FAR NORTH DAY HOSPITAL

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

URN:

Surname:

Given Name:

Date of Birth: Sex:

ADMISSION DETAILS

Specialist Surname: Specialist First Name:

Overnight: ☐ No ☐ Yes Do you know your admission date: ☐ No ☐ Yes Date of admission: / /

Reason for Admission: (if unsure leave blank)

Item Numbers (if known): ☐ My Health Record Opt Out

Is admission due to an injury: ☐ No ☐ Yes Date of injury: / /

How did the injury occur? ☐ At work (going to or from) or as a result of being at work ☐ Motor vehicle accident ☐ Sport

Other (please specify):

Where did the injury occur? ☐ Roadway ☐ Home ☐ Work ☐ Sport ☐ Other (please specify):

Is the person completing the form the patient?: ☐ No ☐ Yes

If No, Your Name: Your Phone No.:

PATIENT DETAILS

Title: Surname: Maiden Name:

Given Name(s): Preferred Name:

Residential Address:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

Postal Address: ☐ As above ☐ Different Details:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

Contact Preferences: (indicate your preferred contact Method) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

If there is a voice message service, may we leave a voice message? ☐ No ☐ Yes

Email:

Your email address is important as it is used to confirm your admission form. It is NOT used for marketing purposes.

Date of Birth: / / Gender: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Child (not at school) ☐ Employed ☐ Home Duties ☐ Retired ☐ Student ☐ Unemployed ☐ Other

Are you an Australian resident? ☐ No ☐ Yes Country / State of Birth:

Are you of Aboriginal / Torres Strait Islander (TSI) descent?

☐ No ☐ Aboriginal ☐ TSI ☐ Both Aboriginal & TSI ☐ Not Stated/Unknown

Are you of Australian South Sea Islander (SSI) descent? ☐ Employed ☐ Home Duties ☐ Retired

Religion:

Do you consent to the Hospital disclosing your name to the following visiting officials (if they are available)?

Chaplain Visit: ☐ No ☐ Yes Veteran Organisation Representative: ☐ No ☐ Yes

Language(s) Spoken: ☐ English ☐ Other (please specify)

Are you able to read and understand English? ☐ No ☐ Yes Interpreter required? ☐ No ☐ Yes

MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ No ☐ Yes Medicare Number: ☐☐☐☐☐☐☐☐☐☐

Medicare Reference No: (number in front of your name) Medicare Expiry Date:(MM/YYYY): / /

NEXT OF KIN

Title: Surname: Given Names:

Address: ☐ Same as patient ☐ Different to patient:

Suburb: Country: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

PERSON TO NOTIFY ☐ Same as NOK ☐ Relationship to patient

Title: Surname: Given Names:

Address: ☐ Same as patient ☐ Different to patient:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

DO NOT WRITE IN THIS BINDING MARGIN

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MR-1A V1-03/21

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PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

☐ Self ☐ Next of Kin ☐ Workers Compensation ☐ DVA ☐ Third Party ☐ Other:

Title: Surname: Given Names:

Address: Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

PENSIONS / CONCESSIONS / HEALTH CARDS / SENIORS CARDS / CONCESSIONAL PHARMACY BENEFITS

Do you have any type of pension/concessional benefits card?

☐ No ☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: Benefit Card No:

Have you reached your Safety Net for Pharmaceuticals? ☐ No ☐ Yes Safety Net No:

HEALTH INSURANCE DETAILS

Do you have entitlements to free treatment under Australian Veteran's Legislation ☐ No ☐ Yes
(If YES, select DVA as your insurance Type and complete the DVA questions)

Has your injury or condition occured due to the negligence of a third party (e.g. workers compensation, motor vehicle accident, common law)? ☐ No ☐ Yes

If yes, have you lodged a claim for compensation or damages ☐ No ☐ Yes Damages ☐ Yes Compensation
(If YES, select Workers Compensation as your Insurance type and answer Workers Compensations questions)

Did your injuryor condition occur at work, going to or from work or as a result of being at work ☐ No ☐ Yes

Insurance Type: ☐ Private Health Fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ ADF
☐ Sefl Funded ☐ Public ☐ Overseas Insurer

Name of Health Fund: Type of Cover:

Membership No: Do you have an excess ☐ No ☐ Yes Amount:$

Have you changed your level of insurance cover in the last 12 months ☐ No ☐ Yes

Workers Compensation Fund Name: Claim No:

Employer: HR Manager:

Phone: Fax No:

Third Party Name: Policy No:

DVA No: DVA Card Colour: Details of cover (white card only):

ADF Service Branch: Approval No: Entitled Personnel ID No:

ADF Medical Officer (MO) On-base: MO Contact Number:

Overseas Insurerance Name: Policy No:

Referring Doctors Surname: First Name:
(Specialist or GP who referred you to the Admitting specialist)

Address:

Suburb: Postcode: Phone No:

General Practitioner (GP) Surname: First Name:
(If same as above write: "AS ABOVE")

Address:

Suburb: Postcode: Phone No:

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within this booklet:

☐ Hospital information (including pre-admission, day of admission, general information about our hospital as well as about no responsibility accepted if you bring valuables to hospital)

☐ Private Patients' Hospital Charter

☐ Your right to privacy under the Privacy Act

By ticking below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent

☐ Payment Information

Person responsible for payment of accounts - Please provide your name, signature and today's date.

Name: Signature: Date: / /

Patient's Signature

Name: Signature: Date: / /

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