CANOSSA PRIVATE HOSPITAL

OPERATING THEATRE ADMISSION

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HOSPITAL ADMINISTRATION SECTION ONLY

FAMILY NAME: *UR:*

FIRST NAMES:

DATE OF BIRTH: *GENDER:*

AFFIX PATIENT LABEL HERE

Date of Admission:	**Surgeon:**

Personal Details		
Surname:		
Given Name:		
Preferred Name:		
Date of Birth:	Sex:	Marital Status: Single ☐ Married ☐ Defacto ☐ Widowed ☐ Divorced ☐
Street Address:		
Telephone: Home: Work: Mobile:		
Occupation:		
Country of birth:	Language spoken at home: Interpreter Required □ Yes □ No	

Health Care Nominated Contact Person/Next of Kin:	
Name:	Relationship:
Street Address:	
Telephone: Home: Work: Mobile: This will be the contact for care staff to discuss any health matters including injury and emergency care while in hospital.	

Ethnic Origin: Aboriginal □ Yes □ No Torres Strait Islander □ Yes □ No
South Sea Islander □ Yes □ No

Have you been discharged from any hospital in the last 7 days? Yes ☐ No ☐

If yes which Hospital:_____

Date of admission to that Hospital: _____ Date of discharge from that Hospital:_____

Have you been admitted to Canossa Private Hospital before? Yes ☐ No ☐

General Practitioner's Details

Usual General Practitioner:_____
Address:_____
Suburb:_____ Postcode:_____ Telephone:_____

Private Health Fund:	
Name of Fund:	Membership No:
Name of Contributor	Relationship to Patient:
Street Address:	
Telephone: Home: Work: Mobile:	
Is the membership – 12 months old? Yes ☐ No ☐	
If no, have you transferred from another fund? Which fund:	

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Workers Compensation/Third Party Insurance Patients

Employer:_____ Address:_____
Phone:_____ Fax:_____ Employer accepted liability? Yes ☐ No ☐
Insurance Company accepted liability for admission? Yes ☐ Approval no:_____ No ☐

Medicare/Entitlement Cards – please bring cards to hospital on the day.

☐
Medicare Card Number __ __ __ __ __ __ __ __ __ __ __

Your name is position _____ on the card Expiry date: _____

Veteran's Affairs Number: _____ White Card: ☐ Gold Card ☐

Pension/ Health Care Card: _____ Expiry Date: _____

Safety Net Card Number: _____ Expiry Date: _____

Commonwealth Senior's Card:_____ Expiry Date: _____

Person responsible for Account:

Name:	Relationship:
Street Address:	
Telephone: Home: Work: Mobile:	

Veteran's Affairs ☐ **WorkCover** ☐ **Other** ☐

DVA transport to be arranged? Yes ☐ No ☐
(Department of Veteran Affairs)

Financial Consent to be completed on admission

I certify the information on this form to be true to the best of my knowledge. I accept full responsibility for accounts rendered by Canossa Private Hospital, including any shortfall in reimbursement by my Health Fund following settlement by Health Fund. I have had the financial cost of my surgery explained to me.

Signature:_____ Print name: _____ Date:_____

Discharge Arrangements:

I have arranged for someone to take me home following my surgery and to stay with me overnight.

Name:	Relationship:
Telephone: Home: Work: Mobile:	
Signature:_____ Print name: _____ Date:_____	

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature:_____ Print name:_____Date:_____