FAR NORTH DAY HOSPITAL

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

URN:

Surname:

Given Name:

Date of Birth: Sex:

ADMISSION DETAILS

Specialist Surname: Specialist First Name:

Overnight: ☐ No ☐ Yes Do you know your admission date: ☐ No ☐ Yes Date of admission: / /

Reason for Admission: (if unsure leave blank)

Item Numbers (if known): ☐ My Health Record Opt Out

Is admission due to an injury: ☐ No ☐ Yes Date of injury: / /

How did the injury occur? ☐ At work (going to or from) or as a result of being at work ☐ Motor vehicle accident ☐ Sport

Other (please specify):

Where did the injury occur? ☐ Roadway ☐ Home ☐ Work ☐ Sport ☐ Other (please specify):

Is the person completing the form the patient?: ☐ No ☐ Yes

If No, Your Name: Your Phone No.:

PATIENT DETAILS

Title: Surname: Maiden Name:

Given Name(s): Preferred Name:

Residential Address:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

Postal Address: ☐ As above ☐ Different Details:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

Contact Preferences: (indicate your preferred contact Method) ☐ Mobile ☐ Phone ☐ SMS ☐ Post ☐ Email

If there is a voice message service, may we leave a voice message? ☐ No ☐ Yes

Email: *Your email address is used to confirm your admission form. It is NOT used for marketing purposes.*

Date of Birth: / / Gender: ☐ Male ☐ Female

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

Employment: ☐ Child (not at school) ☐ Employed ☐ Home Duties ☐ Retired ☐ Student ☐ Unemployed ☐ Other

Are you an Australian resident? ☐ No ☐ Yes Country of Birth:

Are you of Aboriginal / Torres Strait Islander (TSI) descent?

☐ No ☐ Aboriginal ☐ TSI ☐ Both Aboriginal & TSI ☐ Not Stated/Unknown

Are you of Australian South Sea Islander (SSI) descent? ☐ Yes ☐ No

Religion:

Do you consent to the Hospital disclosing your name to the following visiting officials (if they are available)?

Chaplain Visit: ☐ No ☐ Yes Veteran Organisation Representative: ☐ No ☐ Yes

Language(s) Spoken: ☐ English ☐ Other (please specify)

Are you able to read and understand English? ☐ No ☐ Yes Interpreter required? ☐ No ☐ Yes

COVID-19 VACCINATION STATUS ☐ Fully Vaccinated ☐ Partially Vaccinated ☐ Not Vaccinated

MEDICARE DETAILS

Do you have a valid Medicare Number: ☐ No ☐ Yes Medicare Number: | | | | | | | | | | |

Medicare Reference No: (number in front of your name) Medicare Expiry Date:(MM/YYYY): / /

NEXT OF KIN

Title: Surname: Given Names: Relationship to Patient:

Address: ☐ Same as patient ☐ Different to patient:

Suburb: Country: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

PERSON TO NOTIFY ☐ Same as NOK

Title: Surname: Given Names: Relationship to Patient:

Address: ☐ Same as patient ☐ Different to patient:

Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ADMISSION DETAILS

MR-1A

V2-05/22

FAR NORTH DAY HOSPITAL

(AFFIX IDENTIFICATION LABEL HERE)

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

☐ Self ☐ Next of Kin ☐ Other:

Title: Surname: Given Names:

Address: Suburb: State: Postcode:

Telephone (Home/AH): Work/Day: Mobile/Other:

Person responsible for payment of accounts - Please provide your name, signature and today's date.

Name: Signature: Date: / /

PENSIONS / CONCESSIONS / HEALTH CARDS / SENIORS CARDS / CONCESSIONAL PHARMACY BENEFITS

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 your Safety Net for Pharmaceuticals? ☐ No ☐ Yes Safety Net No: _____

HEALTH INSURANCE DETAILS

Do you have entitlements to free treatment under Australian Veteran's Legislation ☐ No ☐ Yes
(If YES, select DVA as your insurance Type and complete the DVA questions)

Has your injury or condition occured due to the negligence of a third party (e.g. workers compensation, motor vehicle accident, common law)? ☐ No ☐ Yes

If yes, have you lodged a claim for compensation or damages ☐ No ☐ Yes Damages ☐ Yes Compensation
(If YES, select Workers Compensation as your Insurance type and answer Workers Compensations questions)

Did your injury or condition occur at work, going to or from work or as a result of being at work ☐ No ☐ Yes

Insurance Type: ☐ Private Health Fund ☐ Third Party ☐ Workers Compensation ☐ DVA ☐ ADF
☐ Overseas Insurer ☐ Self Funded ☐ Public

Name of Private Health Fund: Type of Cover:

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

Have you changed your level of insurance cover in the last 12 months ☐ No ☐ Yes

Third Party Name: Policy No:

Workers Compensation Fund Name: Claim No:

Employer: HR Manager:

Phone: Fax No:

DVA No: DVA Card Colour: Details of cover (white card only):

ADF Service Branch: Approval No: Entitled Personnel ID No:

ADF Medical Officer (MO) On-base: MO Contact Number:

Overseas Insurer Name: Policy No:

REFERRING DOCTOR (Specialist or GP who referred you to the Admitting specialist)

Referring Doctors Surname: First Name:

Address:

Suburb: Postcode: Phone No:

General Practitioner (GP) Surname: First Name:
(If same as above write: "AS ABOVE")

Address:

Suburb: Postcode: Phone No:

HOSPITAL INFORMATION

By ticking the following boxes I acknowledge that I have read and understood the information contained within this booklet:

☐ Hospital information (including pre-admission, day of admission, general information about our hospital as well as about no responsibility accepted if you bring valuables to hospital)

☐ Private Patients' Hospital Charter

☐ Your right to privacy under the Privacy Act

By ticking below I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the following conditions of admission:

☐ Informed Financial Consent

☐ Payment Information

Patient's Name:

Patient's Signature: Date: / /

PATIENT ADMISSION DETAILS

MR–1A V2-05/22

DO NOT WRITE IN THIS BINDING MARGIN

FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

URN:

Surname:

Given Name:

Address:

Date of Birth: Sex:

DISCHARGE PLANNING	N	Y	Please answer these questions	NURSING NOTES
Do you have someone to take you home from hospital and stay with you for a 24 -hour period after your operation?	☐	☐	Name: Contact Number:	

ADVANCED HEALTH DIRECTIVE / POWER OF ATTORNEY	N	Y	If yes, please answer these questions	NURSING NOTES
Do you have a current Advance Health Directive?	☐	☐	Please bring a copy with you on admission	
Do you have an enduring Power of Attorney – health & medical guardian?	☐	☐	☐ Same as next of kin Name: Relationship: Phone:	

PROCEDURE/ADMISSION	N	Y	If yes, please answer these questions If no, please progress to the next question	NURSING NOTES
1. Are you or could you be pregnant?	☐	☐		
2. Is the patient under the age of 18 years?	☐	☐	Name of child's legal guardian: Are the child's immunisations up to date: ☐ No ☐ Yes	
3. Have you had any of the following:				
• X-ray	☐	☐	WHEN/WHERE:	
• Blood tests	☐	☐	WHEN/WHERE:	
• MRI	☐	☐	WHEN/WHERE:	
• Scan	☐	☐	WHEN/WHERE:	
4. Are you currently seeing any other doctors or specialists e.g., cardiologist, physician?	☐	☐	Doctor Consulted: / Speciality:	

PREVIOUS HOSPITALISATION	N	Y	If yes, please answer these questions	NURSING NOTES
5. Have you been admitted to this hospital before?	☐	☐		
6. Have you been admitted to any hospital within the last 28 days?	☐	☐	☐ In the last 7 days ☐ In the last 28 days Reason for admission: Hospital Name:	
7. Have you been admitted to any hospital within the last 12 months?	☐	☐	Reason for admission: Hospital Name:	

PREVIOUS SURGERY / PROCEDURES	N	Y	If yes, please complete table below.	NURSING NOTES
8. Have you had any previous surgeries or procedures? e.g. joint replacements, transplants, implants, colonoscopy?	☐	☐		

OPERATION	YEAR	OPERATION	YEAR	NURSING NOTES

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT MEDICAL HISTORY – GENERAL MR-1C V2-05/22

FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

MEDICATIONS	N	Y		NURSING NOTES
9. Are you currently taking any medication?	☐	☐	If no, please go to question 12. If yes, please answer below.	
10. Have you received advice from Specialist rooms regarding taking/ceasing medications prior to admissions?	☐	☐	Details:	
11. Do you take any of the following:				
- Anti-coagulant or blood thinning therapy (e.g. Warfarin, Coumadin, Clopidogrel, Aspirin, Apixaban, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor).	☐	☐	Still take? ☐ No ☐ Yes Date to be ceased:	
- Cortisone tablets/injections, anti-inflammatory drugs	☐	☐	Still take? ☐ No ☐ Yes Date to be ceased:	
- Regularly take vitamin supplements, over the counter preparations or traditional medicines?	☐	☐	Still take? ☐ No ☐ Yes Date to be ceased:	

IMPORTANT: Please either complete the medication table below OR bring a profile or list to hospital of all medications including anti-coagulant or blood thinning therapy as well as other tablets, puffers, patches, injections, nebulisers, ointments, drops and including non-prescription medications and herbal supplements.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY	NURSING NOTES

LIFESTYLE	N	Y	If yes, please answer these questions	NURSING NOTES
12. Do you have a medically required or special diet? (e.g. diabetic, coeliac disease, lactose intolerance, vegetarian, kosher).	☐	☐	Details:	
13. Do you currently or have ever smoked?	☐	☐	Daily amount: Ceased:	
14. Do you drink alcohol? If so, how much daily?	☐	☐	Daily amount:	
15. Do you use recreational drugs? If so, what drug?	☐	☐	Daily amount: Type:	
16. What is your weight: kg	Nursing staff to record BMI			
17. Have you recently lost weight unintentionally?	☐	☐		☐ *Malnutrition risk*
18. What is your height cm				

PROSTHETICS / AIDS	N	Y	If yes, please answer these questions	NURSING NOTES
19. Do you have any mobility problems / use any aids? (walking sticks, other aids for daily living)	☐	☐	Details:	
20. Do you have any hearing or vision problems?	☐	☐	Details:	
21. Are you paraplegic or quadriplegic? If yes, can you self-transfer?	☐ ☐	☐ ☐	Details:	

PATIENT MEDICAL HISTORY – GENERAL MR–1C V2-05/22

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FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

URN:

Surname:

Given Name:

Address:

Date of Birth: Sex:

MEDICAL CONDITIONS

25. Do you have any **ALLERGIES**? ☐ No ☐ Yes
(if No, go to question 26. If yes, please tick relevant conditions below)

If yes, please tick relevant conditions below	DETAILS	NURSING NOTES
☐ List allergies or sensitivities including medications, latex, sticking plaster, iodine, x-ray dyes, food (e.g. seafood, nuts, gluten), food additives (e.g. salicylates, amines) or insects (e.g. bees, dust mites)		
☐ Have you or a family member has had an adverse reaction to anaesthetic e.g. malignant hyperthermia or post-operative nausea and vomiting.	☐ You ☐ Family member Details:	

ALLERGY INCLUDING FOOD ALLERGIES	DETAILS / REACTIONS	☐ Alert sticker

26. Do you have/had any **CARDIOVASCULAR** problems? ☐ No ☐ Yes
(if No, go to question 27. If yes, please tick relevant conditions below)

If yes please tick relevant conditions below	DETAILS	NURSING NOTES
☐ Elevated cholesterol, triglycerides		
☐ Blood pressure problems e.g. low, high, hypertension		
☐ Cardiac conditions or irregularities e.g. heart attack, congestive heart failure, rheumatic fever, angina palpitations, heart murmur		
☐ Cardiac surgery e.g. pacemaker, implants/devices, prosthetic heart valve, grafts, stents	Type of implant	
☐ Vascular disease e.g. carotid disease, aortic aneurysm, peripheral vascular disease		

27. Do you have/had **DIABETES?** ☐ No ☐ Yes
(if No, go to question 28. If yes, please tick relevant conditions below)

If Yes please tick relevant conditions below	DETAILS	NURSING NOTES
☐ Type 1 diabetes		
☐ Type 2 diabetes	Controlled by: ☐ Diet ☐ Insulin ☐ Tablets	
☐ Gestational diabetes		

28. Do you have/had any **GASTROENTEROLOGY or UROLOGY** problems? ☐ No ☐ Yes
(if No, go to question 29. If yes, please tick relevant conditions below)

If Yes please tick relevant conditions below	DETAILS	NURSING NOTES
☐ Hiatus hernia, gastrointestinal ulcers, reflux		
☐ Liver disease, hepatitis (e.g. A, B, C), cirrhosis		
☐ Bowel problems/habits, stoma, or bowel disease e.g. Crohn's Disease, Irritable Bowel Syndrome		
☐ Bladder problem, frequency, incontinence, urinary retention, indwelling or suprapubic catheter		

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PATIENT MEDICAL HISTORY – GENERAL MR-1C V2-05/22

FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

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(AFFIX IDENTIFICATION LABEL HERE)

MEDICAL CONDITIONS (continued)

29. Do you have/had any **BLOOD OR CANCER** problems? ☐ No ☐ Yes
(if No, go to question 30. If yes, please tick relevant conditions below)

If yes, please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Have you ever had a blood transfusion?	Any reaction: Year transfused:	
☐ History of cancer	Type: Body site: Treatment: Date of diagnosis:	
☐ Blood clot in lung/legs (DVT / PE)		
☐ Blood or bleeding disorders		

30. Do you have/had any **MUSCULOSKETAL** problems? ☐ No ☐ Yes
(if No, go to question 31. If yes, please tick relevant conditions below)

If yes, please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Arthritis e.g. rheumatoid arthritis, osteoarthritis		
☐ Back, neck or injury problems		

31. Do you have/had any **NEUROLOGY** problems? ☐ No ☐ Yes
(if No, go to question 32. If yes, please tick relevant conditions below)

If yes please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Neuromuscular disease e.g. MS, myasthenia gravis, dystrophies, Parkinson's Disease		
☐ Stroke, mini stroke, TIA	Date: Impairment:	
☐ Limb paralysis or weakness		☐ *Falls risk screen required*
☐ Fear of falling, unsteady or have fallen in the last 6 months		☐ *Falls risk screen required*
☐ Epilepsy/fits, faints, blackouts, dizziness		☐ *Falls risk screen required*
☐ Speech or swallowing problems e.g. coughing when eating / drinking		
☐ Difficulties with problem solving, attention span, understanding simple instructions		☐ *Cognitive risk screen*
☐ Other neurological problems e.g. short-term memory loss, dementia, Alzheimer's		☐ *Cognitive risk screen*

32. Do you have/had **BREATHING** problems? ☐ No ☐ Yes
(if No, go to question 33. If yes, please tick relevant conditions below)

If Yes please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Asthma, pneumonia, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary Disease (COPD)		
☐ Shortness of breath e.g. when walking more than 50m, climbing stairs/inclines		
☐ Sleep apnoea		
☐ Use a CPAP machine		
☐ Other lung problems e.g. tuberculosis		

33. Do you have/had any **OTHER** conditions? ☐ No ☐ Yes
(if No, go to question 34. If yes, please tick relevant conditions below)

If Yes please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Chronic pain		
☐ Depression, or any other mental illness		
☐ Lymphoedema or mastectomy		
☐ Thyroid problems, hypothyroidism, goitre		
☐ Any other medical conditions e.g kidney disease	**DETAILS**	

PATIENT MEDICAL HISTORY – GENERAL MR-1C V2-05/22

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FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

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(AFFIX IDENTIFICATION LABEL HERE)

URN:

Surname:

Given Name:

Address:

Date of Birth: Sex:

MEDICAL CONDITIONS (continued)

34. Are you susceptible to possible **INFECTION ISSUES**? ☐ No ☐ Yes
(if No, go to question 35. If yes, please tick relevant conditions below)

If yes, please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Ever had MRSA, VRE, CRE, ESBL or HIV		
☐ I have had other infection issues previously. Please list		
☐ In the last 12 months have you worked in a healthcare facility in Australia or overseas		

35. Are you being admitted in the next 7 days? ☐ No ☐ Yes
(if No, go to question 36. If yes, please tick relevant conditions below)

☐ Do you currently have any wounds or breaks on your skin		
In the last 3 weeks have you:		
☐ Travelled to a country or area with current health alerts (If known)		
☐ Travelled to areas of high prevalence for acute respiratory infections/illness		
☐ Had contact with anyone with acute respiratory infections/illness		
☐ Had vomiting ☐ Had diarrhoea		
COVID-19 Screening Checklist: ☐ Had a fever or respiratory symptoms e.g. couch, sore throat, runny nose ☐ Have you had recent contact with known or suspected COVID-19 case in the past 2 weeks ☐ Have you recently been tested for COVID-19	If Yes, Date of Test: Result of Test:	

36. Are you having an operation on your eyes or having dental surgery? ☐ No ☐ Yes
(if No, go to next section. If yes, please tick relevant conditions below)

If yes please tick relevant conditions below	**DETAILS**	**NURSING NOTES**
☐ Have you had Creutzfeldt-Jakob Disease (CJD)?		
☐ I have an unexplained progressive neurological illness of less than 12 months		
☐ I have a history or receiving human pituitary hormone for infertility or human growth hormone for short stature		

I confirm that the information completed in this Patient Medical History form is correct.

Patient Name PLEASE PRINT FULL NAME:

Signature:

Date:

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT MEDICAL HISTORY – GENERAL MR-1C V2-05/22

FAR NORTH DAY HOSPITAL

PATIENT MEDICAL HISTORY

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON. Please PRINT clearly in block letters and return immediately to confirm your booking.

(AFFIX IDENTIFICATION LABEL HERE)

NURSE USE ONLY

RISK ASSESSMENT	NO	YES	Completed	Signature	Refer Facility Policy
Falls risk assessment required	☐	☐			Refer Facility Policy
Infection risk assessment required	☐	☐			Refer Facility Policy
Pressure injury risk assessment required	☐	☐			Refer Facility Policy
Delirium / Dementia risk assessment required	☐	☐			Refer Facility Policy
Cognitive risk assessment required	☐	☐			Refer Facility Policy
Malnutrition risk assessment required	☐	☐			Refer Facility Policy

Confirmation that Patient Medical History form reviewed by preadmission staff: ☐ No ☐ Yes

Name of Preadmission Nurse:	Signature:	Date:
Designation:		Time:

Confirmation that Patient Medical History form reviewed by Admitting Nurse: ☐ No ☐ Yes

Name of Admitting Nurse:	Signature:	Date:
Designation:		Time:

Confirmation that Patient Medical History form reviewed by DSU staff: ☐ No ☐ Yes

Name of DSU / Ward Nurse:	Signature:	Date:
Designation:		Time:

CLINICAL / PRE-ADMISSION NOTES

DO NOT WRITE IN THIS BINDING MARGIN