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

DONCASTER PRIVATE HOSPITAL

Title Mr/Mrs/Ms/Miss/Master	Given Name: Preferred Name :	Surname:
Address:	Suburb:	Postcode:
Phone No : Mobile No :	Date of Birth (DD/MM/YYYY):	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 Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to answer

Medicare No: ***please advise staff if your Medicare card is reciprocal***	Ref No:	Expiry Date:
Private Health Insurance Fund Name: Policy Number: Policy Name : Do You have an excess? ☐ Yes ☐ No Amount:	Ambulance Cover: ☐ Yes ☐ No Number : ***In the unforeseen event that an ambulance is required, please note that it will be at the patient's expense.***	
Department of Veteran Affairs Card : ☐ Gold ☐ White Number :	Work Cover and TAC Insurance Company : Claim Number :	

Next of Kin (NOK) Contact Details (Person taking you home)

Name: Relationship to you: Contact Number:

Emergency Contact Details

Same as above : ☐ Yes ☐ No If not, Please fill below

Name: Relationship to you: Contact Number:

Power of Attorney (A legal document to appoint someone to make decisions on your behalf)

Do you have a Power of Attorney? : ☐ Yes ☐ No If yes, Please fill below

Name: Relationship to you: Contact Number:

Note: In accordance with The Privacy Act 1988, the Privacy Amendment (Enhancing Privacy Protection) Act 2012, and Victorian Privacy Principles, the management of Doncaster Private Hospital would like to inform you that we gather information from you, when you elect to be a patient of the hospital, in order to enable us to provide efficient, safe and effective quality health service to you. Some of the information that we asked from you are needed by government departments which require us to submit information to them as we are registered with the health department as Day Hospital. The information that we gather may be passed on to other health care providers such as pathologists in order to provide the required services for you.

I, _____ give consent to the management of Doncaster Private Hospital to provide information regarding myself to health workers, government and statutory bodies in order to provide efficient, Safe and effective qualify health services to myself and to satisfy government and statutory laws and regulations.

I acknowledge that I have reviewed the information on patient rights provided above and staff were available to answer my questions

Sign : _____ Date : _____

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

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

DONCASTER PRIVATE HOSPITAL

Title Mr/Mrs/Ms/Miss/Master	Given Name: Preferred Name :	Surname:
Name of person completing this form :	Contact :	
Surgeon Name :	***Date of Procedure :***	

Goals of Care

Definition: Goals of care are the aims for a person's care, as agreed between the patient, their family, carers and healthcare team. A person's goals of care are not always restricted to medical care.

What matters to you during your admission at Doncaster Private Hospital?

Discharge Planning : Someone to escort you home and stay with you overnight

Please provide the name & contact details of the person escorting you home from hospital	Name : Contact No :
Please provide the name & contact details of your carer staying with you overnight after your procedure As above ☐	Name : Contact No :
Are you a resident of an aged care facility/hostel? Yes ☐ No ☐	If Yes, Please bring printed medication chart and health summary

General Information	**Y**	**N**	**More Comments**
Are you able to lie flat on your back?			
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, wounds, cuts, tears, bruising, burns and skin disorder?			
Any denture problems – Loose teeth, Veneers, implants?			
Do you have an advanced care directive for treatment?			If yes Please bring a copy on admission

Please provide your approximate *weight*	**kg**	**Please provide your approximate *height***	**m**

Medical History	**Y**	**N**	**More Comments**
Heart Condition: heart attack/surgery/stents/palpitation/AF			
High blood pressure			
Do you have a pacemaker or any prosthetic devices?			
Tendency to bleed/blood clots/bruise easily			
Migraines/Fainting/Dizziness			
Stroke/Epilepsy			
Dementia/Alzheimer disease/Cognitive impairment/Intellectual disability			Details:
Physical disability			Details:
Psychiatry disorder – Depression/Anxiety/PTSD/Other			Details :
Asthma/Bronchitis/Pneumonia/Sleep Apnoea/Emphysema			Details : On CPAP and Home Oxygen ☐
Reflux/Gastrointestinal disorders – Liver cirrhosis/disease			Details :
Diabetes – Type I ☐ Type II ☐			Insulin ☐ Tablets ☐ Diabetic Medication tablets
Thyroid Problems			Details :
Kidney/Bladder problems/ Incontinence			Details :
Arthritis			Details :
Cancer			Chemotherapy ☐ Radiotherapy ☐
Anaesthesia – Difficulty anaesthesia/Post-anaesthetic confusion in you or your family			Details:
Have you ever had a blood transfusion?			Details:
Female Patient: Could you be pregnant?			Number of Weeks
Female Patient: Are you breastfeeding?			

Patient Medical History

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

DONCASTER PRIVATE HOSPITAL

Lifestyle	Y	N	More Comments
Have you ever smoked?			Frequency Date ceased
Do you drink alcohol?			Frequency Date ceased
Do you use recreational drugs?			Frequency Date ceased
Medications	**Y**	**N**	**More Comments**
Do you take blood thinning/arthritis medicines?			Clopidogrel / Plavix / Iscover / Apixaban / Dabigatran / Rivaroxaban, Prasugrel & Ticagrelor / Warfarin/Coumadin
Have you taken any steroids or cortisone tablets/injections in the last 6 months?			
Are you on warfarin?			Date of test : INR result :
Have you been advised to stop blood thinning medication?			***If so by whom*** ***What date did you cease***
Are you taking non-prescription medicine – Herbal medicines?			

If yes, please list the dose for all medication taken including herbal supplements and vitamins

If the space below does not accommodate your medications, please provide additional information – health summary with medication lists

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies	Y	N	More Comments
Medications			
Food			
Tapes			
Latex			

Infection Prevention & Control	Y	N	Infection Prevention & Control	Y	N
Have you had a dura mater graft before 1990?			Have you been tested positive for HIV?		
Liver condition – Hepatitis B or Hepatitis C			Have you suffered from an unexplained recent progressive neurological illness?		
Have you or a family member been exposed to an infectious disease in the last 2 weeks (Covid-19, shingles, chicken pox, measles, whooping cough and etc)?			Have you had an infection or colonization with a multi-drug resistant organism MRSA, VRE, CRE and/or have you had any other type of infection that affects your health status?		
Have you received human pituitary hormones (growth hormones, gonadotropins) before 1985?			Have you ever been involved in a 'look-back' investigation for CJD or have a 'medical in confidence letter' regarding you CJD risk?		
Within ***the last 12 months*** have you travelled overseas?			Within ***the last 12 months*** have you been admitted to hospital?		

Previous Operations/Procedures

If the space below does not accommodate surgical history, please provide additional information – health summary

Date	
Date	

I hereby acknowledge that I have read and understood the information provided to me in the patient information.

1. **I must not drive/operate machinery/sign legally binding documents within 24 hours of my anaesthetic.**
2. **I acknowledge I must have a responsible adult stay with me on the day of my procedure and overnight.**
3. **Acknowledgment that the patient/representative has filled in this form:**

Patient name: Sign: Date:

Office use only Pre-Admission completed by: Name: _____ Sign:_____ Date:_____

1. Pick up & Carer overnight
2. 24 hrs rest after anaesthetic – no work/ drive/ exercise etc
3. Bowel prep instructions and risk informed consent

Sign:_____ Date:_____ Approve admission Yes ☐ No ☐