



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 _____ Title _____ Sex _____ Marital Status _____ Date of Birth _____
OPTIONAL

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

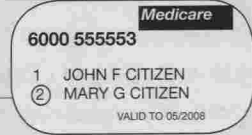
Please Tick INSURED **OR** WORKERS COMP / MVIT **OR** UNINSURED
 NAME OF HEALTH FUND _____ LEVEL OF COVER _____ MEMBERSHIP NUMBER _____ LENGTH OF MEMBERSHIP _____
 If Workers Comp or MVIT, please complete Part D (over page)
 Please note uninsured patients are required to pay the full estimated fee on admission.

CARD DETAILS

PENSION MEDICARE VETERAN'S AFFAIRS
 HEALTH CARE CARD _____ DATE OF EXPIRY _____
 CARD COLOUR _____ Individual patient number (to the left of name on card) _____

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.

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HR 110 PATIENT ADMISSION FORM