

URN:

Patient Admission Form

Please complete this form and return as early as possible prior to surgery.

Patient admission details

Admission date: / /

Admitting doctor:

Procedure:

 Have you been a patient at this hospital before? ☐ Yes ☐ No

 Have you been admitted to hospital in the last 7 days? ☐ Yes ☐ No

If Yes – Name of hospital:

Reason for admission:

Admission date: / / Discharge date: / /

Patient details

Title:

Surname:

First name:

Middle name:

Preferred name:

Previous name(s):

Date of birth: / /

Gender:

Sex at birth:

Legal sex:

Residential address:

Postal address (if different to above):

Home phone:

Work phone:

Mobile phone:

Email address:

 Marital status: ☐ Married (including de facto) ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

 Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander
☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown

 (QLD hospitals only) Are you of Australian South Sea Islander Ancestry? ☐ Yes ☐ No ☐ Unknown

Country of birth:

State (if born in Australia):

Preferred language:

 Interpreter required: ☐ Yes ☐ No

Religion:

Employment status:

☐ Child not at school ☐ Student ☐ Employed ☐ Unemployed ☐ Home duties ☐ Retired ☐ Pensioner ☐ Other

Referring doctor/general practitioner (GP)

Referring doctor surname:

Referring doctor first name:

Practice name:

Practice address:

Practice phone number:

 Is your referring doctor your GP? ☐ Yes ☐ No If No, please complete below.

GP surname:

GP first name:

Practice name:

Practice address:

Practice phone number:

Uploading my health record

 Do you consent to uploading your admission details to My Health Record? ☐ Yes ☐ No

Next of kin

Title:

Surname:

Given name(s):

Relationship to patient:

Best contact number:

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Emergency contact

Title:	Surname:	Given name(s):
Relationship to patient:		Best contact number:

Entitlements (complete for all that apply)

Medicare number:	Reference number:	Expiry date: /
☐ Eligible Australian Resident ☐ Eligible overseas visitor (Reciprocal rights) ☐ Ineligible ☐ Not known		
Do you have any types of pension/concessional benefits card?		
☐ Pension card	Number:	Expiry date: /
☐ Concession card	Number:	Expiry date: /
☐ Safety Net card	Number:	Expiry date: /
Veteran's Affairs number:		Card Colour: ☐ Gold ☐ White ☐ Orange
Australian Defence Force – Service Number/EP ID:		DAN (if known):

How will you claim for this admission (please tick one box only)

- ☐ Private Health Insurance – *complete Section A and C*
☐ Department of Veteran's Affairs/Australian Defence Force – *complete entitlements above*
☐ Worker's Compensation, Third Party, Motor Vehicle – *complete Section B and C*
☐ Self-funded – *complete Section C only*
☐ Overseas Insurance – *complete Section B and C*
☐ Public – *continue to Patient health history*

Section A: Private health insurance

Insured patients: It is recommended you contact your health fund prior to admission to confirm whether the reason for admission is covered under your selected level of cover. Informing the health fund of the item numbers provided by your doctor's rooms will assist your fund with confirming eligibility. You may wish to ask them if there are any additional costs you should expect, such as an excess or co-payment which will be payable on admission.

Health fund name:	
Membership number:	Reference number:

Section B: Worker's compensation, motor vehicle, other third party or overseas insurance

Claim number:	Date of accident/injury: / /
Insurance company name:	Contact number:
Address:	
Worker's compensation only – Approval letter for admission (from your insurance company) must accompany this form.	
Employer name:	Contact number:
Address:	

Section C: Person responsible for account

Is the patient responsible for this account? ☐ Yes (go to next section) ☐ No (complete this section)

Title:	Surname:	First name:
Previous name(s):		
Residential address:		
Postal address (if different to above):		
Home phone:	Work phone:	Mobile phone:
Email address:		
Relationship to patient:		

Confirmation details

Patient/guardian name:	Signature:	Date: / /
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