St John of God Murdoch Hospital
100 Murdoch Dve
MURDOCH WA 6150
Ph: 9366 1111
Fax: 9366 1139
Country: 1800 640 300

ST JOHN OF GOD
Murdoch Hospital

St John of God Health Care Inc.
(Limited Liability) Incorporated in Western Australia
ABN 21 930 207 958

PATIENT ADMISSION INFORMATION

MRN

Admitting Dr _____ Admission Date _____ Time _____

Dr's Phone No _____ Anaesthetist _____

ADMISSION TYPE: (please tick)
☐ Daycase
☐ Inpatient

To CONFIRM your admission, please complete this form and either post or deliver it to the Hospital at your earliest convenience. It must be received no later than **7 days prior to admission.** If this is not possible, please contact our Admission Office by telephone with the details.

PART A — PATIENT / GUARDIAN TO COMPLETE

PATIENT DETAILS

Surname | Given Names | **NB: Surname and given names must match Medicare details**

Preferred Name OPTIONAL | Title | Sex | Marital Status | Date of Birth

Ethnic Origin (eg. Asian, Aboriginal, Caucasian, TSI) | Country / State of Birth | Preferred Spoken Language | Religion OPTIONAL

Are you of Aboriginal or Torres Strait Island Origin? Yes ☐ No ☐

I am happy to be visited by a hospital approved representative of my religious denomination during my stay. Yes ☐ No ☐

Residential Address | Postcode

Postal address (if different from above) | Postcode

Phone No: Home | Other Contact / Mobile No: | Phone No: Work | Email address

Preferred Contact Phone No/Time: _____ ☐ Morning ☐ Afternoon ☐ Evening

Employment Status ☐ Employed full-time ☐ Employed part-time ☐ Retired
☐ Unemployed ☐ Student ☐ Home Duties ☐ Pensioner

Name of GP / Medical Centre | Address

Your General Practitioner may be notified of your hospitalisation. Do you agree to this? Yes ☐ No ☐

PART B — PATIENT / GUARDIAN TO COMPLETE

NEXT OF KIN

Next of Kin | Relationship | Phone No: Home | Phone No: Mobile | Phone No: Work

Residential Address | Postcode

PART C — PATIENT / GUARDIAN TO COMPLETE

HOSPITAL PAYMENT DETAILS

Please Tick		NAME OF HEALTH FUND	LEVEL OF COVER	MEMBERSHIP NUMBER	LENGTH OF MEMBERSHIP
☐	INSURED				

OR

☐ WORKERS COMP / MVIT — If Workers Comp or MVIT, please complete Part D (over page)

OR

☐ UNINSURED — Please note uninsured patients are required to pay the full estimated fee on admission.

CARD DETAILS

☐ PENSION — HEALTH CARE CARD

☐ MEDICARE — DATE OF EXPIRY

Individual patient number (to the left of name on card)

Medicare
6000 555553
1 JOHN F CITIZEN
2 MARY G CITIZEN
VALID TO 05/2008

☐ VETERAN'S AFFAIRS — CARD COLOUR

I CONSENT TO BE VISITED BY A REPRESENTATIVE OF THE EX-SERVICE ORGANISATION'S YES ☐ NO ☐

☐ SAFETY NET — DATE OF ISSUE

PHARMACY

PLEASE BRING ALL YOUR CARDS WITH YOU TO THE HOSPITAL.

Have you been hospitalised or worked in a health care facility in the last 12 months?

YES ☐ NO ☐ If Yes, which hospital? _____ If you were hospitalised, please state discharge date _____

If the Hospital was outside Western Australia please contact our Admissions Office immediately.

TYPE OF ACCOMMODATION PREFERRED: PRIVATE ROOM ☐ SHARED ROOM ☐

Whilst every effort will be made to meet your preferred accommodation we can not guarantee availability on the day of admission and you will be charged for the room which you occupy. Please note that private room fees are higher than those for shared. It is recommended that you check your level of insurance prior to admission.

PLEASE CONTINUE OVER PAGE