Patient Registration
&
Health Questionnaire

Healthscope

NORTHPARK PRIVATE HOSPITAL
Cnr. Plenty & Greenhills Roads
BUNDOORA VIC 3083
Telephone: (03) 9468 0100
Facsimile: (03) 9467 7186
Website: www.northparkprivate.com.au

Please complete this form and return at least 7 days prior to admission & hospital account to be finalised prior to discharge.

Please return this form 7 days prior to admission or ASAP after seeing doctor & hospital account is to be finalised prior to discharge.

Healthscope

Admission No. | Room / Bed No. | UR No.

Northpark Private Hospital
Cnr Greenhills & Plenty Roads, Bundoora, Vic, 3083
Ph (03) 9467 6022
Fax (03) 9467 7186

PATIENT DETAILS

Date of Admission | Time of Admission : am pm | Date of Discharge

Have you been a patient at this hospital before? YES ☐ NO ☐ If yes, when? | Surname Was

Surname | **Given Names**

(Mr, Mrs, Ms, Miss, Dr.)

Address (Include Postcode) | Phone (Home) (Mobile) (Work)

Postal Address

Sex M ☐ F ☐ Marital Status | Date of Birth | Age

Country of Birth (If Australia, which state?) | Are you an Aboriginal or Torres Strait Islander YES ☐ NO ☐

Religion | Occupation | Medicare No. | Expiry Date | Medicare Ref. No.

DVA Gold ☐ White ☐ | DVA No. | Australian Resident YES ☐ NO ☐

For Pharmaceutical Benifits/Healthcare/ Safety Net / Pension (Insert No.) | Interpreter required YES ☐ NO ☐

PERSON TO CONTACT | Relationship | Phone (Home) (Mobile) (Work)

Address

2nd Contact/ Power of Attorney | Relationship | Phone (Home) (Work)

Address

Admitting Doctor

Referring Doctor | Clinic Address

INSURANCE DETAILS | **Name of Health Fund** | Table/Schedule

Membership No.

Date Joined Current Schedule | Date Paid To

Company:

Have you been in any other hospital this year? YES ☐ NO ☐ | If yes, where? | Date

PREFERRED OVERNIGHT ACCOMMODATION

PRIVATE ROOM ☐ SHARED ☐ ***OR*** DAY SURGERY ☐ ***Whilst every effort will be made to provide the type of accommodation requested, Please understand circumstances will not always permit us to do so.***

Please Note - Approval prior to admission is essential for WorkCover, T.A.C. and Veterans' Affairs patients.

WORKCOVER **TAC** *Accidents outside Victoria may not be covered*

Name of Employer	TAC Ref No.
Address	Location Date:
Postcode Phone No.	Reported at (Police Station)
Contact Person	Registration of Vehicles Involved
Date of Accident	Claim Accepted YES ☐ NO ☐	Mode of transport
Insurance Co. Claim No.	Driver/Passenger
Nature of Injury	Other Driver
Has liability been accepted by Insurance Company? YES ☐ NO ☐	Has this admission been approved? YES ☐ NO ☐

PRE-ADMISSION / REGISTRATION

PMG/Ducor HSHNVFMRXX08 04/10

PRE ADMISSION HEALTH QUESTIONNAIRE

UR Number .....

Surname .....

Given Name .....

Date of Birth ..... Sex .....

Age .....

What Operation are you having?	Date of Operation
Please note: Most Day Patients will be treated in the Day Procedure Unit	
Height (if known) Weight (if known)	Language Spoken

ALLERGIES **YES** **NO**

Are you allergic to any medications, foods, tapes, lotions, latex? If yes, what reactions do you have?

PAST HEALTH Do you have or have you ever had:	Yes	No	Comments	
Heart trouble eg heart attack, chest pain, angina, palpitations, irregular heart beat or heart surgery?				
Insertion of pacemaker, heart valve or stent?				
Rheumatic fever?				
Blood pressure problems?				
Stroke, "mini-strokes", blackouts, migraines, brain surgery?				
Blood clot in lung or leg?				
Anaemia, bleeding tendency or blood disorders? eg. leukaemia				
Breathing problems or lung disease eg asthma, bronchitis, emphysema, sinus, hay fever, T.B or pneumonia?				
Fitting or convulsions / epilepsy or fainting?				
Diabetes?			Diet Controlled (1) Tablets (2) Insulin (3)	
Thyroid problems? pancreatitis?				
Kidney or bladder problems? eg incontinence or infections				
Bowel problems? eg constipation, haemorrhoids, bleeding, inflammatory bowel disease?				
Gastric reflux, indigestion, stomach ulcer or hiatus hernia?				
Liver disease eg hepatitis, jaundice?				
Infectious diseases? eg HIV, hepatitis what type? TB?				
Arthritis, back or neck problems, spinal surgery, fractures?				
Mobility problems?				
Psychiatric, psychological problems?				
Eye problems eg glaucoma? do you wear contact lenses/glasses? Are you legally blind?				
Skin problems? eg. eczma or psoriasis				
Hearing problems? do you wear hearing aids?				
Any other health problems not listed above?				
Could you be pregnant?			If yes, please confirm before admission	
Do you smoke? (If yes, do not smoke at least 24hrs prior to your operation)			How many per day?	
Do you drink alcohol?			How much? How often?	
Special diet required? please state				

MR 20

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
and the
AUSTRALIAN ASSOCIATION OF SURGEONS

REQUEST FOR
SURGICAL OPERATION/PROCEDURE

I, ...

of .....

request that the following operation/procedure be performed .....

.....

* upon me/upon .....

The following, specific complications and risks have been explained:- .....

.....

.....

Following a discussion of *my/the patient's present condition including the nature and likely results of the operation/procedure, I accept the professional opinion of Dr_____ that this is the appropriate operation/procedure.

I also request and consent to the administration of anaesthetics, medicines, blood transfusions or other forms of treatment normally associated with this operation/procedure. I understand that other unexpected operation/procedures may be necessary and I request that these be carried out if required.

Although this operation/procedure is carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved.

I also understand that complications may occur with any operation/procedure and I accept the possible risks associated with this operation/procedure.

I have had the opportunity to ask questions about the above operation/procedure and I am satisfied with the information I have received.

"I acknowledge that such operation(s) and such operative procedures may include the administration of a blood transfusion and/or other blood constituents to me. The possible effects of such a transfusion (including the possibility of contracting an infectious disease, fatal or otherwise) have been explained to me by Dr_____ and I consent to such a transfusion of blood and/or its constituents as is deemed necessary for the preservation of my life and health during the course of the operation(s) stated above."

OR (strike out one of these)

I specifically state that I refuse administration of a blood transfusion and/or other blood constituents to me. I realise that serious injury or death may result from this refusal. I now exonerate and absolve absolutely the hospital and its agents and employees from any liability whatsoever for any damage, whether direct or indirect, to any person or persons including myself which may be said to flow from the omission to administer blood/products to me.

.....
Signature of patient/guardian/relative

.....
Signature of Doctor

.....
Full name of Doctor

.....
Witness

* Delete as required

.....
Date

ADMISSION AND DISCHARGE MEDICAL INFORMATION

Admission Date ...../...../.....

Discharge Date ...../...../.....

Doctor .....

TO BE COMPLETED BY DOCTOR ON OR PRIOR TO ADMISSION

Admission diagnosis .....

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.....

Past History .....

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Relevant Test Results .....

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Please arrange the following tests .....

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Management Plan .....

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OperationIProcedure .....

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.....

To be performed on ...../...../.....

Drug Reaction/Allergies

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Medication Orders .....

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Signature of Medical Officer .....

AFFIX PATIENT LABEL HERE

TO BE COMPLETED BY DOCTOR ON DISCHARGE

Discharge Diagnosis (the diagnosis established after study to be chiefly responsible for occasioning the patients episode of care in hospital) .....

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Co-Morbidities (please circle)
(other conditions affecting level of care or increased length of stay)

Hypertension Angina/IHD IDDM

NIDDM COAD/Emphysema/Bronchitis

Leg Ulcer CCF/LVF

Other - specify .....

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OperationIProcedure - specify .....

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.....

Complications (please circle)

Infection Haemorrhage Sepsis

Other - specify .....

.....

.....

Follow up .....

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.....

Signature of Medical Officer .....

MR 015