## **Patient Registration**

Tel: 9115 9888

Email: admin@doncasterhospital.com.au Web: www.doncasterhospital.com.au

Complete forms must be returned to the Hospital 7



days before admission

Title	Given Name: Preferred Name :			Surr	name:			
Address:		Suburb:				Postcode:		
Phone No: Mobile No:		Date of Birth (DD/MM/Y			YY):	Marital Status:		
Email :		Country of Birth: Preferred Language:						
Resident of Australia : Yes No			Name of GP: Address of GP:					
Are you [is the person] of Ab	original or Torres Strait Islander Yes, Torres Strait Islander	origin?	)	al an	d Torres Strait Isla	nder Decline to answer		
Medicare No:	adicara card is resinresal	<u> </u>			Ref No:	Expiry Date:		
*please advise staff if your Medicare card is reciprocal  Private Health Insurance Fund Name:  Policy Number:  Policy Number:  Do You have an excess?  Yes No Amount:					Yes No  It that an ambulance is required, be at the patient's expense.			
Department of Veteran Affa Card : Gold Whi			Work Cover an			Claim Number :		
Next of Kin (NOK) Contact Deta	ils (Person taking you home)							
Name:	Relationship to yo	ou:		Со	ontact Number:			
<b>Emergency Contact Detai</b>	ils							
Same as above:	es No If not, Please fill b							
Name:	Relationship to yo							
	al document to appoint som				on your benail)			
Do you have a Power of Atto	orney?: Yes No	If ye	es, Please fill bel	low				
Name:	Relationship to yo	ou:		С	Contact Number:			
Victorian Privacy Finformation from yeffective quality hefertments which Hospital. The info	ce with The Privacy Act 1988, the Principles, the management of Doyou, when you elect to be a patient ealth service to you. Some of the require us to submit information that we gather may be the required services for you.	oncaster of the inform n to the	Private Hospital hospital, in order action that we as me are regional transfer.	l woo r to e sked ristere	uld like to inform yenable us to provide from you are needed with the health	ou that we gather e efficient, safe and led by government department as Day		
information regard	give consent give consent ging myself to health workers, gove talth services to myself and to satisf	rnment	and statutory bod	dies i	n order to provide e			
l acknowledge that questions	I have reviewed the information o	n patien	t rights provided a	abov	e and staff were ava	ilable to answer my		
Sign:			Date	e : _				

Payment on admission may be made by cash, bank cheque, credit card (Visa, MasterCard) or EFTPOS.

Personal and business cheques are not accepted. Thank you for understanding.

## **Patient Medical History**

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Title	Given Name: Preferred Name:			Surname:			
Name of person completing this form :	Preferred N	ame :	Conta	ct ·			
Surgeon Name :				of Procedure :			
Goals of Care			Date	b) Procedure :			
Definition: Goals of care are the aims for a person care are not always restricted to medical care.	i's care, as agre	ed betwee	en the pa	itient, their family, carers and healthcare team. A person's goals			
What matters to you during your admission at I	Doncaster Priva	ite Hospit	al?				
,							
Discharge Planning : Someone to escort you hor	me and stay wi	th you ov	ernight				
Please provide the name & contact details of the person escorting			Name	2:			
home from hospital			Conta	act No :			
Please provide the name & contact details of you	ur carer staying	with you	Name	2:			
overnight after your procedure	As ab			act No :			
Are you a resident of an aged care facility/hostel?	Yes No			, Please bring printed medication chart and health summary			
General Information	165110	Y	N	More Comments			
Are you able to lie flat on your back?		1	14	Wore Comments			
Can you walk unaided?				If no, What aid do you use?			
Have you had a recent fall?				If yes What was the injury?			
Any compromised skin integrity – Ulcers, wound:	s. cuts. tears.			yee arrac need the injury.			
bruising, burns and skin disorder?	-,,,						
Any denture problems – Loose teeth, Veneers, in	nplants?						
Do you have an advanced care directive for treat	ment?			If yes Please bring a copy on admission			
Please provide your approximate <u>weight</u>		kg	Please	e provide your approximate <u>height</u>			
Medical History		Υ	N	More Comments			
Heart Condition: heart attack/surgery/stents/pal	pitation/AF						
High blood pressure							
Do you have a pacemaker or any prosthetic device	ces?						
Tendency to bleed/blood clots/bruise easily							
Migraines/Fainting/Dizziness							
Stroke/Epilepsy	ant/Intallactual			Potoile			
Dementia/Alzheimer disease/Cognitive impairmed disability	ent/intellectual			Details:			
Physical disability				Details:			
Psychiatry disorder – Depression/Anxiety/PTSD/0	Other			Details:			
Asthma/Bronchitis/Pneumonia/Sleep Apnoea/Emphysema				Details : On CPAP and Home Oxygen			
Reflux/Gastrointestinal disorders – Liver cirrhosis	s/disease			Details :			
Diabetes – Type I Type II				Insulin Tablets			
Thyroid Problems				Details :			
Kidney/Bladder problems/ Incontinence				Details:			
		1		Details :			
Arthritis							
Cancer				Chemotherapy Radiotherapy			
Cancer  Anaesthesia – Difficulty anaesthesia/Post-anaest	hetic confusion	1		Chemotherapy Radiotherapy Details:			
Cancer  Anaesthesia – Difficulty anaesthesia/Post-anaest in you or your family	hetic confusior	1		Details:			
Cancer  Anaesthesia – Difficulty anaesthesia/Post-anaest in you or your family  Have you ever had a blood transfusion?	hetic confusior			Details:  Details:			
Cancer  Anaesthesia – Difficulty anaesthesia/Post-anaest in you or your family	hetic confusior	1		Details:			

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days befor	e admission								
Lifestyle			Υ	N	More Comments				
Have you ever smoked?					Frequency Date ceased				
Do you drink alcohol?					Frequency Date ceased				
Do you use recreational drugs?					Frequency	Dat	e ceased		
Medications			Υ	N	More Comments				
Do you take blood thinning/arthritis medicines?									
Have you taken any ste	eroids or cortisone tablets	s/injections in							
the last 6 months?									
Are you on warfarin?					Date of test	: 11	NR result :		
	I to stop blood thinning m				If so by who	m V	Vhat date did you	cease	
	escription medicine – Her								
	e for all medication taker	_							
	does not accommodate		ons, please						lists
Medication	Dose	Frequency		Medication		Dose	Frequency	Frequency	
Allergies			Υ	N	More Comm	ents			
Medications			•	14	Wiore commi	ents			
Food									
Tapes									
· ·									
Latex									
Infection Prevention & (	Control		/ N	Infection	Prevention &	Control		Υ	N
Infection Prevention & 0		1	/ N					Υ	N
Infection Prevention & O	ter graft before 1990?	1	Y N	Have you	been tested po	Control ositive for HIV? an unexplained r	ecent progressive	Y	N
Infection Prevention & 0	ter graft before 1990?	1	Y N	Have you Have you	been tested po	ositive for HIV?	ecent progressive	Υ	N
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Infection Prevention & O Have you had a dura ma Liver condition – Hepatit Have you or a family infectious disease in th	ter graft before 1990? tis B or Hepatitis C y member been expos ne last 2 weeks (Covid-19	sed to an	YN	Have you Have you neurologic Have you resistant	been tested po suffered from cal illness? had an infecti organism MRS	ositive for HIV?  an unexplained recommend or colonization SA, VRE, CRE and/	with a multi-drug or have you had	Υ	N
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