Minchinbury
Community Hospital

PRE ADMISSION FORM

ADMISSION DATE ____/____/_____

MEDICAL RECORD No.:	
SURNAME:	
GIVEN NAMES:	
DOB:	SEX: M F
AFFIX PATIENT LABEL HERE IF AVAILABLE	

PATIENT to complete PAGES 7-10 and FORWARD to HOSPITAL ADMISSIONS

1. PATIENT DETAILS

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other (please specify) _____

Given Names | Surname

DOB | Sex: ☐ M ☐ F | Previous Name/s

Address | Postcode

Home Phone | Work Phone | Mobile Phone

Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ De facto ☐ Separated ☐ Widowed | Religion

Aboriginal: ☐ Yes ☐ No | Torres Strait Islander: ☐ Yes ☐ No | Interpreter required: ☐ Yes ☐ No

Country of birth | Australian resident? ☐ Yes ☐ No | Language spoken at home:

Medicare Number | Pos | Expiry Date / | Concession Type: Healthcare/Pension/Safety Net | Expiry Date /

2. LOCAL DOCTOR/PRACTITIONER

Name | Suburb | Phone

3. NEXT OF KIN

Name | Relationship to patient

Address | Postcode

Home Phone | Work Phone | Mobile Phone

Enduring Guardianship / Power of Attorney (if applicable) - Name:

4. PAYMENT FOR THIS ADMISSION?

4.1 ☐ **Uninsured** - Payment required on admission. Outstanding account to be settled on discharge

4.2 ☐ **Private health insurance** - Excess and co-payment payable on admission

Health Fund | Membership Number | Has this changed in the last 12 months? ☐ Yes ☐ No

4.3 ☐ **Department of Veterans Affairs**

Card Number | **Colour:** ☐ Gold ☐ White ☐ Orange | Expiry

4.4 ☐ **Workcover** ☐ **Third Party**

Insurance Company / Case Manager

Phone | Claim number | Date of incident

5. PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Is this the patient? ☐ Yes - please sign consent below ☐ No - please complete details below and sign consent

Name | Relationship to patient

Address | Postcode

Home Phone | Work Phone | Mobile Phone

The portion of the estimated hospital fees not covered by a health fund must be paid prior to admission. Any additional fees incurred during your stay are payable on discharge. I have received information from my health fund regarding my estimated expenses and I understand and agree to pay all fees in relation to my hospital stay, including where my health fund or insurance claim is declined for any reason. I understand that the hospital is not responsible for any valuables I bring to the hospital and that I do so at my own risk.

Signature of person responsible for account | **Date**

BINDING MARGIN — DO NOT WRITE

PRE ADMISSION FORM

MR 0001A/2

Minchinbury
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PATIENT HEALTH HISTORY

MEDICAL RECORD No.:	
SURNAME:	
GIVEN NAMES:	
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ADMISSION DETAILS	YES	NO	COMMENTS
Have you been admitted to this hospital before?			
Have you been admitted to any hospital within the last 7 days?			
Have you had x-rays/scans taken for this admission?			Where?
Have you had blood tests for this admission?			Where? When?
Have you donated your own blood for the purpose of this operation?			Where?

ALLERGY / ADVERSE REACTIONS (e.g. medications, food, latex)	REACTION DETAILS

NOTE: Please list all medications including prescribed, over the counter and complementary medicines in the following section (please attach a list if there is not enough room). Consult your GP or surgeon if you are unsure of any details.

MEDICATION	STRENGTH	ROUTE	HOW OFTEN	DATE/TIME OF LAST DOSE	INSTRUCTIONS TO CEASE (if applicable)	DATE CEASED	NURSING NOTES
							☐ Medication List confirmed

PREVIOUS SURGERY / PROCEDURES eg. joint replacement, transplants, implants, colonoscopy

OPERATION	APPROX YR

PATIENT HEALTH HISTORY

What is your height? _____(cm) and weight? _____(Kg)

Have you or anyone in your family had an adverse reaction to anaesthetic? ☐ Yes ☐ No
(e.g. malignant hypothermia) Details: _____

Could you be pregnant? ☐ Yes EDD: _____ ☐ No LMP: _____
Are you breastfeeding? ☐ Yes ☐ No

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

How did this injury occur? _____ Where did it occur? _____

Do you drink alcohol? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

If yes what do you take and how often: _____

Have you ever smoked: ☐ Yes ☐ No Daily amount: _____ Date ceased: _____

Do you require a special diet? ☐ Yes ☐ No Details: _____

Do you use a CPAP Machine? ☐ Yes ☐ No (If yes, please bring with you)

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DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐ Heart problems ☐ Kidney/Bladder disease ☐ Heartburn/Reflux ☐ Cancer

☐ Stroke/Blood clots ☐ Hearing loss ☐ Liver disease ☐ High blood pressure

☐ Asthma/Lung disease ☐ Pacemaker/Defibrillator ☐ Sleep apnoea ☐ Thyroid disorder

☐ Arthritis ☐ Bleeding/Blood disorder/DVT ☐ Fainting or dizziness ☐ Gastric Banding/Sleeve Gastrectomy/Gastric Bypass

☐ Epilepsy/Fits/Blackouts. How frequent are the attacks? _____

Reactions / after effects following seizure? _____

☐ Tuberculosis/HIV/Hepatitis (A, B, C) ☐ Infections e.g. MRSA/VRE/ESBL

☐ A fever and/or respiratory symptoms in the last 7 days (cough, sore throat, runny nose)

☐ Returned from overseas in last 21 days? Country: _____

Do you have a family history of 2 or more relatives with CJD or other progressive neurological disorders? ☐ Yes ☐ No

Have you received human pituitary hormones for infertility or human growth hormones for short stature (prior to 1986)? ☐ Yes ☐ No

Have you previously had brain or spinal cord surgery that included a dura mater graft (prior to 1990)? ☐ Yes ☐ No

☐ Fall within last 2 months ☐ Walking/Mobility aid: _____

☐ Implanted prosthesis/devices/pins/plates Details: _____

☐ Blood transfusion Details of any reaction: _____

☐ Diabetes: Type 1 / Type 2 (circle) Controlled by: ☐ Diet ☐ Insulin ☐ Tablets

☐ Skin problems such as sores, bruises, blisters, rash, dermatitis, wounds, breaks in skin, pressure injury, psoriasis, eczema

Details: _____

☐ Lymphodema Details: _____

☐ Speech or swallowing problems Details: _____

☐ Limb paralysis or weakness Details: _____

☐ Visual aids - glasses contact lenses (Please circle)

☐ Hearing aids or appliance

☐ Dentures caps crowns loose teeth implants (Please circle)

DO YOU SUFFER FROM OR HAVE YOU BEEN TREATED FOR:

☐ Dementia, Alzheimer's, confusion

☐ Depression, anxiety, emotional disorder or other mental illness.Please specify: _____

☐ Delirium

☐ Traumatic brain injury

If ticked, who is your treating Doctor? _____

Other medical conditions or disabilities not mentioned or if any of the above boxes have been ticked, please provide further information:

_____

_____

_____

_____

_____

Please list any specific goals you have for this admission?

Details: _____

_____

PAEDIATRIC PATIENTS: Who will be staying overnight with the child? _____

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CARE AND DISCHARGE PLANNING	YES	NO	COMMENTS
Please provide us with the name of a support person who can be involved in communication and decision making about your care			Name: _____ Contact number: _____ Relationship: _____
Has anyone been appointed as your Power of Attorney and/or Enduring Guardian?			Name: _____ Contact number: _____
Do you have an Advanced Care Directive?			If yes please bring with you to hospital
Do you have any cultural or religious needs relating to your care or hospital stay?			If yes please provide details: _____
Do you live alone?			
Do you have someone to look after you after discharge?			Name: _____ Contact number: _____ Relationship: _____
Are you solely responsible for the care of another person at home?			If yes please provide details: _____
Do you currently receive community support and/or nursing services?			Name of provider: _____ Type: _____
Do you require assistance or have concerns with any aspects of day to day living?			
Do you require an interpreter?			Which language: _____
Are there any resources or equipment that you normally use to assist you with communicating?			If yes please provide details: _____

DAY SURGERY DISCHARGE PLAN (Patients who are NOT staying overnight)

All patients who have an anaesthetic (general or sedation) MUST have a responsible adult collect them from hospital and accompany them home.

How are you getting home? _____

Who is staying with you overnight? Name: _____

Phone: _____

I acknowledge I have read and understood the Patient Rights and Responsibilities, Privacy Policy and Financial Information on page 2 of this booklet. I confirm that the information completed in this Patient History Form is correct.

☐ **I do not consent to my clinical information being added to My Health Record**

Signature: _____

Patient Name (please print): _____ Date: _____

Name of admiting nurse:	Signature:	Date:
Designation:		Time:

PATIENT HEALTH HISTORY

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