BUSINESS OFFICE DETAILS

THIS FORM MUST BE COMPLETED IN FULL PRIOR TO ADMISSION

PERSONAL DETAILS

Title: Mr, Mrs, Miss, Ms, Mst

Surname

Given names

Previous surname

Res. address

Postcode

Postal address

Postcode

Ph Priv. Bus.

Mobile

Sex ☐ Male ☐ Female

Marital Status ☐ Married ☐ De Facto ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Date of birth Religion

Country of birth

Language spoken at home

Occupation

Aboriginal ☐ Yes ☐ No

Torres Strait Islander ☐ Yes ☐ No

MEDICARE / ENTITLEMENTS

Medicare No.

Medicare Ref No. Expiry:____/____

Pension No.

HCC/CSHC Card No.

HCC/CSHC Expiry: ____/____

Safety Net No.

DVA No.

DVA Card Type (please circle) Gold / White / Orange

NEXT OF KIN / CONTACT PERSON

Name

Address

Postcode

Ph Priv. Bus.

Relationship

INSURANCE

Uninsured to pay ☐

Health Insurance ☐ Yes ☐ No

Name of fund

Membership No.

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

OTHER INFORMATION

Allergies ☐ Yes ☐ No

Admitting doctor

Referring doctor

Local GP

Address

Phone

Have you been in any hospital within the last 28 days?

This Hospital ☐ Yes ☐ No

Other Hospital ☐ Yes ☐ No

WORKERS COMPENSATION / WORKCOVER

Date of injury

Employer

Address

Phone

Claim No.

Insurance Company

THIRD PARTY / TRANSCOVER

Claim No.

Insurance Company

Your Solicitor

Address

Phone

I understand and agree to pay all hospital accounts, including any EXCESS, not withstanding any denial of liability of any insurance company.

x _____

Person responsible for account to sign here

OFFICE USE ONLY:

Table

Excess

Table joining date

Membership current ☐ Yes ☐ No

If No, _____

Fund confirmation ☐ Yes ☐ No

U.R. Number

Admission Number

Clover House ☐ Yes ☐ No

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St.Vincents HOSPITAL LISMORE

PATIENT HEALTH QUESTIONNAIRE

MR No.
SURNAME
OTHER NAME
DOB/SEX
DR

(Affix Sticker)

Have you ever had?	Please Tick Yes	No
Heart Trouble		
Angina (heart pains)		
High Blood Pressure		
Do you get unduly short of breath or experience chest pain after exercising or climbing stairs?		
Blood disorders which run in the family		
Bleeding Tendency		
Rheumatic Fever		
Hepatitis / Jaundice		
Diabetes: (If Yes, tick box) ☐ Tablets ☐ Insulin ☐ Diet only		
Asthma or wheezing		
Asthma requiring you to be admitted to hospital?		
Lung disease: (If Yes, tick box) ☐ Bronchitis ☐ T.B. ☐ Emphysema ☐ Pneumonia		
Epilepsy		
Fainting / funny turns / fits		
Stroke		
Stomach or duodenal ulcers		
Gastric Reflux: ☐ Heart burn ☐ Hiatus hernia		
Arthritis		
Muscle disorders		
Hearing difficulties		
Are you on any blood thinning medication e.g. Warfarin, Aspirin, Cartia, Solprin, Ecotrin, Cardiprin?		
Do you have an artificial hip or knee or other artificial device? Specify:		
Do you have any reason to believe you have been exposed to the virus which causes AIDS?		
Do you have someone to collect you on discharge?		
Do you have someone to stay with you the night you leave hospital?		
Have you ever had MRSA ? If Yes, Where? ..... When?		

Fragile DENTAL WORK can be damaged during your operation. If you have expensive dental work, please discuss this with your anaesthetist.
Do you have
Caps, crowns, bridges? ☐ Yes ☐ No
Loose teeth? ☐ Yes ☐ No
False teeth? ☐ Yes ☐ No

Are you allergic to latex (rubber products)? ☐ **Yes** ☐ **No**

Do you have any other known allergies? Type of reaction:

FEMALES:
Some anaesthetic drugs may have an adverse effect on unborn babies, so is there any possibility that you may be pregnant?
☐ Yes ☐ No

Would you describe your alcohol consumption as:
☐ None/Rarely ☐ Weekends only ☐ Most days

If most days, please specify the number of drinks per day:
☐ 1-2 drinks ☐ 3-4 drinks ☐ 4+ drinks

How many cigarettes do you smoke per day?:
☐ Nil ☐ 10-20 ☐ 20-30 ☐ 30+

Do you take recreational drugs (e.g. marijuana)?:
☐ Yes ☐ No

Please list all medications you are on or have taken in the last 6 months

Drug	**Dose (amount)**	**How often**

Please list your previous operations / any anaesthetic problems or other major illnesses.

Operation	**Year**	**Anaesthetic Problems**

Illnesses	**Year**

Has a blood relative ever had a serious anaesthetic problem?
☐ Yes ☐ No If yes, please supply details:

Height: _____ Weight: _____

Special Dietary Needs:

BINDING MARGIN - DO NOT WRITE