



Please tick which Epworth site you are being admitted to:

- Richmond Acute       Richmond Rehab
- Eastern                 Brighton
- Cliveden Hill         Camberwell
- Freemasons Clarendon St
- Freemasons DPC
- Freemasons Maternity

Unit Record Number: ..... Adm. Number: .....

Surname.....

Given Name.....

D.O.B..... Age..... Sex.....

Medical Officer .....

*Affix Patient Identification Label*

### ADMISSION DETAILS

(Doctors Secretary to complete - MUST BE COMPLETED)

Admission Date: \_\_\_\_\_ Admission Time: \_\_\_\_\_

Admitting Dr: \_\_\_\_\_ Dr Phone: \_\_\_\_\_

Procedure: \_\_\_\_\_ Provisional Item Number(s): \_\_\_\_\_

Estimated Length of Stay: \_\_\_\_\_ days Day Case  Overnight Case

### MATERNITY DETAILS

Estimated Date of Delivery:  /  /  Obstetrician:

### PATIENT DETAILS

Have you been a patient at Epworth Richmond/Brighton/Eastern/Freemasons/Camberwell/Cliveden?  Yes  No

Have you stayed in any hospital within the last month?  Yes  No If Yes, Hospital name: \_\_\_\_\_

Title:  Mr  Mrs  Miss  Ms  Master  Other: \_\_\_\_\_

Surname:  Previous Surname:

Given Names:  Sex:  Male  Female Date of Birth  /  /

Country of Birth:  Marital Status:  Preferred Language:

Residential Address:

Suburb / Town:  State:  Postcode:

Postal Address: Tick if as per above

Contact No: Home:  Business:  Mobile:

Aboriginal or Torres Strait Islander:  Yes  No Religion:  Tick if No Religion

Medicare Number:  Number beside name on card  Exp Date:  /  /

Pension / Concession No:  Exp Date:  /  /

PBS Entitlement Card No:  HealthCare Card No:

### NEXT OF KIN / CONTACT PERSON

### ADDITIONAL CONTACT PERSON

Surname:  Surname:

Given Name:  Given Name:

Relationship to Patient:  Relationship to Patient:

Address:  Contact No: Home:  Work:

Suburb / Town:  Postcode:  Mobile:

Contact No: Home:  Work:  Do you have a nominated Medical Power of Attorney?  No  Yes, please bring a copy of documents to the hospital

Mobile:

*If we are unable to contact you directly, we may need to contact your above nominated next of kin to provide information relating to your admission.*

### GP DETAILS

Name of regular Dr:

Dr Address:  State:  Postcode:

Dr Phone:  Fax:  Email:

**OFFICE USE ONLY**  
Is this the Admitting Medical Officer?  Yes  No

We routinely send information about your hospitalisation to your local Dr. If you do not consent to this please tick this box

MR1

ADMISSION DETAILS

11/10

MR1

## PERSON RESPONSIBLE FOR ACCOUNT (if not self)

Surname:  Given Name:   
Home Address:  State:  Postcode:   
Contact No: Home:  Work:  Mobile:

## INSURANCE / CLAIM DETAILS – please tick relevant box

You are advised to contact your health fund to confirm your level of cover prior to this admission, as co-payments or an excess may apply. If you do not have adequate cover or are NIL insured, you are required to pay all costs on admission. **MATERNITY PATIENTS - nil insured patients must pay all costs prior to admission.**

Privately Insured Fund:  Membership No:  Level of Cover:   
 Nil Insured  Overseas Patient  DVA – Card No:   Gold Card  White Card

## WORKCOVER / TAC – please attach claim acceptance letter

OFFICE USE ONLY  
EMU  Yes  No

Approval of your application is necessary prior to your admission. Workcover / TAC will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and accepted liability for your hospitalisation, treatments and other associated costs.

Workcover  TAC Claim No:   
Date of Injury:  /  /  Name of Insurance Company:   
Employer's Name:   
Employer's Address:  State:  Postcode:   
Contact Person:  Contact No:  Fax No:

Please be advised that Workcover, Veteran Affairs and Transport Accident Commission patients are accommodated in shared rooms only - single room charges apply.

## REHABILITATION PATIENTS

Rehabilitation Diagnosis:

Medical Diagnosis:  Subgroup:

ABI:  days  Cardiac:  days  Medical:  days  
 Neurological:  days  Orthopaedic:  days  Pain Management:  days  
 Reconditioning:  days  Respiratory:  days

SIGNATURE OF BOOKING OFFICER:

## EPWORTH MEDICAL FOUNDATION

Epworth Healthcare is a not-for-profit hospital group which relies on the generosity of its community to assist it to continue to deliver excellence in treatment and care.

From time to time the Epworth Medical Foundation contacts patients seeking their support. Please let us know if you **do not** wish to be contacted.

I do not wish to be contacted by the Epworth Medical Foundation.

## DECLARATION

I agree that the information provided within this form is true and correct to the best of my ability.

Signature:  Name:  Date:





# Epworth HealthCare

## **SPECIALIST TRAINEES AT EPWORTH HEALTHCARE**

Epworth HealthCare has for many years undertaken a medical education role and currently there are registrars / fellows in many disciplines within the hospital, including intensive care, emergency medicine, rehabilitation, cardiology and orthopaedics. As part of Epworth HealthCare's broader commitment to ensuring that we can offer our patients the best medical care, the organisation also aims to be at the forefront of medical education and research.

Epworth HealthCare is committed to training the next generation of medical specialists. Specialist trainees are fully qualified and registered doctors who are undergoing advanced training in their chosen medical specialty. Most specialist trainees undertake at least 7 years of training after gaining their medical degree and becoming a medical practitioner in order to gain the appropriate knowledge and skills to be acknowledged as a medical specialist.

Specialist trainees do not have the same level of experience as your treating specialist and hence they work closely with your specialist, under the supervision of your specialist whenever they participate in your care.

### **OPERATIONS AND PROCEDURES**

If you are undergoing an operation or other procedure AND your treating specialist is involved in supervising a specialist trainee, you may be asked whether you consent to a specialist trainee being involved. The specialist trainee may assist or perform some of your operation / procedure as part of their training, but this will always be under the direct supervision of your treating specialist.

### **GENERAL MEDICAL CARE**

Specialist trainees may participate in your medical care during your admission. This may include taking your history, ordering tests and liaising with your treating specialist. Under supervision, they may participate in providing treatment.

If you do not wish specialist trainees to be involved in your medical or surgical care during your admission, or if you would like further information about specialist trainees at Epworth HealthCare, please feel free to discuss this with your treating specialist.

### **EMERGENCY MEDICAL CARE**

Trainees play an essential role at Epworth HealthCare in providing emergency assistance when your specialist is not on site at the Hospital. In an emergency, and if your specialist is not immediately available, Epworth will ensure that necessary medical care is provided. In these circumstances, it is the role of the medical staff to ensure that you are medically stable and that your treating specialist is notified immediately of any medical concerns. Further management and treatment requirements will be determined by your treating specialist.



**Epworth  
HealthCare  
DAY SURGERY –  
PATIENT HEALTH HISTORY**

Please complete ALL sections before admission

Unit Record No \_\_\_\_\_

Surname \_\_\_\_\_

Given Names \_\_\_\_\_

D.O.B. \_\_\_\_\_ Doctor \_\_\_\_\_

ATTACH PATIENT I.D. LABEL

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient wishes to be addressed as: \_\_\_\_\_

Primary language: \_\_\_\_\_

Interpreter required:  Yes  No

**HEALTH INFORMATION**

What is your Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood group \_\_\_\_\_ (if known, please bring document)

High/Low blood pressure  No  Yes

Diabetes: Type 1/Type 2  No  Yes

Do you smoke?  No  Yes, frequency \_\_\_\_\_

Have you ever smoked?  No  Yes, frequency \_\_\_\_\_

**SURGICAL HISTORY**

Please list any previous operations and anaesthetics

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH BEHAVIOURS**

Do you drink alcohol?:  Yes  No

State average daily intake \_\_\_\_\_

Short of breath or chest pain while exercising?

Specify \_\_\_\_\_  Yes  No

Do you require a special diet?  Yes  No

Specify: \_\_\_\_\_

**ALLERGIES/REACTIONS**

Please tick if you have allergies to the following:-

Anaesthetic  Latex  Tapes

Post Anaesthetic Complication – Self/Family

specify: \_\_\_\_\_

Drugs: Specify drug and reaction \_\_\_\_\_

\_\_\_\_\_

Foods: Specify food and reaction \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY** please tick **Yes No**

Anaemia

Arthritis; Location: \_\_\_\_\_

Asthma/Bronchitis/Emphysema

Bleeding Disorder/Anticoagulants

Blood clot in legs/lungs

Blood Transfusion

Cancer: Location: \_\_\_\_\_

Chemotherapy/Radiotherapy

Cough at present; Type: \_\_\_\_\_

Date of last menstrual period (if relevant) \_\_\_\_\_

Dentures

Epilepsy/Fits

Gastric Reflux

Hayfever

Hearing Impairment (hearing aid?)

Heart Attack/Angina

Hepatitis; State type \_\_\_\_\_

Infectious Disease eg. HIV

Kidney Disease

Mental Illness/Anxiety Attacks

Pacemaker: Make/model \_\_\_\_\_

Physical Disability: \_\_\_\_\_

Pneumonia

Prostate problems

Prosthesis: Site: \_\_\_\_\_

Recent Cortisone Treatment

Rheumatic Fever

Sleep Apnoea

Speech/Swallow Impairment

Stomach Ulcer/Bowel Bleeding

Strokes/Mini-Strokes

Thyroid Problems

Tuberculosis

Valve Replacement

Vision Impairment

If yes to any medical conditions indicated, or if any other medical conditions, give further details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MR9AA

10/10

Please complete over page

DAY SURGERY – PATIENT HEALTH HISTORY

MR9AA

**MEDICATIONS: List ALL medications including vitamins & supplements you are currently taking**

Current medications brought in?  Yes  No

Medication	Dose & Freq.	Taken this morning		Medication	Dose & Freq.	Taken this morning	
		yes	no			yes	no

**Bring in your current medications**

Have you been instructed to stop any medications prior to your admission?  Yes  No

**CREUTZFELDT JAKOB DISEASE QUESTIONS**

Have you had a dura mater graft between 1972 and 1989?  Yes  No

Do you have a family history of two or more relatives with Creutzfeldt Jakob Disease or other unspecified neurological disorder?  Yes  No

Have you received human pituitary hormones (growth hormone or gonadotrophins) prior to 1985?  Yes  No

Has the patient suffered a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?  Yes  No

**PLANNING FOR DISCHARGE**

You will be required to be accompanied home. Do you have someone to take you home?  Yes  No

Name: ..... Contact No.: .....

Do you have someone to stay with overnight after discharge?  Yes  No

**PLEASE DO NOT BRING ANY VALUABLES/JEWELLERY INTO HOSPITAL**

I am aware that any jewellery or valuables kept on me or in the day surgery unit are my responsibility and I understand that the hospital is not accountable for any loss.

Information Obtained from:  Patient  Relative  Other .....

*Please ask this person to sign below*

I declare that the above information is true and accurate to the best of my knowledge.		
Signature: .....	Name: .....	Date: .. / .. / ..

**Clinical Pre-Admission Nurse**

Signature: ..... Name: ..... Designation: ..... Date: .. / .. / ..

**Admitting Nurse**

Signature: ..... Name: ..... Designation: ..... Date: .. / .. / ..