Book.No.& MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

LONGUEVILLE PRIVATE HOSPITAL

Pre-Admission Form
Patient Details

To be completed by Patient
Please PRINT clearly. Your responses are valuable in planning your admission and caring for you during your stay.

Admission Details

Date of Admission: .... / .... / ....

Admission Time: ....

ADMITTING DOCTOR: ....

Admission Diagnosis / Procedure: ....

Personal Details

Title: .... Surname: .... Previous Surname (*if applicable*) ....

Given Names: .... Preferred Name: ....

Address .... Suburb.....................................State .... Postcode:................

Telephone: (Home) .... (Business) .... (Mobile) ....

Sex: ☐ Male ☐ Female Date of Birth: .... / .... / .... Age: ....

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ....

Are you an Australian Resident? ☐ Yes ☐ No Country of Birth: .... If Australia, specify state ....

Are you of Aboriginal / Torres Strait Islander (TSI) descent? ☐ No, ☐ Yes, Aboriginal, ☐ Yes, TSI, ☐ Yes, both Aboriginal and TSI

Religion: .... Do you wish to be visited by a member of your clergy? ☐ Yes ☐ No

Person to Contact (Next of Kin)

Name: .... Relationship to patient: ....

Address: .... State: .... Postcode: ....

Telephone: (Home) .... (Business) .... (Mobile) ....

Email ....

Second Contact / Power of Attorney: .... Telephone: ....

Section A: Private Health Insurance

Fund Name: .... Membership Number: .... Date Joined: .... / .... / ....

Has the level of cover changed in the last 12 months? ☐ No ☐ Yes

Type of cover: ☐ Single ☐ Family ☐ Other .... ☐ Level of cover (*if known*) ....

Do you have an excess? ☐ No ☐ Yes Amount $ .... Have you paid an excess this year? ☐ No ☐ Yes Amount $ ....

Section B: Workers' Compensation or Third Party

☐ Workers' Compensation ☐ 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:...

Address: ....State: .... Postcode: ....

Telephone: .... Claim No: .... Authorised by: ....

Has your insurance company accepted liability: ☐ Yes ☐ No. Please specify reason (*if no*) ....

Workers' Compensation Patients Only – Employer Details: Name of Employer: ....

Address: ....State: .... Postcode: ....

Telephone: .... Date of Accident: ..... / ..... / ...... Has your employer completed a Report of Injury Form? ☐Yes ☐No

Have you completed a Workers' Compensation Claim Form? ☐ Yes ☐ No

PRE-ADMISSION FORM FADM 046 v1

PRE-ADMISSION FORM FADM 046 v1

Entitlements

Medicare Card No: | | | | | | | | | | | Medicare Reference No: ..... Medicare Exp. Date: ..../ ..../........

Pension / Health Care Card No: | | | | | | | | | | | Expiry Date: ..../ ..../........

Safety Net No: | | | | | | | | | | |

Repatriation No: | | | | | | | | | | | Card colour: ☐ White ☐ Gold ☐ Other

Do you wish to be visited by a member of an Ex-Service Organisation? *Please indicate:*

☐ No ☐ Yes, I will organise it ☐ Yes, please organise it for me.

GP / Local Doctor

Full name of GP: ....

GP Address: ....

GP Telephone: .... GP Facsimile: .... GP e-mail: ....

Previous Hospitalisation

Have you previously been treated at this Hospital? ☐ No ☐ Yes Year: ....

Have you been hospitalised within 7 days prior to this admission? ☐ No ☐ Yes

Which Hospital? .... Dates: ....

How will this Admission be claimed? (please ✓ tick)

- ☐ Private Health Insurance – please complete Sections A
- ☐ Repat / Veterans Affairs – please complete Entitlements
- ☐ Workers' Compensation / Third Party – please complete Sections B
- ☐ Self Insured

Financial Consent / Valuables

I understand the portion of my estimated hospital fees not covered by a health fund must be paid on admission and any additional fees incurred during my stay are payable on discharge.
I 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 brought to the hospital.

Signature of patient / parent / guardian: .... Date .... / .... /........
Print name of patient / parent / guardian. ....

LONGUEVILLE PRIVATE HOSPITAL

Health Professional Referral
Patient History Form

MRN	
Surname	
Other Names	
DOB / Sex	
Ward / Doctor	

HEALTH PROFESSIONAL REFERRAL FADM 045 v1

To be completed by referring Health Professional.

Admission Date:

Admission Diagnosis: ....

Transfer Source: .... Ward: ....

Contact: .... Phone: ....

Original Date of Admission: .... Previous Hospital if any: ....

INFECTION STATUS	YES	NO	SPECIFY DETAILS
Any current or past Infectious Conditions?			
Multi Resistant Organism Status – MRSA / VRE / ESBL / Other **If NO, please swab the following:** **Nose, Axilla, Groin, All wounds/Skin breaks, IDC – urine, indwelling devices – CVC, IVC, PICC, PEG, SPC**			
Has the ward had any gastro / flu symptoms in the past 4 days?			

MEDICATIONS	YES	NO	
ALLERGIES **Any allergies to medications, food, intravenous dyes, sticking plaster, latex / rubber (*e.g. balloons, gloves)* or other substances?**			Specify :
Is the patient on blood thinning/arthritis medication (Aspirin Based) Clopidogrel (Plavix/Iscover) Anti-inflammatories, Dipyridamole (Asasantin / Persantin), Warfarin ?			Name of medication:
Has this medication been ceased?			Date last taken / / or still taking ☐ Yes
Any steroids or cortisone tablets/injections in the last 6 months?			Name of medication Date last taken / / or still taking ☐ Yes

MEDICAL HISTORY	YES	NO	SPECIFY DETAILS
Weight			Specify: _____________ kgs
Diabetes			Managed by: ☐ Diet ☐ tablets ☐ Insulin
Cancer year diagnosed………………………..			Site:
Stroke date ……./……../……..			Residual problems ☐ Yes ☐ No
High blood pressure			
Heart attack / chest pain / angina, especially heart failure or changed chest pain. *(circle)*			Date: / /
Cardiac Surgery or Stent *(circle)*			
Prosthetic heart valve			Type:
Palpitations / irregular heart beat / heart murmur			
Pacemaker			Make .... Model .... last checked / /
Rheumatic Fever			
Tendency to bleed / bruise easily			
Arthritis			
Asthma / bronchitis / pneumonia / hay fever			
Liver disease / hepatitis (Specify type A,B,C)			
Kidney / bladder problems			
Hiatus hernia / gastro-intestinal ulcers / bowel disorder			
Thyroid problems			
Epilepsy / fits / febrile convulsions			
Depression/ /other mental illness			
Migraines			

Continued over page

HEALTH PROFESSIONAL REFERRAL FADM 045 v1

PRINT PATIENT NAME:

MEDICAL HISTORY	YES	NO	SPECIFY DETAILS
Cognitive Issues			☐ Alert ☐ Orientated ☐ Co-operative ☐Confused ☐ Dementia ☐ Absconding Risk ☐ Aggression ☐ Behavioural Issues: ………………………………….. ……………………………………………………………
Recent cold or flu			
Impairment e.g. vision, hearing, mobility			Specify:
Leg or lung clots			
Skin Integrity			☐ Intact ☐ Wound ☐ Pressure Injuries ☐ Dressings – Type + Frequency: ……………………. ………………………………………………………………
Other health problems			

PREVIOUS OPERATIONS / PROCEDURES / MEDICAL REQUIREMENTS

Previous operations – please list the year/s and operation/s performed:

……

……

	YES	NO	SPECIFY DETAILS
Blood transfusion			Details of any reaction
Oxygen			Dosage:
IV / CVC / PICC			Specify:
MOBILITY / TRANSFERS			
Weight Bearing			☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for _____ more weeks)
Mobility Aid			Type:
Transfers independently			
Transfers with assistance			☐ ___________ person (s) assist required ☐ Hoist
Fear of falling or have fallen within the last 12 months?			
PROSTHESIS / AIDS / OTHERS			
Glasses / contact lenses / eye problems			
Hearing aid or other hearing appliance			
Dentures / caps / crowns / loose teeth			
Artificial joints or limbs			
Continence Aids			☐ Incontinent Urine ☐ Incontinent Faeces ☐SPC ☐ IDC ☐ Colostomy
LIFESTYLE			
Does the patient smoke?			Daily amount .... or date ceased / /
Alcohol consumption			Daily amount ....
Recreational drugs			Type .... Daily amount ....
Special dietary requirements?			Type of diet
SLEEP APNOEA Sleep apnoea?			☐ CPAP machine at home

DISCHARGE PLANNING *(this information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete)*

	YES	NO	SPECIFY DETAILS
Over 75 years of age?			
Live alone?			
Solely responsible for the care of another person at home?			
Currently receiving community support services?			
Require assistance with any aspect of day-to-day living?			☐ Independent ☐ Supervision ☐ Minimum Assist ☐ Moderate Assist ☐ Full Assist
Multiple health problems?			
More than 1 – 2 external or internal stairs in their home?			

DISCHARGE PLAN

Planned discharge destination:	
Name of Carer:	Relationship: