Minchinbury
Community Hospital

REQUEST FOR ADMISSION

☐ **DAY ONLY**

☐ **OVERNIGHT** Number of nights _____

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

DOCTOR to complete PAGE 5 & PART A PAGE 6 and PATIENT to 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

Street Address

Suburb | State | Postcode

Home Phone | Work Phone | Mobile Phone

Financial Details: ☐ DVA ☐ Workers Compensation/CTP ☐ Self Insured ☐ ADF ☐ Health Insurance

Health Fund Provider | Membership/DVA Claim Number

2. ADMISSION/PROCEDURE DETAILS

Admission Date | **Provisional Diagnosis**

Planned procedure(s)

CMBS Item Number(s)

☐ LA
☐ Sedation
☐ GA
☐ Other _____

Allergies/ Adverse Reactions

Comorbidities

3. EQUIPMENT, PROSTHETIC AND PERIOPERATIVE INSTRUCTIONS

Details

4. PRE-OPERATIVE INVESTIGATIONS/TESTS

Please organise the following tests: ☐ UEC/U&C ☐ FBC/FBE ☐ COAG ☐ G&H ☐ X-Match _____ Units ☐ ECG ☐ LFT ☐ INR ☐ X-RAY

Other: _____

Could the patient be pregnant? ☐ Yes ☐ No

5. DRUG ORDERS ON ADMISSION (Include current medications - valid for 24 hours)

Drug	Dose	Route	Freq.	Doctor's Signature	Given by	Time	Given by	Time

6. VMO/MINCHINBURY COMMUNITY HOSPITAL ACCREDITED PRACTITIONER

Name | Provider No.:

Signature | Date

BINDING MARGIN — DO NOT WRITE

REQUEST FOR ADMISSION

MR 0001A/2