CLEAR FORM

Epworth

Please tick which Epworth site you are being admitted to:

- ☐ Brighton
- ☐ Camberwell
- ☐ Cliveden
- ☐ Eastern (Box Hill)
- ☐ Eastern (Kew)
- ☐ Freemasons Clarendon St
- ☐ Freemasons Victoria Parade
- ☐ Geelong
- ☐ Hawthorn
- ☐ Richmond
- ☐ Richmond Rehab

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

Surname .....

Given Name.....

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

Medical Practitioner .....

Affix Patient Identification Label

ADMISSION DETAILS (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 ☐

MR1P1

PATIENT DETAILS

Has your child been a patient at Epworth? ☐ **Yes** ☐ **No** **Most recent date:**

Has your child 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: Work: Mobile:

Email:

We may use your mobile phone number or email address to send you a reminder for an appointment or follow up care, other admission related puposes or to ask for feedback about your experience with us.

Is the child 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:

CONTACT PERSON

Title:

Surname:

Given name:

Relationship to patient:

Address:

Suburb/Town: Postcode

Contact No: (home)

Contact No: (work)

Contact No: (mobile)

MEDICAL ATTORNEY / GUARDIAN / MEDICAL TREATMENT DECISION MAKER

Do you have - please tick:

- ☐ Advance Care Directive
- ☐ Medical Treatment Decision Maker
- ☐ Appointed Support Person
- ☐ Refusal of Treatment Certificate
- ☐ Enduring Power of Attorney (Medical Treatment)
- ☐ Guardian
- ☐ Advance Care Plan

In order for Epworth to respect your wishes, please bring in the relevant documents so Epworth can make a copy for our records.

ADMISSION DETAILS - PAEDIATRIC

MR1P1

10/19

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:

Epworth routinely send information about your hospitalisation to your treating clinician for continuum of care e.g.your Discharge Summary.

Do you consent to Epworth sending information about your hospitalisation to your treating clinician? ☐ Yes ☐ No

Referring Specialist: ..... Phone: ..... Fax: .....

Referring Specialist Address: .....

Do you have a regular community pharmacist? ☐ Yes ☐ No If Yes, please provide their name and contact number:

.....

PERSON RESPONSIBLE FOR ACCOUNT (if not patient)

Surname: Given Name:

Home Address: State: Postcode:

Contact No: Home: Work: Mobile:

Email address:

By providing this information you consent to us disclosing information regarding your admission to the person responsible for the account, and you acknowledge that the person responsible for the account is entitled to provide us with informed financial consent before accepting responsibility for the account.

INSURANCE / CLAIM DETAILS – please tick relevant box

We recommend you contact your Private Health Insurer to check if your reason for admission, including any surgery is covered under your level of insurance. You may wish to ask if there are any additional costs you should expect, such as an excess or co-payments. All out-of-pocket expenses are required to be paid prior to your admission.

☐ Privately Insured Health Fund:

Membership No: Level of Cover:

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

The hospital may contact your Health Fund and/or Medicare for verification of you 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.

FUNDRAISING SUPPORT

Epworth 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 to seek my support.

DECLARATION

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

Signature: Name:

Relationship to patient: Date: