ST JOHN OF GOD
Bendigo Hospital

BE001

PATIENT REGISTRATION

U.R. Number

Surname

Given Names

Date of Birth / / Sex

FOR OFFICE USE ONLY

Use Label If Available or BLOCK LETTERS

St John of God Health Care are dedicated to providing the best possible care during your stay. We require you to complete this form in detail. Should you have any questions please do not hesitate to contact the admission department.

Please return the completed form to the Hospital as soon as possible to confirm your admission.

PATIENT DETAILS

Proposed Admission Date: ____ /____ /____ Admitting Doctor: _____

Title: Mr Surname: _____ Previous Surname: _____

Given Name(s): _____ Preferred Name(s): _____

Have you been hospitalised or worked in a hospital in the last 12 months? ☐ Yes ☐ No

Details _____

Sex: ☐ Male ☐ Female ☐ Indeterminate Date of Birth ____ /____ /____

Residential Address: _____

Suburb / Town: _____ State: Victoria Postcode: _____

Postal Address (if different to residential): _____

Mobile: _____ Other Contact: _____ Preferred contact time: morning

Email Address: _____

Marital Status: ☐ Married ☐ Never married ☐ Widow/Widower ☐ Divorced ☐ Separated ☐ Unknown

Employment: ☐ Child not at school ☐ Student ☐ Unemployed ☐ Employed
☐ Home Duties ☐ Retired ☐ Pensioner ☐ Other

Do you have a disability that we should be aware of, that requires particular support/understanding? ☐ Yes ☐ No

Please state the disability and support required (e.g. Auslan interpreter, wheelchair)

_____

Religion: _____ Tick if no religion ☐

Do you consent to a visit from a hospital accredited representative of your faith community? ☐ Yes ☐ No

Do you have any specific religious or cultural beliefs, practices or customs that may affect the way we care for you and your family? ☐ Yes ☐ No

Are you an Australian Resident? ☐ Yes ☐ No

Country of birth: _____ If Australia, which state? Not Applicable

Indigenous status: ☐ Aboriginal ☐ Aboriginal & Torres Strait Islander
☐ Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander

Language spoken at home: _____ Interpreter required? ☐ Yes ☐ No

NEXT OF KIN / CONTACT PERSON

Surname: _____

Given Name(s): _____

Relationship to Patient: _____

Address: _____

Suburb/Town: _____ Postcode: _____

Mobile: _____ Other Contact: _____

ADDITIONAL CONTACT PERSON

Surname: _____

Given Name(s): _____

Relationship to Patient: _____

Address: _____

Suburb/Town: _____ Postcode: _____

Mobile: _____ Other Contact: _____

If we are unable to contact you directly, we may need to contact your above nominated next of kin or contact person/s to provide information relating to your admission.

GP DETAILS

Name of regular Dr/Clinic/GP: _____

Dr Address: _____ Dr Phone: _____

We routinely send information about your hospitalisation to your GP. If you do not consent to this please tick this box ☐

NO WRITING IN MARGINS

PATIENT REGISTRATION

MR 001

SGHBOFMR0001 01/16

ST JOHN OF GOD
Bendigo Hospital

PATIENT REGISTRATION

U.R. Number.....

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DECISION MAKING

Have you legally appointed a substitute decision maker? ☐ Yes ☐ No
Do you have a financial Power of Attorney? ☐ Yes ☐ No
Have you prepared an Advance Care Plan, which is a statement of preferences about health and personal care and preferred health outcomes? ☐ Yes ☐ No
If yes to any, copies of such documents must be supplied to the hospital prior to or on admission.

FINANCIAL

Private Patient: ☐ Yes **Public Patient:** ☐ Yes **Uninsured/Self Funded:** ☐ Yes **Overseas Resident:** ☐ Yes

Medicare No.: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐ Medicare Person Number ☐ Valid to: ____ /____

Benefits Card: ☐ Pension ☐ Health Care Card ☐ Other Please Specify _____

Card No.: _____ Card Expiry Date: ____ /____ /____

Pharmacy Safety Net: ☐ Yes ☐ No Card No.: SN _____ CN_____

Health Insurance: ☐ Yes Name of Fund _____Membership No.:_____

Veteran Affairs: ☐ Yes Card No.: _____ Card Colour: select colour Card Expiry Date: ____ /____ /____

Workcover: ☐ Yes Date of injury ____ /____ /____ Claim No.: _____

If known: Insurance Co.: _____ Employer Name: _____

Employer Address: _____ Employer Tel. No: _____

MVIT/TAC: Claim No.: ☐☐/☐☐☐☐☐ Date of Accident: ____ /____ /____

Type of Accommodation Preferred: Private room ☐ Shared Room ☐ Either ☐
Whilst every reasonable effort will be made to provide you with the type of room accommodation indicated above, the Hospital does not guarantee that such a room will be available for you at any time during your admission. Please note that the private room rates are higher than the shared room rates and that by signing this admission form you acknowledge that you will be charged, and obliged to pay, for the type of room which you actually occupy regardless of your accommodation preference.

PRIVACY

The St John of God Health Care Privacy Brochure outlines how St John of God Health Care collects, obtains, holds, uses and discloses your personal information in accordance with St John of God Health Care's Privacy Policy. A copy of our Privacy Brochure has been provided to you and a copy is also available on request.

I consent to my treating practitioner(s) having full access to my health records. ☐ Yes ☐ No

I consent to being contacted by St John of God Health Care Marketing in relation to other services it offers. ☐ Yes ☐ No

ST JOHN OF GOD FOUNDATION

St John of God is a not-for-profit hospital group which relies on the generosity of its community to assist it to continue to deliver excellence in treatment and care. From time to time the St John of God Foundation contacts patients seeking their support. Please let us know if you **do not** wish to be contacted.

☐ I **do not** wish to be contacted by the St John of God Foundation.

ST JOHN OF GOD RESEARCH

I consent to being contacted by St John of God Health Care in relation to future research projects/studies as outlined in St John of God Health Care's Privacy Policy. ☐ Yes ☐ No

I consent to allow my health information to be used for research, teaching and quality assurance projects aimed at improving health care, on the understanding that my information will be kept confidential at all times in accordance with St John of God Health Care's Privacy Policy. ☐ Yes ☐ No

DECLARATION

I agree that the information provided within this form is true and correct to the best of my knowledge.

I confirm I have contacted my health fund and understand my level of cover for this admission. ☐ Yes ☐ Not privately insured

Signature: _____ Name: _____ Date:____ /____ /____

Form completed by: ☐ Patient ☐ Parent/Guardian ☐ Next of kin ☐ Carer ☐ Other

NO WRITING IN MARGINS

IMPORTANT

Please complete **all pages** and return to the hospital with your patient registration **as soon as possible.** Use the envelope provided. This form contains information that may be important to the anaesthetist and the nurses prior to your admission. Your answers will help us give you the very best care during your stay with us.

This form ***must*** be completed fo**r *each*** admission regardless of how recent your last visit to our hospital was.

If you are having surgery please contact your doctor as soon as possible regarding which medications you should continue or cease.

SURNAME…….. GIVEN NAME…….. DOB……/……/……	
DATE OF ADMISSION……/……/……..	**DOCTOR/SURGEON……..**
REASON FOR ADMISSION……..	
Is the reason for admission related to an accident or injury? Yes ☐ No ☐	
Date of accident or injury:……/……/…….. Where did it occur?.....	
How did it occur?(fall from ladder,twisting car accident etc.).....	

PHONE NUMBERS		OFFICE USE ONLY	
			SIGN
SURGICAL ADMISSIONS (Day & overnight cases)	**03 5434 3496**	MEDICAL HISTORY REVIEWED	
PREADMISSION CLINIC	**03 5434 3425**	ANAESTHETIC REFERRAL ATTENDED	
		CefOXITin ☐ CephAZOLin ☐ Gentamycin ☐ N/A ☐	

We will call you the day prior to your admission to advise you of your admission and fasting times. If your procedure is on a Monday, you will receive your call on the Friday before. Please do not call us, we will call you.

DISCHARGE TIME IS 10AM for overnight patients. Day procedure patients will be given their approximate discharge time when they are admitted.

Name of person collecting patient on discharge:……Contact no……

Discharge destination? Home ☐ Other……

Please be aware that all day stay patients must have overnight support of a responsible adult. Has this been arranged? YES☐ NO☐ Please provide details

……

ST JOHN OF GOD
Bendigo Hospital

PATIENT HISTORY
MR/010

U.R. Number.....

Surname .....

Given Names.....

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

Use Label If Available

BE010

PREVIOUS OPERATIONS *and/or* MAJOR ILLNESSES: Please list

Date	Description	Date	Description

ALLERGIES

Please list any allergies (and the reaction) you have to ***DRUGS, TAPES, LOTIONS, LATEX or FOOD***

Allergy	Signs and Symptoms

MEDICATIONS

List all the medications you are currently taking
Please include any ***ASPIRIN, WARFARIN, CORTISONE, STEROIDS*** **or** ***NATURAL THERAPIES***
(eg vitamins and supplements)

Medication	Dose	Frequency	Medication	Dose	Frequency

☐ **Webster Pack** ☐ **Dosette Box**

PLEASE BRING ALL YOUR MEDICATIONS TO THE HOSPITAL WITH YOU

MEDICAL HISTORY *Please tick appropriate column for **EACH** condition*

HEIGHT .....cm WEIGHT .....kg		Currently have	Had in past	Never had	**COMMENTS** Please feel free to write any additional information here.
Cancer (specify)					
High blood pressure					
Chest pain / Palpitations					
Heart attack / Angina					
Artificial heart valve					
Pacemaker or implanted defibrillator					
Recent Heart attack (less than 6 mths)					
Rheumatic fever					
Asthma					
Shortness of breath at rest / Home Oxygen					
Bronchitis / Emphysema					
Sleep apnoea / CPAP machine					
Tuberculosis / Pneumonia					
Epilepsy / Seizures					
Stroke / Blackouts					
Diabetes	Type I				
	Type II				
	Insulin				
	Tablets				Complete referral to Diabetic Educator
	Diet only				
Anaemia					Referral complete: Yes
Blood clot in leg /lung					Name:
Bleeding disorders					Date:
Hepatitis / Jaundice					Sign:
Kidney disease					
Renal Dialysis					
Indigestion / Reflux					
Arthritis					
Back or neck problems					
Muscle disorders					
Dementia					
Stress related conditions					
Extreme anxiety / Depression					
Psychiatric disorder (eg bi polar, schizophenia)					
Chronic pain syndrome					
Do you use recreational drugs?					
Other major infections (eg Hep B,C, HIV, Golden Staph, VRE)					
Eczema / hayfever					
Previous blood transfusion					
History of major anaesthetic complication					
History of allergic reaction or anaphylaxis					
Previous awareness or awake under anaesthetic					
Known “difficult airway” intubation					
Personal or family history of malignant hyperthermia					
Weight > 120 kg					
Currently taking Warfarin, Plavix or Ticlidopine					
Other					

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	YES	NO	DETAILS
Have you travelled overseas in the past 30 days? If yes, which country? _____			
Have you been hospitalised in an overseas health facility in the past 12 months?			
If yes, do you have signs or symptoms of a respiratory infection or fever?			
How far can you walk without getting short of breath?			
• around the house			
• less than 50 metres			
• greater than 50 metres			
Do you use a walking aid? (specify)			
Do you wear glasses / contact lenses?			
Do you have impaired hearing or wear a hearing aid?			
Do you have a dental appliance, crown or bridge?			
Do you smoke? If yes how many?			
Did you smoke in the past? When did you stop?			
Do you drink alcohol? If yes average daily.			
Have you had a recent change in weight?			
Do you have any problems with your bowels?			
Do you have any problems with your urine?			
Do you take any medications to sleep?			
Are you pregnant? If yes estimated due date			
Do you require a special diet? - Diabetic			
- Vegetarian			
- Gluten free			
- Cardiac			
- Other			

PATIENT VALUABLES

Do not fill out prior to admission. To be completed with the Admitting Nurse upon admission

Please Note: We recommend that patients do not bring valuable items into hospital. No jewellery (except a wedding band) may be worn during surgery. The hospital cannot accept responsibility for valuable items brought onto the premises.

Belongings	With Patient:	In Patient's Luggage	Given to / Date	In Safe
Jewellery (list)				
Watch				
Glasses				
Hearing Aid x1 x2				
Money / Wallet				
Other				

Patient Signature: .....

Admitting Nurse Name and Designation: .....

Admitting Nurse Signature:.....

EMAIL FORM