy	
Pregnant N/A			Due date ___ / ___ / ___	If yes, advise anaesthetist
Last menstrual period			Date ___ / ___ / ___	
Breastfeeding N/A				
Impairment ☐ Vision ☐ Hearing			Aids used:	
Do you have glaucoma?			Treatment:	
Dental problems			Specify:	
Do you have dentures			Specify:	
Limited jaw movement			☐ Caps ☐ Crowns ☐ Loose teeth	

INFECTION CONTROL ASSESSMENT				Staff use
(Please Circle) Have you had a cough/cold/ chest infection recently?			Currently taking antibiotics? ☐ Yes ☐ No Surgeon aware? ☐ Yes ☐ No	Infection Control notified ☐ 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 Creutzfelt Jacob Disease (CJD) or progressive neurological disorder of less than 12 months duration?				**Staff use** Infection Control notified ☐ Yes ☐ No __ / __ / __
Do YOU have acute dementia or progressive neurological disorder of less than 12 months duration?				Infection Control to manage ☐ Yes ☐ No __ / __ / __
Were you a recipient of a dura mater graft prior to 1990?				No further action required as per plan ☐ Yes ☐ No __ / __ / __
Have you been a recipient of human pituitary-derived hormones for infertility or short stature prior to 1985?				
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

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

LIFESTYLE	YES (Please Tick)	NO (Please Tick)		Staff use
Do you smoke?			Daily amount: _____	Consider Nicotine patches
Have you ever smoked regularly?			Date ceased: ___ / ___ / ___	
Have you discussed nicotine replacement therapy or cessation with your Doctor?				
Alcohol intake			Amount: Frequency:	
Recreational drug use?			Type:	

NUTRITIONAL ASSESSMENT

Staff use

Height _____cms Weight: _____kgs

Have you lost weight recently without trying? ☐ Yes ☐ No = 0 ☐ Unsure = 2

If yes to weight loss: ☐ 1-5kg = 1 ☐ 6-10kg = 2 ☐ 11-15kg = 3 ☐ >15kg = 4

Have you been eating poorly due to a decrease in appetite? ☐ Yes = 1 ☐ No = 0

Food intolerance or allergies ☐ Yes ☐ No Describe exact food and response

Special dietary needs ☐ Yes ☐ No

Please specify:

Do you require assistance with meals ☐ Yes ☐ No

☐ Cut up ☐ Packets opened ☐ Special utensils ☐ Assistance with eating

Staff use: BMI= Hovermat in IBA ☐ __ / __ / __

Nutritional Assessment

Score of 2 or above – refer to dietician ☐ __ / __ / __

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 ☐ Alone ☐ Spouse/Partner with Carer ☐ With Family ☐ Other, specify

Home environment ☐ House/flat/apartment ☐ SRS ☐ Nursing Home ☐ Retirement Village ☐ Hostel ☐ Other, specify

At home there are ☐ Steps ☐ Ramps/rails ☐ External toilet ☐ Shower chair ☐ Separate shower ☐ Shower over bath ☐ Toilet Frame ☐ Bathroom handrails ☐ Toilet handrails ☐ Stairs Are the stairs available ☐ Yes ☐ No

Activity assessment – Do you cope independently with daily living activities eg showering, dressing?

☐ Yes ☐ No, specify assistance required _____

Support services at home ☐ No services ☐ Family / Friends ☐ Personal carer ☐ Delivered meals ☐ Shopping ☐ Home Nursing ☐ Home Help ☐ Personal alarm ☐ Care package Case Manager _____ Phone No: _____

Name of GP: _____ Phone No: _____ Fax No: _____

Do you plan to return to your current accommodation directly from hospital? ☐ Yes ☐ No

If No, specify plans:

Are you a carer for others at home? ☐ Yes ☐ No Specify:

Staff use: Issues identified

Referred ☐ Home Health ☐ Social Work __ / __ / __

☐ O.T. ☐ N/A

Any additional patient information:

_____

_____

_____

Signature _____ Date ___ / ___ / ___ Time _____

Pre-Admission Form Sighted / Triage ☐ Green No - Further Action Required ☐ Orange ☐ Red

☐ Refer to MR2B Signed: _____ Date: ___ / ___ / ___

Unit Nurses Signature: _____ Date: ___ / ___ / ___ Time: _____