

Place ID Label Here**PRE-ADMISSION FORM****To be completed by Patient and forwarded to admit@esphospital.com two weeks prior to admission**Have you been a patient in this Hospital before: ☐ Yes ☐ No Year _____Have you been Hospitalised within 7 days prior to this admission: ☐ Yes ☐ No

Which Hospital? _____ Date: _____

Admitting Doctor: _____

Date of Admission: _____ Date of Operation: _____ Admission Type: ☐ Inpatient ☐ Day Patient

Procedure / Reason for Admission: _____

PERSONAL DETAILS

Title: Mr., Mrs., Miss., Ms. _____ Surname: _____

Previous Surname (if applicable): _____

Given Names: _____ Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Not Specified Date of Birth: _____ Age: _____

Marital Status: _____

Are you an Australian Resident? ☐ Yes ☐ No

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Email: _____

Are you of Aboriginal/Torres Strait Islander (TSI) descent? _____

Religion: _____

Country of Birth _____ Nationality: _____

Language spoken at home: _____

Interpreter Required: ☐ Yes ☐ No**PERSON TO CONTACT (NEXT OF KIN)**

Name: _____ Relationship to patient: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Email: _____

Second Contact/Enduring Guardian: _____ Telephone: _____

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ENTITLEMENTS

Medicare Card Number: _____ Medicare Reference No: _____
Medicare Expiry Date: _____ Pension/Health Care Card Number: _____
Expiry Date: _____ Safety Net Number: _____
Repatriation Number: _____

GP / LOCAL DOCTOR

Full name of GP: _____
GP Address: _____
GP Telephone: _____
GP Email: _____ GP Fax: _____
Permission to share discharge information: ☐ Yes ☐ No

MY HEALTH RECORD

☐ I DO NOT give permission for my information to be uploaded to the national electronic My Health Record.

ADVANCED CARE DIRECTIVE (LIVING WILL)

Do you have an advanced care directive (such as a living will, or a NFR order?) ☐ Yes ☐ No

If yes, you must bring a copy with you on the day of your surgery and present this to your admissions nurse.

SECTION A: PRIVATE HEALTH INSURANCE

Fund Name: _____ Membership No: _____ Date Joined: _____
Type of cover: ☐ Single ☐ Family ☐ Other Level of cover (if known): _____
Has this level of cover changed in the last 12 months? ☐ Yes ☐ No
Do you have an excess? ☐ Yes ☐ No Amount \$ _____
Have you paid an excess this year? ☐ Yes ☐ No Amount \$ _____
Date aware of present symptoms/condition: _____

SECTION B: WORKCOVER OR THIRD PARTY

☐ Work cover or ☐ Third Party (Please tick one box)

• The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company: _____

Claim No: _____ Date of Accident: ____ / ____ / ____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: _____

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HOW WILL YOU CLAIM FOR THIS ADMISSION

(please tick ✓ one box only)

- ☐ Private Health Insurance - Please complete Sections A and C
- ☐ Work cover/Third Party - Please complete Sections B and C
- ☐ Repat/Veterans Affairs - Please complete Entitlements and Section C
- ☐ Uninsured - Please complete Section C only

SECTION C: PAYMENT OF ACCOUNT - ALL PATIENTS TO COMPLETE

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. Any additional fees incurred during your stay are payable on discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or insurance claim is declined for any reason.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

By signing below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

- ☐ Informed Financial Consent ☐ Payment Information

Person responsible for payment of accounts - *Please provide your name, signature and today's date.*

Name: _____ Signature: _____ Date: _____

Patient's Signature: _____ Signature: _____ Date: _____

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

- ☐ Preadmission, Admission and Discharge information (Page 3-4)
- ☐ Australian Charter of Healthcare Rights (see page 5 "My Healthcare Rights")
- ☐ Your right to privacy under the Privacy Act (see page 6)
- ☐ Feedback and complaints process (see page 6)
- ☐ Patient and Visitor Code of Conduct (see page 6)

I consent to the use of my personal information for the purposes outlined above (See page 7)

☐ Yes ☐ No

PHYSIO REFERRAL

Physio Name: _____

Physio Contact: _____

Physio Fax: _____