



Please tick which Epworth site you are being admitted to:

- Richmond
- Brighton
- Freemasons Clarendon Street
- Freemasons DPC
- Freemason Maternity
- Cliveden Hill
- Eastern
- Camberwell

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?  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:   
 Mobile:

**Do you have a nominated Medical Power of Attorney?**

No  Yes, please bring a copy of documents to the hospital

**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:  **OFFICE USE ONLY**  
 Is this the Admitting Medical Officer?  Yes  No  
 Dr Address:  State:  Postcode:   
 Dr Phone:  Fax:  Email:

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

MR1

June 2010

ADMISSION DETAILS

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 healthfund 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 HEALTHCARE CORRESPONDENCE

From time to time Epworth HealthCare and the Epworth Medical Foundation provide patients with information, newsletters and appeals. Please let us know if you **do not** wish to receive this information.

I **do not** wish to receive additional information from Epworth HealthCare or 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  
Freemasons**

PLEASE PRINT

Patient Name: ..... D.O.B. ....

Admission Date (required): .....

Operation Date (required): .....

Treating Doctor: .....

**PART A To be completed by the TREATING MEDICAL PRACTITIONER**

I have informed....., of the:  
*Print name of patient/ person responsible*

● Reason and nature of his/her admission .....

OR

● Nature, likely results and risks of the planned procedure .....  
*Planned operation/ procedure including side and site*

Patient does not consent to having a blood or blood products transfusion

Interpreter used. Language .....

Treating Medical Practitioner .....  
*Signature Print name Date*

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**PART B To be completed by the PATIENT / person responsible**

Doctor ..... and I have discussed treatment of my condition  
*Print name of Treating Medical Practitioner*

I acknowledge that I have consented to this admission to Epworth for: .....  
*Reason for admission/ procedure consented to(side and site if applicable)*

I understand that:

- The administration of medicine / anaesthetic / blood transfusion may be needed in association with this admission/procedure and that these carry some risks.
- Epworth staff administer care under the treating doctor's direction, or in an emergency, medical and nursing care is administered as required.
- I may withdraw the consent I gave to my doctor at any time.

I acknowledge that:

- I listened to the explanation the doctor gave me as to the need, benefits, risks and complications related to this admission or procedure.

I have had the opportunity to ask questions and these have been answered in a way I understand.

.....  
*Signature patient*

.....  
*Date*

.....  
*Print name of patient*

.....  
*If person responsible signs, state relationship to patient*

**PART C Involvement of Specialist Trainees:      Applicable      Not Applicable      (please delete)**

Epworth HealthCare is committed to training the next generation of medical specialists. Specialist trainees are fully qualified and registered medical practitioners who are undergoing advanced training in their chosen medical speciality but they do not have the same level of experience as your treating specialist.

Under the direct supervision of your treating specialist, a specialist trainee may participate in your surgery/procedure and may perform some of your operation/procedure as part of their training. Your specialist will always be present in the operating theatre during the operation or during your procedure.

I agree / do not agree to the involvement of the specialist trainee in my operation / procedure.

I understand and acknowledge consent that .....  
may be performing part of my surgery or procedure. *Print name of Speciality Trainee*

.....  
*Signature patient*

.....  
*Date*

.....  
*Print name of patient*

.....  
*If person responsible signs, state relationship to patient*





**MEDICATIONS: List Medications (Prescribed, over the counter, complementary)**

| Medication | Dose & Freq. | Medication | Dose & Freq. |
|------------|--------------|------------|--------------|
|            |              |            |              |
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|            |              |            |              |

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**

How are you getting home? \_\_\_\_\_

Who is accompanying you home?

Name: \_\_\_\_\_ Contact no. \_\_\_\_\_

**PERSONAL BELONGINGS: This is to be completed for all patients on admission by nursing staff**

| Personal belongings | Yes | No | Dispensed to whom |
|---------------------|-----|----|-------------------|
| Money/Credit Card   |     |    |                   |
| Jewellery/Watch     |     |    |                   |
| Dentures/Bridges    |     |    |                   |
| Glasses/Contacts    |     |    |                   |
| Hearing Aid         |     |    |                   |
| Assistive Devices   |     |    |                   |
| Other:              |     |    |                   |
|                     |     |    |                   |
|                     |     |    |                   |

**Must be completed for all patients on admission**

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

Signature: \_\_\_\_\_

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

**Health history information was collected from:** \_\_\_\_\_

(eg. Patient, family, significant other) – please ask this person to sign.

I declare that the above information is true and accurate to the best of my knowledge

Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Admitting Nurse**

Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Designation: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



Epworth  
Freemasons

# Epworth Freemasons

## Childbirth and Parenting Education

### Booking Form

To book into our education programs, please complete this form promptly and return it to:

Childbirth & Parenting Education  
Epworth Freemasons  
320 Victoria Parade  
East Melbourne Vic 3002

#### Personal Details

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Date Due: \_\_\_\_\_ Health Fund: \_\_\_\_\_

Support Person's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Daytime Phone No: \_\_\_\_\_

Mobile No: \_\_\_\_\_

Home Phone No: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please tick which class you and your partner would like to attend.

Confirmation of your booking will be sent by mail.

- Three Week Series (\$140 light supper included)  
Circle Preferred Day      Monday / Wednesday / Thursday
- Saturday Day Class (\$140 lunch included)
- Sunday Day Class (\$140 lunch included)
- Refresher Class (\$90)
- Fathers Session and Breastfeeding Class (\$10.00 per father)
- Grandparents Class (\$10.00 per person)

Please indicate how many attending: \_\_\_\_\_

- Twins Session

#### Costs

The majority of Private Health Insurance Funds have an agreement with Epworth Freemasons and will cover the cost of your antenatal class. If your fund is not one of these or you are self insured, you will be notified of payment methods when you receive class booking confirmation.

If you have any queries regarding our education program, please phone the Childbirth & Parenting Education office on 9418 8314. Staff are available on Thursdays between 9am and 1pm. If calling on an alternative day please leave a message.

