Patient Registration Form

nexus | Crows Nest Day Hospital

This form is URGENTLY required PRIOR to your date of admission. Please take the time to complete this form and all other enclosed forms and deliver either in person or by mail no later than 5 days prior to admission to:

Patient Label

Crows Nest Day Surgery
Level 1, 22 Clarke Street, Crows Nest, NSW 2065
Phone: (02) 9955 5677 Fax: (02) 9966 4869

Date of Admission / / Time of Admission (Office Use Only)

Admitting Practitioner

Proposed Procedure

Have you been a patient at Crows Nest Day Hospital before? ☐ NO ☐ YES Year

PERSONAL / DEMOGRAPHIC DETAILS

Title Given Name Surname

Address

Suburb State Post Code

Telephone (h) (m) Email address

Date of Birth / / Gender ☐ Male ☐ Female

Country of Birth Are you an AUSTRALIAN Resident? ☐ YES ☐ NO

Are you of Aboriginal/Torres Strait Island (TSI) descent? ☐ NO ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, Both

Marital Status ☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

Religion Occupation

PERSON TO CONTACT (NEXT OF KIN) This is the person we will contact during your stay

Given Name Surname Relationship

Address

Suburb State Post Code

Telephone (h) (m) Email address

Second Contact: Name Telephone

ENTITLEMENTS

Medicare Card ☐☐☐☐ ☐☐☐☐☐ ☐ Valid to ____/____ Ref No ____

Pension Card ☐☐☐☐☐☐☐☐☐☐ Expiry Date ____/____/____

Safety Net Number ☐☐☐☐☐☐☐☐☐☐

GENERAL PRACTITIONER

Name of GP

Surgery Address

Suburb State Post Code Telephone

CLAIMING FOR THIS ADMISSION

How will you claim for your admission to Crows Nest Day Hospital?

☐ **Private Health Insurance** (complete section A) ☐ **DVA** (complete section B)
☐ **WorkCover/Third Party** (complete section C) ☐ **Self Insured** (Contact Hospital for an estimate)

Only complete the section which relates to your admission.

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Claiming Details

Patient Label

CLAIMING DETAILS

Eligibility Check Complete ☐ Yes ☐ No (OFFICE ONLY)

SECTION A - PRIVATE HEALTH INSURANCE

Excess Payable $ _____

Fund Name _____ Membership Number _____

Type of cover ☐ Single ☐ Family ☐ Other Do you have any EXCESS? Amount $ _____

Have you held this cover for greater than 12 months? ☐ YES ☐ NO

SECTION B - DVA

Repatriation Number _____ Card colour ☐ GOLD ☐ WHITE

SECTION C - WORKCOVER/THIRD PARTY ☐ WorkCover ☐ Third Party

The approval letter (from the insurance company) for this admission MUST be received prior to surgery, otherwise alternate arrangements for payment will need to be made, which may include upfront payments based on an estimate.

Name of Insurance Company _____

Address _____

Suburb _____ State _____ Post Code _____

Telephone _____ Fax _____

CLAIM NUMBER _____ **CONTACT PERSON** _____

Has your insurance company accepted liability? ☐ YES ☐ NO Specify reason _____

Employer Details (WorkCover Patients ONLY to complete)

Name of Employer _____

Address _____

Suburb _____ State _____ Post Code _____

Telephone _____ Fax _____

Date of Accident / / _____

Has your employer completed a Report of Injury Form? ☐ YES ☐ NO Have you completed a WorkCover Claim Form? ☐ YES ☐ NO

The above information is accurate and correct and I understand and agree to disclose health fund details and to pay all fees relating to my hospital visits, including where my health fund or insurance claim is declined for any reason. I have read & understood my rights & responsibilities, the complaint process, and consent to the disclosure of my personal details for the relevant bodies as detailed on Pages 4 & 5 in this information booklet. I also understand that the hospital will not be liable for any valuable that I bring to the hospital.

Signature _____ Date: _____

(PATIENT or PARENT/GUARDIAN – PLEASE INDICATE)

Please Sign Here

Patient History

Patient Label

Please complete the following and ensure this form is forwarded with all other pre-admission documents immediately to Crows Nest Day Hospital

ADMISSION DETAILS	YES	NO	PLEASE PROVIDE DETAILS
Is this admission for a past or present injury?			Cause of injury: Place: Date:
Have blood tests been taken for this admission?			Pathologist: Results with:
Have x-rays been taken for this admission?			With patient (✓) please tick With Doctor
Height..... Weight.....			Blood group (if known).....

ALLERGIES			
Have you any allergies to medication, food, sticky plaster, latex/rubber (balloon, gloves) or other substances?			Specify details and reactions

MEDICATIONS			PLEASE PROVIDE DETAILS
Have you recently taken blood thinning medication or Aspirin in the last 2 weeks?			Name of medication:
Have you been instructed to cease this medication?			Date last taken / / or still taking Y / N
Have you previously taken any anticoagulant therapy (Warfarin)?			Date last taken / / or still taking Y / N
Have you taken any steroids or cortisone tablets in the last 6 months?			Name of Medication Date last taken / / or still taking Y / N
Are you taking any other prescription, non-prescription or complimentary medication? List the medications you currently take (include the name of the medication).			

GENERAL MEDICAL CONDITION			PLEASE PROVIDE DETAILS
Asthma/bronchitis/obstructive airways/hay fever			(circle type)
Recent cold/flu/pneumonia			
Heart attack/chest pain/angina Palpitations/irregular heart beat/heart murmur			(circle type) Date / /
Pacemaker or heart valve			Make: Model: Last checked / /
High Blood Pressure			
Rheumatic fever			
Tendency to bleed, clot or bruise easily			
Diabetes			Type 1 Type 2 Unsure Managed by: Diet: Tablet: Insulin: (please ✓)
Thyroid problems			
Liver Disease/hepatitis (specify type A,B,C)			(circle type)
Hiatus hernia/gastrointestinal ulcers/bowel disorder			(circle type)
Stroke			Date / / Residual problems
Epilepsy/fits/febrile convulsions			(circle type)
Depression/dementia or other mental illness			(circle type)
Migraines			
Arthritis			
Broken skin or pressure areas			
Eye disease			
Impairment e.g. vision, hearing or mobility			
Have you fallen in the last 2 months?			
Exposure to other people with a communicable disease in the last 2 weeks.			
Infectious Diseases/recent infections/MRSA/VRE/HIV/CRE			
Female patients - could you be pregnant?			No. of weeks
Kidney/bladder problems			(circle type)
Cancer			Site:
Any other issue not mentioned above			

PROSTHESES/AIDS/OTHER			
Glasses/contact lenses			
Hearing aids			
Dentures/caps/crowns/loose teeth/implants			
Artificial joints or limbs/metal plates or pins			

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Previous Operations, Procedures or Anaesthetic Details

Patient Label

Please list any previous operations; include the dates and procedures performed

Date: / / ..... Date: / / .....

Date: / / ..... Date: / / .....

ADMISSION DETAILS	YES	NO	PLEASE PROVIDE DETAILS
Have you had any anaesthetics in the past?			
Have you had any problems with anaesthetics?			
Have you any blood relatives with anaesthetic problems?			
Have you ever had a problem with a blood transfusion?			

LIFESTYLE

Have you ever smoked?			Daily amount or date ceased / /
Do you drink alcohol?			Daily amount
Do you use recreational drugs?			Type daily amount
Do you have a special diet?			Type of diet
Do you require an interpreter? Indicate if you have an interpreter			Language spoken Name and contact details.

CREUTZFELDT JAKOB DISEASE (CJD) - (In the event of 'yes', please contact Infection Control Consultant)

Have you had a dura mater graft between 1972 – 1989?			
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorder?			
Have you received human pituitary hormones (growth hormones gonadotrophins) prior to 1985?			
Have you ever suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?			
Have you been involved in a "Look Back" study for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD?			

ACUTE RESPIRATORY INFECTIONS (Seasonal and Pandemic)
- (In the event of 'yes' to all 3 questions, please contact Infection Control Consultant)

Do you have fever and respiratory symptoms?			
Have you travelled to areas of high prevalence for acute respiratory infections (seasonal or pandemic) either overseas, or in Australia within the last 4 – 6 weeks?			
Have you had an overnight stay in an overseas residential aged care facility or hospital in the past 12 months?			

DISCHARGE PLANNING

Do you currently receive community support?			
Do you require nursing support after discharge?			
Have you organised for any necessary support aids on discharge?			

Patient Compliance Statement

1. I am aware of the danger to me of food or liquid in my stomach during anaesthesia and certify that I have not had and will not have anything to eat or drink from the time instructed.
2. I certify that I have a responsible adult to accompany me home and to stay with me overnight.
3. I understand the importance of following instructions regarding my post-operative care and agree to follow these instructions.
4. I am aware of the danger to myself/others and undertake to not drive a motor vehicle, operate machinery, drink alcohol or sign important documents for 24 hours following my anaesthetic.

Patient Please Sign Here

Name of escort/carer _____ Phone No _____

Signed: _____ Witness _____

(PATIENT or PARENT/GUARDIAN - PLEASE INDICATE)

NURSE USE ONLY – PRE ADMISSION ASSESSMENT

ADMISSION CRITERIA MET ☐ YES ☐ NO if No, what action was taken _____

Name of Nurse _____ Date / / Signature _____