Epworth HealthCare

MR1

Please tick which Epworth site you are being admitted to:

- ☐ Brighton
- ☐ Camberwell
- ☐ Cliveden
- ☐ Eastern
- ☐ Freemasons Clarendon St
- ☐ Freemasons Victoria Parade
- ☐ Hawthorn
- ☐ Richmond
- ☐ Richmond Rehab

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

Surname ....

Given Name ....

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

Medical Officer ....

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 ☐

MATERNITY DETAILS

Estimated date of delivery: ☐ Obstetrician: ☐

PATIENT DETAILS

Have you been a patient at Epworth? ☐ **Yes** ☐ **No** **Most recent date:** ____/____/____

Have you 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: / /

Country of Birth: ☐ Marital Status: ☐ Preferred Language: ☐

Residential Address: ☐

Suburb / Town: ☐ State: ☐ Postcode: ☐

Postal Address: Tick if as per above ☐

Contact No: Home: ☐ Business: ☐ Mobile: ☐

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No Religion: ☐ Tick if No Religion ☐

Medicare Number: ☐ Number beside name on card ☐

Pension / Concession No: ☐ Exp Date: / /

PBS Entitlement Card No: ☐ HealthCare Card No: ☐

NEXT OF KIN / CONTACT PERSON

Title: ☐ (Mr/Mrs/Miss/Ms/Master)

Surname: ☐

Given Name: ☐

Relationship to Patient: ☐

Address: ☐

Suburb / Town: ☐ Postcode: ☐

Contact No: Home: ☐ Work: ☐

Mobile: ☐

ADDITIONAL CONTACT PERSON

Title: ☐ (Mr/Mrs/Miss/Ms/Master)

Surname: ☐

Given Name: ☐

Relationship to Patient: ☐

Contact No: Home: ☐ Work: ☐

Mobile: ☐

Do you have a nominated Medical Power of Attorney?

☐ No ☐ Yes, please bring a copy of documents to the hospital

If we are unable to contact you directly, we may need to contact your above nominated next of kin to provide information relating to your admission. If you ***do not*** *consent to us contacting your next of kin, please tick here* ☐

ADMISSION DETAILS

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:

We routinely send information about your hospitalisation to your local Dr. If you do not consent to this please tick this box ☐

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:

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

Fund: Membership No: Level of Cover:

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

I understand that the hospital may contact my Health Fund and/or Medicare for verification of my 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.

EPWORTH MEDICAL FOUNDATION

Epworth Healthcare 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.

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.

DECLARATION

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

Signature: Name: Date: