MR1M

Please tick which Epworth site you are being admitted to:

☐ Epworth Freemasons Maternity
☐ Epworth Geelong Maternity

Unit Record Number:.......................... Adm. Number:........................
Surname ....
Given Name...
D.O.B. .... Age...................... Sex.......................
Medical Practitioner ....
Affix Patient Identification Label

MATERNITY DETAILS

Estimated Date of Delivery: ______ Obstetrician: ______

PATIENT DETAILS

Have you been a patient at Epworth ☐ **Yes** ☐ **No** **Most recent date:** ______
Have you stayed in any hospital within the last month? ☐ **Yes** ☐ **No** **If Yes, Hospital name:** ______

Title: ______ (Mr/Mrs/Miss/Ms/Master)

Surname: ______ Previous Surname: ______

Given Names: ______ Preferred Name: ______

Sex: ☐ Male ☐ Female Date of Birth ______ Do you require an interpreter? ☐ Yes ☐ No

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: ______

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

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

Surname: ______

Given Name: ______

Relationship to Patient: ______

Address: ______

Suburb / Town: ______ Postcode: ______

Contact No: Home: ______ Work: ______

Mobile: ______

ADDITIONAL CONTACT PERSON

Surname: ______

Given Name: ______

Relationship to Patient: ______

Contact No: Home: ______ Work: ______

Mobile: ______

Do you have a nominated Medical Power of Attorney or have you appointed a Medical Treatment Decision Maker?

☐ Yes ☐ No, 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. Do you consent to this information being sent ☐ Yes ☐ No

ADMISSION DETAILS - MATERNITY

MR1M

PERSON RESPONSIBLE FOR ACCOUNT (if not patient)

Surname: ______ Given Name: ______

Home Address: ______ State: ______ Postcode: ______

Contact No: Home: ______ Work: ______ Mobile: ______

INSURANCE / CLAIM DETAILS – please tick relevant box

We recommend you contact your Private Health Insurer to confirm your level of cover prior to this admission, as co-payments, excess or non-covered pre-natal services may apply.

If you do not have adequate cover or are self insured, you are required to pay all costs on admission.

MATERNITY PATIENTS - self insured patients must pay all costs prior to admission.

☐ Privately Insured Fund: ______ Membership No: ______ Level of Cover: ______

☐ Self Insured ☐ Overseas Patient ☐ DVA – Card No: ______ ☐ Gold Card ☐ White Card

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.

We have a fundraising body called the Epworth Medical Foundation, which hosts and undertakes fundraising activities.

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: ______