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
Gender: ❑ Male ❑ Female	Email:
Date of Birth:	Marital Status: ❑ Single (never married) ❑ Married ❑ Defacto ❑ Widowed ❑ Divorced ❑ Separated
Residential Address:	
	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

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

PATIENT REGISTRATION FORM

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NEXT OF KIN / EMERGENCY CONTACT 1

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

NEXT OF KIN / EMERGENCY CONTACT 2

Name:	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 to admission

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

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

❑ *I do not wish for my name to be supplied to the Pastoral and Spiritual Care Team*

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

Table:	Membership Financial ❑ Yes ❑ No	Date:
Excess:	Eligibility Confirmed ❑ Yes ❑ No	Signature:
Co-Payment:	Estimate of Costs $	UR No.:
Table joining date:	Patient notified ❑ Yes ❑ No	Admission No.:

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PATIENT HEALTH QUESTIONNAIRE

(Please complete the following sections to help us plan your care)

(Affix patient identification label here)

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❒ F ❒

TO BE COMPLETED BY THE PATIENT (or their representative)

Admission Date: ...../...../..... Form completed: ...../...../.....Are you filling this form out for yourself? Yes ❑ No ❑

If No, 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 performed and any problems with anaesthetics.

.....

.....

.....

Do you have someone to take you home from hospital and stay with you overnight? Yes ❑ No ❑.....

ALLERGIES AND ADVERSE REACTIONS

Do you have any allergies or sensitivities? ❑ Yes ❑ No

Have you had an allergic reaction to any drugs, tapes, lotions, Latex or rubber, foods (e.g. peanuts)? Yes ❑ No ❑

If Yes, specify allergy and reaction:

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 you are currently taking (including complimentary therapies/over the counter medications), in the original packaging and repeat / authority prescriptions. On admission, please bring a list of your current medications from your GP.

	Yes	No	
Do you take or have you recently taken blood thinning medication i.e. Aspirin, Warfarin, Clopidogrel or anti-inflammatory drugs?	❑	❑	Name of Medication: ..... Date last taken: .....OR still taking ❑ Yes
Are you taking any other prescription or non-prescription medications or complimentary medicines including vitamins / minerals / fish oil / herbal remedies?	❑	❑	If Yes, please list your 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	
Have you ever had a multi-resistant infection? (e.g. MRSA, UK-EMRSA, VRE, ESBL)	❑	❑	Specify Type: .....Year: ..... Facility / Hospital?.....
Have you ever had Tuberculosis?	❑	❑	Specify at what age: .....
Have you had any recent vomiting or diarrhoea?	❑	❑	When?.....
Hepatitis	❑	❑	Type: ..... Year: .....
Have you ever been notified you may be at risk of Creutzfeldt-Jakob Disease (CJD)?	❑	❑	If family history of CJD, please specify who: .....
Do you have a family history of 2 or more first degree relatives with CJD or other Prion Disease?	❑	❑	If other Prion Disease: has a genetic cause been excluded? ❑Yes ❑No
Have you been involved in a "Look Back: study for CJD or are you in possession of a "Medical in Confidence letter" regarding risk of CJD?	❑	❑	
Have you received human pituitary growth hormone treatment for infertility or growth hormone for short stature, prior to 1986?	❑	❑	When?..... Why?.....
Have you had surgery on the brain or spinal cord before 1990 that may have involved a Dura Mater graft?	❑	❑	Surgeon: ..... Hospital: .....Year: .....
Do you have a pre-existing neurological disease that is awaiting medical assessment?	❑	❑	Specify: ....

PATIENT HEALTH QUESTIONNAIRE

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PATIENT HEALTH QUESTIONNAIRE

(Please complete the following sections to help us plan your care)

(Affix patient identification label here)

UR:

Family Name:

Given Names:

Date of Birth: Gender: M ❒ F ❒

PATIENT HEALTH QUESTIONNAIRE

Do you have, or have you ever had, any of the following? If **yes**, please provide further details.

Chest pain / Heart attack / Angina	❑ Yes ❑ No	Details:
High blood pressure	❑ Yes ❑ No	Details:
Pacemaker / Implantable defibrillator	❑ Yes ❑ No	Make / Model / Serial No.:
Palpitations / Irregular heartbeat / Heart murmur	❑ Yes ❑ No	Details:
Rheumatic Fever	❑ Yes ❑ No	If yes, when?.....
Shortness of breath / chest pain after exercising or climbing stairs	❑ Yes ❑ No	Details:
Asthma	❑ Yes ❑ No	Frequency of attacks? ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly ❑ Never Exacerbations requiring hospitalisation / GP monitoring? ❑ Yes ❑ No
COPD / Emphysema / Lung disease	❑ Yes ❑ No	Frequent / recent infection / exacerbations? ❑ Yes ❑ No Details:
Sleep apnoea	❑ Yes ❑ No	CPAP: ❑ Yes ❑ No (If yes, please bring CPAP machine)
Stroke / Mini stroke (TIA)	❑ Yes ❑ No	Specify any residual weakness / symptoms:
Multiple Sclerosis / Motor Neuron Disease / Parkinson's	❑ Yes ❑ No	
Faints / Blackouts / Dizzy spells	❑ Yes ❑ No	Details:
Epilepsy / Fits / Seizures	❑ Yes ❑ No	Frequency of attacks? ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly ❑ Never Details:
Fallen in last 12 months	❑ Yes ❑ No	Details:
Short term memory loss / Confusion / Dementia	❑ Yes ❑ No	Details:
Diabetes : ❑ Pre-diabetes ❑ Type 1 ❑ Type 2	❑ Yes ❑ No	Managed by: ❑ Diet ❑ Tablets ❑ Insulin
Comorbidities related to your diabetes? (e.g. neuropathy, retinopathy, PVD, renal failure)	❑ Yes ❑ No	Details:
Blood / Bleeding / Bruising disorders	❑ Yes ❑ No	Details:
Blood clots (i.e. DVT or PE)	❑ Yes ❑ No	Details: ❑ Legs ❑ Lungs
Have you ever had a blood transfusion?	❑ Yes ❑ No	Date of last transfusion: ..... / ...../.....
If yes, did you have a reaction?	❑ Yes ❑ No	Details:
Reflux / Stomach or duodenal ulcers / Hiatus hernia	❑ Yes ❑ No	Details:
Chronic bowel disease (e.g. Crohn's, Ulcerative Colitis)	❑ Yes ❑ No	Details:
Chronic kidney disease	❑ Yes ❑ No	Dialysis: ❑ Yes ❑ No
Special dietary requirements	❑ Yes ❑ No	Details:
Have you ever smoked tobacco?	❑ Yes ❑ No	Have you smoked in the last 30 days? ❑ Yes ❑ No
Do you take recreational (party) drugs?	❑ Yes ❑ No	What do you take and how often?
Do you drink alcohol?	❑ Yes ❑ No	Circle standard drinks / day Nil 1-2 3-4 4+
Arthritis	❑ Yes ❑ No	❑ Rheumatoid ❑ Osteoarthritis ❑ Other .....
Implants or prostheses? (e.g. joint replacement, vascular stents, cardiac stents / valves)	❑ Yes ❑ No	Details:
Impaired: ❑ Vision (Left / Right) ❑ Hearing (Left / Right)	❑ Yes ❑ No ❑ Yes ❑ No	Specify aids:
Dental treatment	❑ Yes ❑ No	❑ Caps ❑ Crowns ❑ Dentures ❑ Implants ❑ Loose teeth
Have you or any family members had reactions to anaesthetic? (e.g. malignant hyperthermia)	❑ Yes ❑ No	Details:
Difficulty swallowing, opening your mouth or moving your neck?	❑ Yes ❑ No	Details:
Lymphoedema?	❑ Yes ❑ No	Site:
Are you currently taking any cytotoxic medication?	❑ Yes ❑ No	Date of last dose: ..... / ...../.....
Anxiety, depression or emotional disorders?	❑ Yes ❑ No	Details:
Female patients – could you be pregnant?	❑ Yes ❑ No	Date of last period:...../...../.....

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

Office Use Only: (Nurse to initial each action)

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

Commence Infection Control Care Plan? ..... Complete OR Risk Alert Form? ❑ Yes ❑ N/A .....

ICC Contacted (ICC Notification Form)? ..... **ID Alert Bands:** (please circle) **RED** **WHITE** .....

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