



Office Use Only:

Pre-Adm:	UR:	P
Ch:	R/A / New	C
Adm:	Bed:	A
		N

Patient Admission Form

If you require any assistance in completing this form, please contact the Admissions Dept on 8408 2163 or 8408 2166.

Admission Date:	Admission Time:	Admitting Doctor:
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Surname:	Mr/Mrs/Ms/Dr/Miss/Mast		
Given names:	Sex: Male / Female		
Date of birth:	Previous name: (if applicable)		
Residential Address:	P/Code		
Postal Address: (if different from above)	P/Code		
Telephone:	Home:	Business:	Mobile:
Religion:			
Country of birth:			
Marital Status:	Single / Married / Widowed / Divorced / Separated / DeFacto		
Indigenous Status:	Are you of Aboriginal or Torres Strait Islander Origin? <input type="checkbox"/> No		<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, TSI

Medicare number:	_____	Position on card: _____	Expiry date: __ / __
Ambulance membership number:			
Pension / concession / Health care card number:			
Dept Veteran's Affairs Entitlement number:	Card Type: Gold / White		

CONTACT PERSON DETAILS:

Contact Person (name):	Relationship		
Address:			
Telephone:	Home:	Business:	Mobile:
Emergency contact name:	Telephone:		

SPECIFIC REQUIREMENTS:

Do you have any specific food allergies or therapeutic dietary requirements?	Details:
Do you have any disabilities that require special consideration?	Details:

Continued overleaf.....

GENERAL PRACTITIONER DETAILS

General Practitioner :	Telephone:
Surgery Address:	
GP Notification	Do you consent to your GP being notified of your admission to hospital? Yes / No

FOR ACCOUNT PURPOSES

• PRIVATELY INSURED PATIENTS ONLY:

Health insurance benefit arrangements can be complex. It is advisable to check your level of cover prior to your admission. If you would like more information regarding any hospital excess payments, please contact the hospital on 84082099 or 84082098. Any excess, gap or co payment relating to your Hospital admission must be settled prior to admission.

Health Insurance Fund Level of cover:

Membership no: Contributors name:

• DEPT OF VETERANS PATIENTS ONLY:

Is this admission being claimed through DVA? DVA Entitlement No:

• WORKCOVER / COMPENSATION PATIENTS ONLY:

Is this admission related to a claim through : WorkCover / Third Party / Public Liability / Other ?

Claim no: Date of injury / accident:

Employer contact details: Employer Telephone

Address

Insurer contact details Contact Person / Claim Manager:

Company name: Telephone

Address

• UNINSURED PRIVATE PATIENTS ONLY:

Uninsured private patients are required to pay the estimated costs of hospitalisation on Admission. If you would like any more information regarding these estimated costs, please contact Patient Accounts on 8408 2016.

• PERSON RESPONSIBLE FOR ACCOUNT (if other than patient):

Name: Relationship:

Address: P/Code

Telephone: Home Business Mobile

If available, what level of accommodation would you prefer?
(Please note: While every effort is made to meet your preferred level of accommodation, this may not always be possible)

Single 2 bed share 4 bed ward

OFFICE USE ONLY

Previous hospitalisation in last 7 days? Yes / No

If yes, name of Hospital:

Adm: Disch:

I certify that the information on this form is true to the best of my knowledge. I accept full responsibility for accounts rendered by St Andrew's Hospital, including any shortfall in reimbursement by my Health Fund / Medicare or Insurer.

Signature: Date: