SOUTH BANK
DAY HOSPITAL

Patient Admission Form

ADMISSION DETAILS

Admitting doctor: Admission date:

Planned procedure: Item number(s):

PATIENT DETAILS

Is the person completing the form the patient? Yes ☐ No ☐
If No, Your Name: Your phone No:

Is the patient under the age of 18 years? Yes ☐ No ☐
If Yes; what is the name of the legal guardian?

Title: ________ Family name: ________
Given name: Preferred Name:

Residential Address: ________
Suburb: State: Post Code:

Postal Address: ________
Suburb State: Post Code:

Telephone: Home: ________ Work: ________ Mobile: ________
If there is a message service, may we leave a message? Yes☐ No☐ Can we send SMS? Yes☐ No☐

eMail Address:
Your email address is important as it is used to confirm that your admission form has been received.

Date of birth: ________ Gender: Male ☐ Female ☐ Indeterminate ☐
Marital status: Defacto ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐
Employment: Unemployed ☐ Retired ☐ Employed ☐ Occupation: ________

Are you an Australian resident? Yes ☐ No ☐ Country of birth: ________
Are you of Aboriginal or Torres Strait Islander descent? Yes ☐ No ☐
If Yes; are you Aboriginal ☐, Torres Strait Islander ☐, both Aboriginal and Torres Strait Islander ☐

What language is spoken at home? Is an interpreter required? Yes ☐ No ☐

CONTACT PREFERENCES

Indicate your preferred method of contact; Home phone ☐ Mobile ☐ eMail ☐ SMS ☐ Post ☐

NEXT OF KIN

Title: Family name: Given name: Relationship:

Address: ________
Suburb: State: Post Code:

Telephone: Home: Work/Day: Mobile:

PERSON TO NOTIFY ON DISCHARGE

Title: Family name: Given name: Relationship:

Address: ________
Suburb: State: Post Code:

Telephone: Home: Work/Day: Mobile:

ENDURING POWER OF ATTORNEY

If Yes; please provide a copy to the hospital.

Do you have a current Advance Health Directive? Yes ☐ No ☐

Do you have a current Enduring Power of Attorney – Health and Medical Guardian? Yes ☐ No ☐
Name: Relationship: Telephone:

Do not write in this binding margin

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PERSON / ORGANISATION RESPONSIBLE FOR PAYMENT OF ACCOUNT

Self ☐ Next of Kin ☐ Third Party ☐ Name Details

Worker's Compensation ☐ Claim No: Employer: Date of accident:

DVA ☐ Card No: Expiry: Gold ☐ Orange ☐ White ☐ Condition:

MEDICARE DETAILS

Medicare No.: Reference number on card: Expiry date:

CARD DETAILS - CONCESSION

Do you have any type of pension / concessional benefits card?

No ☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card ☐

Name of Pension / Benefit: ____ Benefit Card No: ____

Have you reached the Safety Net for pharmaceuticals? Yes ☐ No ☐ Safety Net No: ____

HEALTH INSURANCE DETAILS

Insurance type: Private Health Fund ☐ Third party ☐ Worker's Compensation ☐ DVA ☐ Self insured ☐
Public patient ☐ Defence ☐

Name of Health Fund: ____ Type of cover: ____

Membership No: ____ Do you have an excess Yes ☐ No ☐ If Yes; Amount $____

Have you changed your cover in the last 12 months? Yes ☐ No ☐

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained therein

Hospital Booklet ☐ Private Patient's Charter of Rights ☐ My right to privacy under the Privacy Act ☐

By ticking the following boxes I acknowledge that I have read, understood and agree to those conditions of admission; Informed Financial Consent ☐ Payment information ☐

DIETARY REQUIREMENTS

Please list any specific Dietary requirements?

CONSENT AND AGREEMENT

- I accept responsibility for full payment of all amounts for hospital charges not paid by my insurer.
- I consent to the collection, use, and disclosure of my personal information as outlined in the hospital handbook and in accordance with the relevant provision of the Commonwealth Privacy Act.
- I consent to South Bank Day hospital staff contacting my next of kin with the outcome of treatment or to obtain consent to necessary treatment if I am not able to provide such consent.
- I have been advised that a responsible adult must accompany me home and stay with me for at least 24hrs following discharge.
- I will not drive a car, motorcycle, ride a bicycle or operate machinery for 24 hrs after my anaesthetic.
- I will not drink alcohol for 24hrs before and after my anaesthetic.
- I will not make any important decisions or sign a contract within 24hrs of my anaesthetic.
- I acknowledge that the hospital does not accept any responsibility for the loss of any money or valuables that I bring with me.
- I certify that the information I have provided on this admission form is true and correct to the best of my knowledge.

Patient / Guardian Name: Signature: Date:

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