MACQUARIE UNIVERSITY HOSPITAL

3 Technology Place, Macquarie University NSW 2109

Please complete surname and D.O.B as a minimum.

UR

Surname

Given name

Date of birth

PRE ADMISSION FORM

Patient to complete and fax to Hospital Admissions on +61 2 8088 6370 or forward to MUH.

1. PATIENT DETAILS

Title: Mr / Mrs / Ms / Miss Other (please specify)_____

Given Names

Surname

DOB

Sex: M / F

Previous Name/s

Address

Postcode

Home Phone

Work Phone

Mobile Phone

Email

Marital status: Single / Married / Divorced / De facto / Separated / Widowed

Religion

Aboriginal: Yes / No

Torres Strait Islander: Yes / No

Interpreter required: Yes / No

Country of birth

Australian resident? Yes / No

Language spoken at home

Medicare Number Pos Expiry Date / Concession Type : Healthcare/Pension/Safety Net Expiry Date /

BINDING MARGIN DO NOT WRITE

2. LOCAL DOCTOR / PRACTITIONER

Name

Suburb

Phone

3. NEXT OF KIN

Name

Relationship to patient

Address

Postcode

Home Phone

Work Phone

Mobile Phone

4. PAYMENT FOR THIS ADMISSION?

4.1 ☐ **Uninsured** – Payment required on admission. Outstanding account to be settled on discharge.

4.2 ☐ **Private health insurance** – Excess and co-payment payable on admission.

Health Fund

Membership Number

Has this changed in the last 12 months? Yes / No

4.3 ☐ **Department of Veterans Affairs**

Card number

Colour: Gold / White / Orange

Expiry

4.4 ☐ **WorkCover** ☐ **Third Party**

Insurance Company / Case Manager

Phone

Claim number

Date of incident

5. PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Is this the patient? ☐ Yes – please sign consent below ☐ No – please complete details below and sign consent

Name

Relationship to patient

Address

Postcode

Home Phone

Work Phone

Mobile Phone

The portion of the estimated hospital fees not covered by a health fund must be paid prior to admission. Any additional fees incurred during your stay are payable on discharge. I have received information from my health fund regarding my estimated expenses and I understand and agree to pay all fees in relation to my hospital stay, including where my health fund or insurance claim is declined for any reason. I understand that the hospital is not responsible for any valuable I bring to the hospital and that I do so at my own risk.

Signature of person responsible for account

Date

PRF ADMISSION FORM F1

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DAY ONLY PATIENT QUESTIONNAIRE

Patient to complete and fax / send with Pre Admission form.

1. GENERAL HEALTH

Please complete and print clearly. Your responses are valuable to us in planning your admission and care.

- ☐ Heart Problems
- ☐ Pacemaker/Implants
- ☐ High Blood Pressure
- ☐ Stroke/Blood Cots
- ☐ Bleeding/Blood Disorder
- ☐ Thyroid Disorders
- ☐ Asthma/Lung Disease
- ☐ Heartburn/Reflux
- ☐ Any other serious illness
- ☐ Arthritis
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Hepatitis / Liver Disease
- ☐ Fits/Faints
- ☐ Tuberculosis
- ☐ Kidney/Bladder Disease
- ☐ Sleep Apnoea
- ☐ Wounds/Breaks in skin
- ☐ Do you smoke?
- ☐ Have you ever smoked? Date ceased ___/___/___
- ☐ Are you pregnant?
- ☐ Significant Infection Eg. MRSA, VRE
- ☐ Recent Respiratory Infection Eg. Cold, Flu
- ☐ Travel overseas in the last 14 days
- ☐ Hearing Loss
- ☐ Walking Aids
- ☐ Recent dental work

If any of the above boxes have been ticked, please provide further information:

Do you have a special diet? ☐ Yes ☐ No Specify _____

Weight: _____ Kg Height: _____ cm

2. ALLERGIES / PAST HISTORY

Please list allergies/adverse reactions (including foods, medication, latex etc)	Please list major operations and dates (include all operations within the last six months)

Have you or your family ever experienced problems with anaesthetic? ☐ Yes ☐ No Specify _____

3. MEDICATIONS

Please list current medications (include HRT, the pill, complimentary therapies)

Are you currently or have within in the last 12 months taken Warfarin/Plavix/ blood thinning medication? ☐ Yes ☐ No

If Yes, have you been instructed to cease this medication? ☐ Yes ☐ No Date last taken

4. CREUTZFELDT JACOB DISEASE (CJD)

- Have you had a dura mater graft between 1972 and 1989? ☐ Yes ☐ No
- Do you have a family history of 2 or more relatives with CJD or other progressive neurological disorder? ☐ Yes ☐ No
- Have you suffered from recent progressive dementia, the cause of which has not been diagnosed? ☐ Yes ☐ No
- Did you receive human pituitary hormone (growth hormones)prior to 1986? ☐ Yes ☐ No
- Have you been involved in a "look back" for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD? ☐ Yes ☐ No

5. DISCHARGE PLANNING

Will you have someone to take you home? ☐ Yes ☐ No

Will you have someone at home to look after you for 24 hours? ☐ Yes ☐ No

BINDING MARGIN DO NOT WRITE

DAY ONLY PATIENT QUESTIONNAIRE F5