PATIENT REGISTRATION FORM

Please mail back forms to :

Marianne/Tracey
Medical Consulting Suites
Echuca Regional Health
25 Francis Street
ECHUCA 3564

Office Use Only.
UR No:

Proposed Admission Date: / /

Proposed Surgery Date: / /

Personal Details (Patient)

Title: Mr.❑ Mrs.❑ Miss.❑ Ms.❑ Other:

Surname:

Given Name(s) in Full:

Previous Surname(s):

Date of Birth: / /

Sex: Male ❑ Female ❑

Country of Birth:
If Australia, what state:

Marital Status: Married ❑ Single ❑ Widowed ❑
Separated ❑ De Facto ❑ Divorced ❑

Do you wish to be visited
by a Church Representative Yes ❑ No ❑
Religion:

Aboriginal / Torres Strait Islander: Yes ❑ No ❑

Address:

Postcode:

Phone No. (AH) (BH)

Next of Kin / Contact Person.

Name:

Address:

Phone No. (AH) (BH)

Relationship to Patient:

Medicare No:

Card I.D. No: Expiry Date:

HCC/Pension No:

HCC/Pension No Exp Date:

Veterans Affairs Information.

D.V.A. No:

Colour of Card:

Other Details.

Name of your G.P.:

Have you been a patient in this Hospital or had pathology/Xrays done here. Yes ❑ No ❑

Do you have Private Health Insurance. Yes ❑ No ❑

Health Insurance Details.

Name of Fund:

Membership No:

Table:

Level of Insurance: Top ❑ Intermediate ❑
Basic ❑ Extras Only ❑

Does an Excess Apply: Yes ❑ No ❑

Excess Amount $

WorkCare / TAC / Workers Comp.

Approval must be obtained prior to admission.

Correspondence verifying liability must be presented on admission

Date of Injury / Accident: / /

Phone No:

Insurance Company:

Claim No:

Your Solicitor:

Address:

Phone No:

If WorkCare / Workers Comp.

Employer:

Address:

Private Insurance.

If you elect to be a private patient, the Hospital will claim bed fees on your behalf. Please bring your membership book at time of admission.

The information you provide on this form does not oblige you to elect whether you are treated as a public or private patient until you are admitted.
Contact your Health Fund if you have any queries about your coverage AND please read the notes on the back of this form.

ECHUCA REGIONAL HEALTH

PRE-SURGICAL HEALTH ASSESSMENT

SURNAME: ..... UR NUMBER: .....

GIVEN NAME: .....

D.O.B: ..... SEX: ..... WARD: .....

V.M.O: .....

USE LABEL IF AVAILABLE

GENERAL HEALTH INFORMATION

	YES	NO	DON'T KNOW	COMMENTS
Have you been admitted to a hospital in the last three months?				Provide details-
Do you smoke?				Provide details-
Previous smoker?				Quit Date -
Do you drink alcohol?				How much per week?
Do you use recreational drugs?				What?
Do you have caps, crowns, loose, damaged teeth or dentures?				What/where?
Do you have any reason to believe that you have been exposed to HIV/AIDS?				
Female patients only: Are you pregnant?				Estimated delivery date-
Are you allergic to any drugs, adhesive tapes, latex/rubber or foods?				Product/Reaction

HEIGHT- CM **WEIGHT-** KG

SURGICAL HISTORY

Have you ever had any operations? (If yes please provide details) YES NO

	YEAR

MEDICATIONS

Current medications including inhalers, patches, vitamins, alternative and unprescribed medications	DOSE	FREQUENCY

Are you taking Warfarin, Aspirin or other blood thinning medications? YES NO

Do you need an Interpreter? YES NO If yes, what language? .....

PRE-SURGICAL HEALTH ASSESSMENT MR/10C

JUL 2007 VER 2

Anaesthetic History

Do you have or have you ever had any of the following?	Yes	No	Don't Know	Details
Diabetes				How is it controlled?
High Blood Pressure				
Heart Attack				When?
Angina/Chest Pain				When?
Palpitations or irregular heart beat				
Congestive Heart Failure				
Insertion of heart valve, stent or pacemaker				When? Type?
Rheumatic fever				
Asthma or shortness of Breath				
Bronchitis or emphysema				
Pneumonia or Tuberculosis				
Stroke or Mini Stroke				
Neurological condition				
Epilepsy, fits, fainting or "funny turns"				Which/when?
Organ Transplant				What/when?
Kidney disorders-dialysis, infections, stones or failure				
Liver disease- jaundice, hepatitis or cirrhosis				
Bruise or bleed easily				
Blood disorder- anaemia, leukaemia				What type?
Blood transfusion				When?
Clots in the legs or lungs				When?
Gastric reflux, heart burn or indigestion				
Psychiatric problems				
Significant back or neck injury?				What/when?
Have you ever had a general anaesthetic?				When?
Have you ever had any problems with an anaesthetic or surgery- nausea, temperature or prolonged drowsiness?				What?
Do you have any family members who have had problems with anaesthetics?				What relation?
Any serious illnesses- eg. cancer, thyroid disease, adrenal or gastrointestinal disorders?				What?
Have you received a Dura Mater graft before 1989?				
Do you have 2 or more first-degree relatives who have had Creutzfeldt-Jakob Disease?				
Have you received Human Pituitary Hormone Therapy prior to 1985?				

The answers I have given are true to the best of my knowledge.

Full name of the person completing the form. Please print.

Signature of the person completing the form.

Date:

ECHUCA REGIONAL HEALTH

ADMISSION REQUEST FORM

Surname..... UR No.....
Given Names.....
DOB ...../...../..... Sex ..... Ward.....
Doctor.....
USE LABEL IF AVAILABLE

SURGEON:.....

DATE OF ADMISSION: / / DATE OF OPERATION: / / AM / PM

LENGTH OF STAY: ❑ Day Case ❑ Overnight ❑ Longer Stay (.....nights)

INTENTION: ❑ Public ❑ Private Insured ❑ Self Funded ❑ Repat/DVA ❑ WC ❑ TAC

MR, MRS, MS, MISS:..... (Surname) (Given Name)

ADDRESS:..... POST CODE:.....

DATE OF BIRTH: / / PHONE: AH..... BH.....

PROVISIONAL DIAGNOSIS / INDICATION:.....

PROPOSED OPERATION:.....

.....

ANAESTHETIST:..... ANAESTHETIC CHECK REQUIRED: ❑ Yes ❑ No

PLANNED ANAESTHETIC: ❑ General ❑ Local ❑ Spinal ❑ Sedation ❑ Regional

PRE-OPERATIVE CLINIC VISIT: ❑ Yes ❑ No (Required for all overnight cases)

DATE: / / TIME:..... POTENTIAL ACU POST-OPERATIVELY: ❑ Yes ❑ No

SPECIAL REQUIREMENTS (IMAGE INTENSIFIER, EQUIPMENT):.....

MEDICAL HISTORY:

❍ NIDDM ❍ IDDM ❍ Pacemaker ❍ Warfarin ❍ Other Anticoagulant Therapy

❍ Other Medical History (Specify):.....

OTHER RELEVANT INFORMATION:(Border baby, Significant past history):.....

.....

ALLERGIES / DRUG REACTIONS:.....

DRUG ORDERS DATE / TIME	DOSE	ROUTE	FREQUENCY DURATION	DOCTOR'S SIGNATURE	RECORD OF ADMINISTRATION DATE / TIME GIVEN / GIVEN BY

REQUESTING DOCTOR'S SIGNATURE:..... DATE: / /

JUL 2007 VER 1

ADMISSION REQUEST FORM MR/10B