Western Private Hospital

PATIENT REGISTRATION

PLEASE COMPLETE ALL 6 PAGES PRIOR TO SUBMITTING FORM. OPTION TO SUBMIT IS AT END OF FORM. (Form must be saved locally before filling in)

Please follow the following instructions for filling the form

Step 1: Download/save form first onto your computer.
DO NOT complete the form in Browser.
DO NOT complete the form before downloading/saving it on local PC.Á

Step 2: Open the downloaded/saved form in Adobe Reader. You may need to download/install Adobe Acrobat Reader before you start.

Step 3: Complete the form by typing in all the required fields (in red) and all other fields as applicable. To avoid delays at the time of admission, please complete all relevant fields.

Step 4: You can save the filled form at any time by clicking on File/Save or File/Save As option in Adobe reader menu bar

Step 5: Once completed and saved, Click on **'Submit'** button in the end of form to e-mail it to **preadmissions@westernprivate.com.au**

Alternatively, you can attach completed form and e-mail it using your e-mail to **preadmissions@westernprivate.com.au**

Additional information for Mac users:

In OS X, Apple's 'Preview' is the default application for opening a number of file types, including PDF's Preview will NOT allow you to complete this PDF form with editable content.
Follow these instructions to set Adobe Acrobat Reader as the default application for opening PDF files.

Step 1: Single click on WESTPH_MR100_MR200-for-web PDF file already saved on the local computer while holding the Control key. Select GET INFO from the menu you've opened.

Step 2: Click on the drop down menu for OPEN WITH

Step 3: Select ADOBE ACROBAT READER from the menu

Step 4: Click on CHANGE ALL button to keep the changes

Step 5: Complete the form using Adobe Acrobat Reader

Submitting completed form:

Via email (preferred method) to:
preadmissions@westernprivate.com.au

or, Mail to:
Western Private Hospital
P.O. Box 4258,
West Footscray
VIC 3012

or, Fax to:
03 9319-3184

or, Print and drop completed form to:
Western Private Hospital
1-9 Marion Street,
Footscray
VIC 3011

MR 100

Western Private Hospital

PATIENT REGISTRATION

PLEASE COMPLETE ALL 6 PAGES PRIOR TO SUBMITTING FORM. OPTION TO SUBMIT IS AT END OF FORM.
(Form must be saved locally before filling in)

Attach patient identification label

Patient Details

UR No: .... Admission No: ....

Surname: ....

Given Name: ....

Date of Birth: DD/MM/YYYY Gender: ....

Dr: ....

Specialist	**Diagnosis**
Admission Date DD/MM/YYYY **Same Day admission** **Overnight Admission**	**Procedure**

OUR ADMISSION STAFF WILL CONTACT YOU PRIOR TO YOUR ADMISSION REGARDING ANY OUT OF POCKET EXPENSES AND TO CONFIRM YOUR TIME OF ADMISSION

PATIENT DETAILS

Title Surname Maiden Name

Given Name | D.O.B. | Sex Male Female

Address | Post Code

Postal address | Post Code

Telephone (Home) | Telephone (Work) | Mobile

Email address

Marital Status Single Married Defacto Separated Divorced Widowed

Country of Birth | If Australia, Name State | Resident of Australia No Yes

Are you of Aboriginal / Torres Strait Islander (TSI) Origin? No Yes | If YES (please select) Aboriginal Torres Strait Islander Both

Interpreter Required No Yes | Preferred Language

Religion ☐ Consent for Clergy Visit

PERSON TO CONTACT

Next of Kin | Relationship | Tel (H) | Mobile

Second Contact | Relationship | Tel (H) | Mobile

LOCAL DOCTOR - Your GP may be notified of your admission – please advise staff on admission if you do not wish this to occur

Usual GP | Telephone

Address

REFERRING DOCTOR (The Doctor who referred you to your specialist for this admission)

Name | Telephone

Address

Pharmacy Name | Telephone

PREVIOUS HOSPITALISATION

Have you ever been a patient at Western Private Hospital before? No Yes If Yes - When? (year)

Have you been hospitalised within 7 days prior to this admission? No Yes

If YES - Which hospital? | Dates:

MEDICAL RECORDS AND PRIVACY

Records will be kept of your condition and treatment. They are confidential. The contents will be divulged only with your consent or where justified by law. Western Private Hospital complies with the Privacy Act 1988, including the way in which we collect, store, use and disclose health 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 (eg. to your health fund, DVA, the Supplier / manufacturer of your prosthesis, to our insurer, your local doctor).

A full version of our Privacy Policy is available on our website: http://westernprivatehospital.com.au/patients-visitors/privacypolicy/

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

TO BE COMPLETED BY PATIENT

PATIENT REGISTRATION

MR 100

BINDING MARGIN – DO NOT WRITE IN THIS AREA

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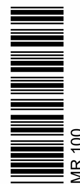

FINANCIAL INFORMATION

Attach patient identification label

UR No: .... Admission No: ....

Surname: ....

Name: ....

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

Dr: ....

Patient Details

PERSON RESPONSIBLE FOR ACCOUNT		
Title Surname	Given Name/s	
Address		Postcode
Telephone (Home)	Telephone (Work)	Mobile
Email address		

ENTITLEMENTS		
Medicare No. ☐☐☐☐☐☐☐☐☐☐ Number next to patient name ☐ Valid to	Pension No.	Expiry Date
	Health Care Card No.	Expiry Date
	Ambulance No.	Expiry Date
Safety Net Card No N Yes	Card No.	

How will this admission be claimed? - please tick one	
Private Health Insurance - Please complete section A	Repat/Veterans Affairs-Please complete Veterans Affairs VX No.
Workcover - Please complete section B	Uninsured/Travel or Overseas Insurance - Please contact us on 9318 3177 for an estimate of your hospital costs. - These costs are payable on admission
TAC or Third Party - Please complete section C	
Veterans Affairs VX No.	DVA Card Colour Gold White

SECTION A: Private Health Insurance		
Health Insurance Fund	Table / Level of Cover	
Membership No.	Date Joined	Date Paid to
Excess	Excess paid this year	Co-payments

Western Private Hospital recommends that you confirm your level of cover with your health fund prior to your admission to ensure that you are covered for this admission and any procedure performed. Certain levels of cover have out of pocket costs that patients are required to pay for their hospitalisation.

These costs not covered by your health fund are payable on admission. Any additional fees (ie. pharmacy) are payable on discharge.

SECTION B: Workcover	
Employers Name / Address	
Contact Person at Workplace	Telephone
Date of Injury	
Name of Work Insurance Co.	Claim Number
Contact Person at Insurance Co.	
Has your claim been accepted by Workcover?	

SECTION C: TAC or Third Party	
Date of Injury	Accident location
TAC Claim Number	Contact Person at TAC
Has your claim been accepted by TAC?	

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MR 200

Western Private Hospital

PRE-ADMISSION HEALTH QUESTIONNAIRE

Attach patient identification label

Patient Details

UR No: .... Admission No: ....

Surname: ....

Given Name: ....

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

Dr: ....

Admission Date:		STAFF USE ONLY	Admission Text Tracking			Initial of Staff Member ↓
Admission Time:			Text Sent	Date:	Time:	
			Response Received	Date:	Time:	

PATIENT HISTORY - *Please tick appropriate box.*				**STAFF USE ONLY**
Reason for Admission / Operation:				
Proposed operation / procedure:				
Do you require an interpreter?	No	Yes	Language:	Refer Policy C30P
Do you have any religious / cultural needs:	No	Yes	Specify:	
Height:	Weight:		BMI (Staff Use Only):	Theatre notified if BMI >40

ALLERGIES - *Please document any known allergies.*			**STAFF USE ONLY** *Please initial*
Latex allergy: No Yes	Drug allergy: No Yes		Theatre notified?
Food allergy: No Yes			Kitchen notified?
ALLERGY / SENSITIVITY	**REACTION**		Red alert bands applied?
			Adverse Reaction Alert Record & Medication Chart completed
To list more allergies, please tick (nurse to check before admission)			

CURRENT MEDICATIONS - *Please list ALL medications and bring these into hospital with you in their original containers / boxes.*

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency
To list more medicines, please tick (nurse to check before admission)			Staff Use Only	Documented on Medication chart?	

Have you had a previous blood transfusion? No Yes Did you have any reaction? No Yes

SURGICAL HISTORY - *Please list any previous surgery you have had.*

Any previous problems with Anaesthetics? No Yes If Yes, Specify below	Theatre notified?

TO BE COMPLETED BY THE PATIENT

PRE-ADMISSION HEALTH QUESTIONNAIRE MR 200

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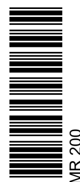
UR Number: .... Patient Name: .... DOB: ....



ENDOCRINOLOGY - *Please tick appropriate box.*			*Name of Treating Dr*			**STAFF USE ONLY** *Please initial*
Diabetes?	No	Yes	Type 1		Type 2	☐ *Diabetic chart in history* ☐ *BSL on admission* ☐ *IBA Diet List updated* ☐ *Management plan documented*
controlled by			Diet	Tablets	Insulin	
Thyroid problems?	No	Yes	Specify:			
GASTROINTESTINAL - *Please tick appropriate box.*			*Name of Treating Dr*			**STAFF USE ONLY** *Please initial*
Indigestion / reflux	No	Yes	Specify:			
Gastric / Peptic Ulcer	No	Yes	Specify:			
Bowel elimination issues	No	Yes	Ileostomy		Colostomy	*Bowel management plan / stomal therapist required? Y N*
			Constipation		Diarrhoea	
Liver Disease	No	Yes	Specify:			
Hepatitis	No	Yes	Type A	Type B	Type C	
OTHER - *Please tick appropriate box.*						**STAFF USE ONLY** *Please initial*
Do you have existing wounds, pressure areas, ulcer, broken or reddened skin?	No	Yes	Specify:			*Wound chart completed? Y N* *Riskman completed? Y N*
Females - Are you pregnant?	No	Yes	____________ Weeks	Breastfeeding? No Yes		*Consultant notified? Y N*
Do you drink alcohol?	No	Yes	How many per day?			*MR 715 AWS required? Y N*
Smoker?	No	Yes	How many per day?			
Ex-smoker?	No	Yes	When ceased?			
Do you use recreational drugs?	No	Yes	Specify:			
Visual Aids?	No	Yes	Glasses		Contact Lenses	*Aids labelled? Y N*
			Slight impairment		Prosthesis	
Hearing Aids?	No	Yes	Left	Right	Both	*Aids labelled? Y N*
Walking Aids?	No	Yes	Stick	Crutches	Wheelchair	*Aids labelled? Y N*
			Pick up frame	2 wheel frame	4 wheel frame	
Dentures?	No	Yes	Specify:			
Do you have Creutzfeldt Jacob Disease (CJD)?	No	Yes	Unsure			
Have you had Human Pituitary Growth Hormone prior to 1985?	No	Yes				*Theatre notified? Y N*
Have you had neurosurgery prior to 1985?	No	Yes	Specify:			
Have you or do you have MRSA, VRE or any other infectious disease?	No	Yes	Specify:			*NUM and Infection Control notified? Y N*
PATHOLOGY / MEDICAL IMAGING - *Please tick appropriate box.*						**STAFF USE ONLY** *Please initial*
For **this admission** have you had any:						
Pathology tests	No	Yes	At:	Date:		*Received? Y N* *Sign:*
ECG / Stress ECG	No	Yes	At:	Date:		*Received? Y N* *Sign:*
Echocardiogram / Stress Echo	No	Yes	At:	Date:		*Received? Y N* *Sign:*
X-rays	No	Yes	At:	Date:		*Received? Y N* *Sign:*
CT / MRI / CT Coronary Angiogram	No	Yes	At:	Date:		*Received? Y N* *Sign:*
Other (Specify)	No	Yes		Date:		*Received? Y N* *Sign:*

BINDING MARGIN – DO NOT WRITE IN THIS AREA

MR 200

BINDING MARGIN – DO NOT WRITE IN THIS AREA

UR Number: .... Patient Name: .... DOB: ....

NEUROLOGICAL - *Please tick appropriate box.*			*Name of Treating Dr*		***STAFF USE ONLY*** *Please initial*
Stroke	No	Yes	Residual effects:		*Falls risk? Y N*
Epilepsy / Seizures	No	Yes	Last episode:		*Falls chart completed? Y N*
Short term memory loss / Confusion	No	Yes	Specify:		
Alzheimer's / Dementia	No	Yes	Specify:		
MS / MND / Parkinson's	No	Yes	Specify:		
Mental Illness, Anxiety / Depression	No	Yes	Specify:		
HAEMATOLOGICAL DISORDERS - *Please tick appropriate box.*			*Name of Treating Dr*		***STAFF USE ONLY*** *Please initial*
Leukaemia / Myeloid Disorders Coagulopathy / Dyscrasia Other	No	Yes	Specify:		
CARDIOVASCULAR - *Please tick appropriate box.*			*Name of Treating Dr*		***STAFF USE ONLY*** *Please initial*
Elevated cholesterol / triglycerides	No	Yes	Taking cholesterol medication? No Yes		*Admission ECG? Y N*
High blood pressure / Hypertension	No	Yes	Taking blood pressure medication? No Yes		*Preadmission Echo? Y N*
Chest pain / angina	No	Yes	Specify:		
Palpitations, irregular heartbeats / AF	No	Yes			
Rheumatic fever / heart murmur / valvular disease	No	Yes			
Replacement / Repair heart valve	No	Yes	Year:	Type:	
Previous DVT, pulmonary embolism, varicose veins	No	Yes			*TEDS required? Y N*
Coronary Bypass Surgery	No	Yes	Year:	Vessels Bypassed:	
Coronary / Vascular stent	No	Yes	Year:	Vessels Stented:	
Pacemaker / AICD	No	Yes	Year:	Model:	
Heart attack / AMI	No	Yes			
Heart failure	No	Yes			*Fluid Balance Chart? Y N*
Family history of heart disease	No	Yes	Specify:		
Peripheral Vascular Disease	No	Yes	Specify:		
RESPIRATORY - *Please tick appropriate box.*			*Name of Treating Dr*		***STAFF USE ONLY*** *Please initial*
Bronchitis / Asthma / COAD / Emphysema / Asbestosis	No	Yes	Specify:		*CXR required? Y N*
Sleep Apnoea or Snoring	No	Yes	CPAP used? No Yes		*CPAP machine in hospital? Y N*
Shortness of breath or other lung problem	No	Yes	Specify:		
RENAL - *Please tick appropriate box.*			*Name of Treating Dr*		***STAFF USE ONLY*** *Please initial*
Renal failure / Impairment	No	Yes	Last Creatinine	Date	*Preadmission pathology? Y N*
Renal Disease	No	Yes	Specify:		*FBC required? Y N*
Are you on renal dialysis?	No	Yes	Peritoneal or Haemodialysis Access site - specify:		
Bladder issues	No	Yes	Specify:		
Urinary incontinence	No	Yes	Specify:		

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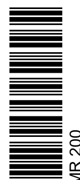

UR Number: .... Patient Name: .... DOB: ....

CARE DIRECTIVES - *Please tick Yes or No.*							***STAFF USE ONLY***
Do you have any of the following in place? If yes, please ensure you bring a copy to the hospital.	Advanced Care Directive	No	Yes	End of life Plan	No	Yes	*Please document on ADR*
	Medical Power of Attorney	No	Yes	Refusal of Treatment	No	Yes	

DISCHARGE PLANNING / READMISSION RISK SCREENING - *Please tick appropriate box.*					***STAFF USE ONLY*** *Please initial*
Do you live alone?	No	Yes	Partner	Spouse	
			Family	Other	
Comment: ______________________________					
Are you the primary caregiver for another person?	No	Yes	Specify:		
Do you live in your own home?	No	Yes	Hostel	Independent living unit	
			Nursing home	Other	
Comment: ______________________________					
Have you tripped or fallen in the last 6 months?	No	Yes	Specify:		*Falls Risk chart completed? Y N*
Where do you plan to go after discharge?					
Who will be caring for you after discharge?	Name:			Phone:	
Who can we contact during your admission regarding discharge issues?	Name:			Phone:	
Discharge time is 10am. Who will transport you home?	Name:			Phone:	
List any community services you have in place.					

ORIENTATION TO WARD (Staff Use ONLY)		
☐ ID Band	☐ Visiting hours	☐ Meal times
☐ Toilet / bathroom	☐ Bed controls	☐ Lounge room
☐ Fire Exits	☐ Telephone	☐ Direct phone number
☐ WiFi password	☐ TV / Call bell	☐ Valuable policy

VALUABLE POLICY

I understand that whilst care is taken, all personal belongings are left at my own risk. Western Private Hospital can take no responsibility for belongings left in our care.

I have carefully read all the above and certify that the information I have given is correct and true to the best of my knowledge.

Patient Name: ______________________________

Signature: ______________________________ Date: ______________

(To be signed when at hospital) Please confirm that you have provided all relevant information and Click on Submit button --> Submit

Preadmission Planner	*Name:*	*Signature / Designation:*	*Date:*
Admitting Nurse	*Name:*	*Signature / Designation:*	*Date:*
Accepting Ward Staff	*Name:*	*Signature / Designation:*	*Date:*

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