JOHN FAWKNER PRIVATE HOSPITAL

275 Moreland Road,
Coburg, Vic. 3058

Telephone: (03) 9385 2500
Fax: (03) 9385 2170

Pre-Admission Form

URNo: ..... **Admission No.:** .....
Surname: .....
Given Names: .....
Date of Birth: .....
Surgeon/Specialist Physician: .....
.....

To be completed by Patient.
Please PRINT clearly. Your responses are valuable in planning your admission and caring for your stay. Please return to John Fawkner Private Hospital as soon as possible.

Admitting Surgeon/Specialist Physician .....
Date of Admission: ...../...../..... **Date of Operation:** ...../...../.....
Admission Time: .....

ADMISSION TYPE
❑ Inpatient ❑ Day Patient
❑ Outpatient

Previous Hospitalisation

Have you previously been treated at this hospital? ❑ Yes ❑ No Year .....
Is this admission for a child? ❑ Yes ❑ No
Have you been hospitalised within 7 days prior to this admission? ❑ Yes ❑ No Which Hospital? ..... Dates: .....

Personal Details

Title: ..... Surname: ..... Previous Surname (if applicable): .....
Given Names: ..... Preferred Name: .....
Address: ..... Suburb: ..... State: .....
Postcode: ..... Telephone (Home): ..... (Business): ..... Mobile: .....
Sex: ❑ Male ❑ Female Date of Birth: ...../...../..... Age: .....
Marital Status ❑ Single ❑ Married ❑ De facto ❑ Separated ❑ Divorced ❑ Widowed
Are you an Australian Resident? ❑ Yes ❑ No Country of Birth: ..... **If Australia, Specify State** .....
Are you of Aboriginal/Torres Strait (TSI) descent? ❑ Yes ❑ No ❑ Yes, Aboriginal ❑ Yes, TSI ❑ Yes, both Aboriginal and TSI
Religion: ..... would you like a religious visit? ❑ Yes ❑ No

Person To Contact (Next of Kin)

Name: ..... Relationship to patient .....
Address: ..... Suburb: ..... State: .....
Postcode: ..... Telephone (Home): ..... (Business): ..... Mobile: .....
Second Contact/Power of Attorney: ..... Telephone: .....
Do you agree to your health information to be released to your next of kin? ❑ Yes ❑ No

Entitlements

Medicare Card No: ☐☐☐☐☐☐☐☐☐☐ ☐
Number preceeding your name on Medicare card
Medicare Reference No.: ..... Medicare Expiry Date: .....
Name on card: .....

Pension
Health Care Card No: ☐☐☐☐☐☐☐☐☐☐
Expiry Date: ..... Safety Net No: ☐☐☐☐☐☐☐☐☐☐

Repatriation No: ☐☐☐☐☐☐☐☐☐☐ Card colour: ❑ White ❑ Gold ❑ Orange

Veterans do you wish to be visited by a member of an Ex-service organisation? Please indicate: ❑ Yes ❑ No ❑ Yes, please organise it for me

GP / Local Doctor

Full name of GP: .....
GP Address: .....
GP Telephone: ..... GP Facsimile: ..... GP email: .....
Do you agree to your health information to be released to your GP ❑ Yes ❑ No

PRE-ADMISSION FORM MR 30

How Will You Claim For This Admision (please tick ✔ one box only)

❑ Private Health Insurance - Please complete Sections A and C

❑ Workcover/Third Party/TAC - Please complete Sections B and C

❑ Repat/Veterans Affairs - Please complete Entitlements and Section C

❑ Uninsured - Please complete Section C only

Section A: Private Health Insurance

Fund Name: ..... Membership No: ☐☐☐☐☐☐☐☐☐☐ Date Joined: ...../...../.....

Has this level of cover changed in the last

Type of cover: ❑ Single ❑ Family ❑ Other Level of cover (if known) ..... 12 months? ❑ No ❑ Yes

Summary of out of pocket costs (office use only) $ .....

Patient notified by: .....

Section B: WorkCover or Third Party

❑ Workcover or ❑ Third Party or ❑ TAC (Please tick on box)

- The approval letter for this admission (from your insurance company) must accompany this form.

Insurance Company Details: Name of Insurance Company: .....

Address Street: .....

.....

Suburb: ..... State: ..... Postcode: .....

Telephone: ..... Claim No: ..... Authorised by: .....

Has your insurance company accepted liability ❑ Yes ❑ No Please specify reason (if no): .....

Workcover Patients Only - Employer Details: Name of Employer: .....

Address Street: .....

.....

Suburb: ..... State: ..... Postcode: .....

Telephone: ..... Date of Accident: ...../...../.....

Has your employer completed a Report of Injury Form?: ❑ Yes ❑ No Have you completed a Workcover Claim Form?: ❑ Yes ❑ No

Please go to Section C - "Payment of Accounts"

Account Details

Is the Patient responsible for this account? ❑ No (Complete this section) ❑ Yes (Go to next section)

Name: ..... Relationship to Patient: .....

Address Street: .....

.....

Suburb: ..... State: ..... Postcode: .....

Telephone (Home): ..... (Business): ..... Mobile: .....

Preferred Accomodation

Whilst every effort is made to accomodate your request, we cannot always guarantee availability on the day of admission. Overnight Patients only - please indicate your preferred accomodation below. Note: Veterans Affairs. Workcover and Third Party Patients are covered for shared Room Accomodation only - a separate charge may apply for a single room.

❑ Shared Room ❑ Single Room **Please check level of health insurance cover if requesting a single room**

Section C: Payment Of Account - all patients to complete

The portion of your estimated hospital fees not covered by a health fund must be paid on admission. and additional fees incurred during your stay are payable on discharge. I understand and agree to pay all fees relating to my hospital visit, including where my health fund or my insurance claim is declined for any reason.
I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of person responsible for account: ..... Date: ...../...../.....

Witness (admission clerk) .....

MR 3C PATIENT HISTORY FORM