StVincent's LISMORE

PATIENT REGISTRATION FORM

To be completed by the patient (or support person) and returned immediately to confirm your booking

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Gender: M ❑ F ❑

PATIENT DETAILS

Title: (please circle) Mr / Mrs / Ms / Miss / Dr /	Phone (Home):
Surname:	Phone (Work):
Previous Surname:	Phone (Mobile):
Given Names:	May we leave a voice message / SMS alert? ❑ Yes ❑ No ❑ N/A
Sex at birth: Gender identify as:	Email:
Date of Birth:	Marital Status: ❑ Single (never married) ❑ Married ❑ Defacto
Residential Address:	❑ Widowed ❑ Divorced ❑ Separated
	Occupation:
Suburb: Post Code:	Religion:
Postal Address (if different from above):	Country of Birth:
	Are you (is the person) of Aboriginal or Torres Strait Islander origin?
Suburb: Post Code:	❑ No ❑ Yes, Aboriginal ❑ Yes, Torres Strait Islander
Have you been a patient at St Vincent's before? ❑ Yes ❑ No	❑ Yes, both Aboriginal and Torres Strait Islander
Have you been a patient in any hospital within the last 28 days?	Preferred Language: Interpreter: ❑ Yes ❑ No
This Hospital: ❑ Yes ❑ No Other Hospital: ❑ Yes ❑ No	Are you an Australian Resident? ❑ Yes ❑ No

MEDICAL OFFICER DETAILS

Admitting Doctor:	Local Doctor:
Date of Surgery: Admission Date:	Address:
Referring Dr:	Suburb: Post Code:
Address:	Phone: Fax:

MEDICARE CARD DETAILS

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Reference No. ☐ (in front of your name on the card) Exp:...../.....

CONCESSION CARD DETAILS

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

❑ No ❑ Health Care Card (Green) ❑ Pensioner Concession Card (Blue) ❑ Commonwealth Seniors Card (Orange)

Benefit Card No: Benefit Card Expiry date: / /

Have you reached the PBS Safety Net for Pharmaceuticals? ❑ Yes ❑ No

Type of Card: ❑ SN Entitlement Card Card No: SN

❑ CN Concessional Card Card No: CN

DVA Card No: DVA Card Colour (please circle): Gold / White / Orange Exp:...../.....

Details of cover (white card only):

HEALTH INSURANCE DETAILS

If using Private Health Cover, please confirm these details with your Fund prior to completion

Insurance Type: ❑ Private Health Fund ❑ Self Funded

Health Fund: Table:

Membership No: Do you have an excess or co-payments? ❑ Yes ❑ No Amount: $

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

BINDING MARGIN – DO NOT WRITE

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NEXT OF KIN / EMERGENCY CONTACT 1

Name: Title:	Relationship to patient:
Address:	Phone (Home):
	Phone (Work):
Suburb: Post Code:	Phone (Mobile):

NEXT OF KIN / EMERGENCY CONTACT 2

Name: Title:	Relationship to patient:
Address:	Phone (Home):
	Phone (Work):
Suburb: Post Code:	Phone (Mobile):

ADVANCED HEALTH DIRECTIVE / ENDURING POWER OF ATTORNEY

Do you have a current Advance Health Directive? ❑ Yes ❑ No

Do you have enduring power of attorney – health and medical guardian? ❑ Yes ❑ No

Name: Relationship: Phone:

WORKERS COMPENSATION / THIRD PARTY

Written approval will be required prior

Claim No.:	Date of Injury/Accident:	
Employer:	Phone No.:	Fax No.:
Address:	Suburb:	Post Code:
Insurance Company:	Phone No.:	Fax No.:
Address:	Suburb:	Post Code:
Contact Person:		

ACCOMMODATION PREFERENCE

St Vincent's cannot guarantee your accommodation preference will be granted as room allocations are based on availability and clinical need

Room Preference: ❑ Shared room ❑ Private room (please be aware that a copayment may be required for a private room)

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the following information:

❑ Patient Information Booklet ❑ Australian Charter of Healthcare Rights ❑ St Vincent's Privacy Policy

❑ *During my stay I would like a wellbeing visit from a social contact volunteer (non-religious) or a chaplain*

❑ *I do not wish to receive information about the Hospitals services and activities, including fundraising appeals*

Patient's Signature: ..... **Date:** .....

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following: ❑ Informed Financial Consent ❑ Payment Information

Person responsible for payment of accounts to sign here:

Name: ..... Signature:..... Date: .....

Has this form been completed by the patient: ❑ Yes ❑ No

If No, your name: ..... Contact No.: .....

OFFICE USE ONLY	❑ Booking Completed	❑ Pre-Ad Compilation	❑ Funds/IFC Completed	❑ Foldering	Nurse Pre-ad: ❑ Y ❑ N
	Date:	Date:	Date:	Date:	
	Name:	Name:	Name:	Name:	
	UR No:	Signature:	Signature:	Signature:	
	Adm No:	❑ Pt notified of Estimate of Costs $..... Date:		Initials:	

PATIENT REGISTRATION FORM

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PAEDIATRIC HEALTH QUESTIONNAIRE

(Please complete the following to help us plan your child's care)

(Affix patient identification label here)

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❒ F ❒

TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN

Admission Date: ...../...../..... Date form completed: ...../...../.....

Name of person completing form:..... Relationship to patient: .....

Reason for Admission: .....

.....

Medical / Surgical History (attach a list if insufficient space). Please list previous operations, dates and any problems with anaesthetics.

.....

.....

.....

.....

If your child is required to stay overnight, who will be staying with your child? .....

Please ensure you bring any overnight necessities. Please do not bring any valuables into hospital.

ALLERGIES AND ADVERSE REACTIONS

Does your child have any allergies or sensitivities? ❒ Yes ❒ No (If Yes, please specify below)

Has your child had an allergic reaction to any drugs, tapes, lotions, latex or rubber, foods (e.g. peanuts)? ❒ Yes ❒ No

Allergic To:	Reaction	Allergic To:	Reaction

MEDICATIONS

Please tick Yes or No to all of the following questions and provide details as requested.

Please bring to hospital all medications your child is currently taking (both prescription and non-prescription) in their original packaging. This includes complementary therapies, over the counter medications, vitamins and supplements.

Please also bring any repeat/authority prescriptions, safety net and concessions cards.

	Yes	No	
Does your child take or has recently taken blood thinning medication (i.e. Aspirin, Warfarin, Clopidogrel or anti-inflammatory drugs)?	❒	❒	Name of Medication:..... Date last taken:..... OR still taking ❒
Does your child take any medication for weight loss or diabetes? (e.g. Ozempic, Wegovy, Mounjaro, etc.)	❒	❒	Name of Medication:..... Date last taken:..... OR still taking ❒
Is your child taking any other prescription or non-prescription medication or complementary medicines including vitamins/minerals/fish oil/herbal remedies?	❒	❒	If Yes, please list their current medications below *(attach a separate list if insufficient space)*

Medication	Dose/Frequency	Medication	Dose/Frequency

INFECTION CONTROL ASSESSMENT (Please tick Yes or No to all of the following questions and provide details as requested)

	Yes	No	
Has your child ever had a multi-resistant infection? (e.g. MRSA, UK-EMRSA, VRE, ESBL, CRE)	❒	❒	Specify Type:..... Year: ..... Facility/Hospital?.....
Has your child ever had Tuberculosis?	❒	❒	Specify at what age: .....
Has your child had any recent vomiting or diarrhoea?	❒	❒	When? .....
Admitted to any overseas hospital in last 12 months?	❒	❒	When/where?.....
Has your child ever been notified they may be at risk of Creutzfeldt-Jakob Disease (CJD)?	❒	❒	If family history of CJD, please specify who: .....
Does your child have a family history of 2 or more first degree relatives with CJD or other Prion Disease?	❒	❒	
Has your child been involved in a "Look Back: study for CJD or are they in possession of a "Medical in Confidence letter" regarding risk of CJD?	❒	❒	If other Prion Disease: has a genetic cause been excluded? ❒ Yes ❒ No

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PAEDIATRIC HEALTH QUESTIONNAIRE

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(Please complete the following to help us plan your child's care)

(Affix patient identification label here)

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❒ F ❒

DIETARY CONSIDERATIONS If **Yes**, please provide further details in the right-hand column			
Does your child require a special diet?	❑ Yes	❑ No	Details:
Is your child having any formula and/or breastfeeding?	❑ Yes	❑ No	Details:
Does your child have speech or swallowing difficulties?	❑ Yes	❑ No	Details:
DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? If **Yes**, please provide further details in the right-hand column			
Heart conditions	❑ Yes	❑ No	Specify interventions:
Has your child ever had a blood transfusion?	❑ Yes	❑ No	Year:..... Did they have a reaction? ❑ Yes ❑ No
Blood or clotting problems (self or family)	❑ Yes	❑ No	
Does your child have any Implants or prostheses (e.g. cardiac stents/valves/plates/pins)?	❑ Yes	❑ No	Details:
Liver condition (e.g. hepatitis)	❑ Yes	❑ No	Details:
Diabetes: ❑ Pre-diabetes ❑ Type 1 ❑ Type 2	❑ Yes	❑ No	Managed by: ❑ Diet ❑ Tablets ❑ Insulin
Kidney condition	❑ Yes	❑ No	Details:
Asthma	❑ Yes	❑ No	Last attack:..... Medication ❑ Yes ❑ No
Breathing problems (e.g. sleep apnoea)	❑ Yes	❑ No	CPAP: ❑ Yes ❑ No (If yes, please bring CPAP machine)
Has your child ever smoked tobacco?	❑ Yes	❑ No	If Yes, have they smoked in the last 30 days? ❑ Yes ❑ No
Has your child ever used vapes/e-cigarettes?	❑ Yes	❑ No	If Yes, have they used them in the last 30 days? ❑ Yes ❑ No
Reflux	❑ Yes	❑ No	Medication ❑ Yes ❑ No
Chronic bowel disease (Crohn's, Ulcerative Colitis)	❑ Yes	❑ No	Details:
Epilepsy / Fits / Seizures	❑ Yes	❑ No	Last occurrence: ..... Medication ❑ Yes ❑ No
Impaired: ❑ Vision (Left / Right) ❑ Hearing (Left / Right)	❑ Yes ❑ Yes	❑ No ❑ No	Specify aids:
Dental treatment	❑ Yes	❑ No	❑ Caps ❑ Crowns ❑ Dentures ❑ Implants ❑ Loose teeth
Developmental delays	❑ Yes	❑ No	Details:
Physical disability / mobility issues	❑ Yes	❑ No	How does your child mobilise? ❑ Walk ❑ Crawl ❑ Mobility Aide ❑ Carried
❑ Anxiety ❑ Depression	❑ Yes	❑ No	Medication: ❑ Yes ❑ No
Behavioural issues	❑ Yes	❑ No	If yes, specify management:
Has your child had any lymph nodes removed?	❑ Yes	❑ No	Site (e.g. axilla-under arm, groin):
Are they currently taking any cytotoxic medication?	❑ Yes	❑ No	Date of last dose:...../ ...../ .....
Have they or any family members had reactions to anaesthetic? (e.g. malignant hyperthermia)	❑ Yes	❑ No	Details:

COMMENTS

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.....

.....

.....

Patient weight: ..... Kg Patient height:.....cm / ft (confirmed on admission) BMI: ..... (Nurse to complete)

Office Use Only: (Nurse to initial each action)

Commence Infection Control Care Plan? .....

ICC Contacted (ICC Notification Form)? .....

Form reviewed by Nurse: ...../...../ ..... (sign).....

Complete OR Risk Alert Form? ❑ Yes ❑ N/A .....

ID Alert Bands: (please circle) **RED** **WHITE** .....

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