

Admissions Office

Level 4, 75 Crown St, Woolloomooloo NSW 2011

Email: admit@esphospital.com

Ph: 02 9001 2000 Fax: (02) 9001 2001

Place ID Label Here**REQUEST FOR ADMISSION**

To be completed by Doctor and forwarded to admission office two weeks prior to admission: Admit@esphospital.com.
The ESPH online admission form and Patient Health Questionnaire must be completed by patients at least 7 days prior to admission at: esph.admission.com.au. Or use QR code for link:

**PLEASE ADMIT**Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Mx ☐

Date of Admission: _____

Surname: _____ Given Names: _____

Address: _____

Telephone: Home _____

Business _____

Date of Birth: _____

Sex: ☐ Male ☐ Female☐ Non-Binary

Health Fund: _____

Member No: _____

Medicare No: _____

Ref No: _____ Expiry: _____

CLINICAL DETAILS

Presenting symptoms: _____

Principal diagnosis, i.e. the condition which best accounts for patient's stay in hospital: _____

Relevant allergies/ co-morbidities/ medications: _____

OPERATION

Proposed operation/treatment: _____

Date of Operation: _____ Item Numbers: _____

Expected length of stay: ☐ Day-only patient OR ☐ Inpatient **If inpatient please specify number of nights** _____

Expected length of operation: _____

Specific pre-operative instructions (including tests required): _____

Specific surgical equipment requirements i.e. loan sets/prosthesis/implants: _____

SPECIFIC ORDERS ON ADMISSIONPlease list specific instructions you require. i.e.: **Medications/Pathology etc****Radiology required** ☐ Yes ☐ No**Referring Doctor's Details**

Name: _____ Signature: _____

Physician referral: ESPH Request for Admission acts as a standing order referral for ESPH physician to review patient if required
(eg: medical review in the event of deterioration, medications review and reconciliation, etc)