

THE AVENUE HOSPITAL

40 The Avenue, Windsor, Victoria 3181
Telephone 61 3 9529 7377 Facsimile 61 3 9529 6815

PRE ADMISSION REGISTRATION

OFFICE USE ONLY

UR No.: Admission No:

Surname:

Given Names:

Date of Birth: Doctor:

Patient Details

Admission Details (Patient to complete)

Date of Admission: Day: Month: Year: **ADMISSION TYPE**
 Date of Operation: Day: Month: Year: **Overnight Stay**
 Admission Time: **Day Stay**
 Admitting Doctor:
 Admission Diagnosis:
 Procedure/Treatment:

Personal Details

Title: Surname: Previous Surname (if applicable):
 Given Names: Preferred Name:
 Address: Suburb: State:
 Postcode: Telephone (Home): (Business): Mobile:
 Sex: Male Female Date of Birth: / /
 Age:
 Marital Status: Single Married De facto Separated Divorced Widowed
 Occupation:
 Are you an Australian Resident? Yes No Country of Birth: If Australia, specify state
 Are you of Aboriginal/Torres Strait Islander (TSI) descent?
 No Yes, Aboriginal Yes, TSI Yes, both Aboriginal and TSI
 Religion:

Person To Contact (Next of Kin)

Name: Relationship to patient:
 Address: Suburb: State: Postcode:
 Telephone (Home): (Business): Mobile:
 Second Contact/Power of Attorney: Telephone:

GP / Local Doctor

Full name of GP:
 GP Address:
 GP Telephone: GP Facsimile: GP email:

Previous Hospitalisation

Have you previously been treated at this Hospital? No Yes Year:
 Is this admission for a child? No Yes
 Have you been hospitalised within 7 days prior to this admission? No Yes
 Which Hospital? Dates:

Preferred Accommodation (Overnight Patients Only)

Whilst every effort is made to accommodate your request, we cannot guarantee availability on the day of admission.
 Overnight Patients only – please indicate your preferred accommodation below. Note: Veterans Affairs, Workcover and Third Party Patients are covered for shared Room Accommodation only – a separate charge will apply for a single room.

Shared Room Single Room **Please check level of health insurance cover if requesting a single room**

BINDING MARGIN - DO NOT WRITE

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MR 100

IF YOU HAVE A PENSION OR SAFETY NET CARD, PLEASE ENSURE THAT YOU COMPLETE THIS SECTION. THIS WILL ENSURE THAT YOUR REQUIRED PHARMACY WILL BE BILLED AT THE APPROPRIATE RATE.

Entitlements

Medicare Card No: [] [] [] [] [] [] [] [] [] [] Medicare Reference No: Medicare Expiry Date:

Pension/Health Care Card No: [] [] [] [] [] [] [] [] [] [] Expiry Date:

Safety Net No: [] [] [] [] [] [] [] [] [] []

Repatriation No: [] [] [] [] [] [] [] [] [] [] Card colour: White Gold Other

Do you wish to be visited by a member of an Ex-Service Organisation? No Yes, please organise

How Will This Admission be Claimed (please ✓ tick)

- Private Health Insurance - Please complete Sections A and C Workcover/Third Party/TAC - Please complete Sections B and C
 Repat/Veterans Affairs - Please complete Entitlements and Section C Uninsured - Please complete Section C only

Section A: Private Health Insurance

Fund Name: Membership No: Date Joined: / /

Has this level of cover changed in the last 12 months? No Yes

Type of cover: Single Family Other Level of cover (if known)

Do you have an excess? No Yes Amount \$ Have you paid an excess this year? No Yes Amount \$

Section B: WorkCover / TAC or Third Party

Workcover or Third Party or TAC (Please tick one box)

- The approval letter for this admission (from your insurance company/TAC) must accompany this form.

Insurance Company Details: Name of Insurance Company:

Address Street:

Suburb: State: Postcode:

Telephone: Claim No: Authorised by:

Has your insurance company/TAC accepted liability? Yes No Please specify reason (if no):

Date of Accident:

Workcover Patients Only - Employer Details: Name of Employer:

Address Street:

Suburb: State: Postcode:

Telephone:

Has your employer completed a Report of Injury Form?: Yes No

Have you completed a Workcover Claim Form?: Yes No

Section C: Person Responsible For Account

Name: Relationship to patient:

Address Street: Suburb: State:

Postcode: Telephone (Home): (Business): Mobile:

Privacy Statement

I understand and have been made aware of The Avenue Private Hospital's Privacy Policy. I also understand how my information is disclosed to The Avenue Private Hospital and other Health Facilities as required. Furthermore I understand and have been made aware that a Privacy Information Brochure is available to me.

I understand that the hospital will not be liable for any valuables I bring to the hospital.

Signature of Patient / Guardian: Date: / /