



Please tick which Epworth site you are being admitted to:

- Richmond Acute Richmond Rehab
- Eastern Brighton
- Cliveden 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

Title: (Mr/Mrs/Miss/Ms/Master)
 Surname:
 Given Name:
 Relationship to Patient:
 Address:
 Suburb / Town: Postcode:
 Contact No: Home: Work:
 Mobile:

Title: (Mr/Mrs/Miss/Ms/Master)
 Surname:
 Given Name:
 Relationship to Patient:
 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

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

Name of regular Dr:
 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

ADMISSION DETAILS

Referring Specialist: Phone: Fax:

Referring Specialist Address:

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

I understand that the hospital may contact my Health Fund and/or Medicare for verification of my eligibility for treatment.

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.

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

Affix Patient Identification Label

Unit Record Number
Surname
Given name
D.O.B. Age Sex
Medical Officer

Date: ____ / ____ / ____

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? Yes No

Specify date of last event: _____

ALLERGIES/REACTIONS

Please tick if you have allergies/sensitivities 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

Hearing impairment (hearing aid?) Yes No

Speech / swallow impairment Yes No

Vision impairment Yes No

Sleep apnoea / CPAP Yes No

Asthma / bronchitis / emphysema Yes No

Cough / cold at present - type: _____ Yes No

Pneumonia Yes No

Thyroid problems Yes No

Heart attack / angina Yes No

Pacemaker - make / model: _____ Yes No

Valve replacement Yes No

Gastric reflux / stomach ulcers Yes No

Kidney disease Yes No

Are you pregnant / breastfeeding? Yes No

Anaemia Yes No

Bleeding disorder / anticoagulants Yes No

Blood clot in legs / lungs Yes No

Blood transfusion Yes No

Significant infections Yes No

Tuberculosis Yes No

Rheumatic fever Yes No

Mental illness / anxiety attacks Yes No

Epilepsy / fits Yes No

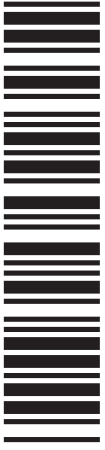
Strokes / mini-strokes Yes No

Arthritis - location: _____ Yes No

Cancer - location: _____ Yes No

Hepatitis - state type: _____ Yes No

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



MR9AA

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.	Last taken date: / /	Medication	Dose & Freq.	Last taken date: / /

Bring in your current medications

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

Which medications?

Have you been on Warfarin / cortisone previously? No Yes

CREUTZFELDT JAKOB DISEASE QUESTIONS

Do you have cCJD or do you have **two or more** first degree relatives with cCJD?

(i.e mother, father, brother or sister) Yes No

Did you receive pituitary hormone for infertility or Human Growth Hormone prior to 1986? Yes No

Have you had brain or spinal surgery before 1990 that involved dura mater grafting? Yes No

Is this admission related to rapid onset dementia? Yes No

Have you been involved in a look back for cCJD or do you have a "medical in confidence letter" regarding your risk of cCJD? (e.g. in relation to corneal transplant surgery). Yes No

STAFF USE ONLY: If yes to any of the above questions, refer to the CJD Protocol

PLANNING FOR DISCHARGE

Please note: If having an anaesthetic, you will not be able to drive home after your procedure.

You will be required to be accompanied home. Do you have a responsible adult to take you home and stay with you for the day and night? Yes No

Name: Contact 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.

Valuables: with patient sent home with N.O.K. Other, please specify:

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: ____ / ____ / ____