Personal Details
Pre – Admission Form

(Affix Patient Identification Label Here)

PLEASE NOTE: ANY HOSPITAL FEES INCLUDING HEALTH FUND EXCESS ARE TO BE PAID IN FULL ON DAY OF ADMISSION. PLEASE RETURN THIS COMPLETED FORM AS SOON AS POSSIBLE TO: PO BOX 1125 HERVEY BAY QLD 4655, EMAIL: reception@hbsurgical.com OR IN PERSON

(**Patient to complete**)

Date of Admission:________________________Surgeon/Specialist:____________________________

Operation/Procedure:____

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Child ☐ Other:_____________ Female ☐ Male ☐

Surname:________________________________ Given Names:___________________________

Maiden Name:_____________________________ Date of Birth:_____________ _____________

Home Address:____

____ Postcode:_____________

Postal Address if different from above:____

____

Telephone Numbers: Home_________________Mobile_________________Business______________

General Practitioner:__________________________________ Telephone Number ________________

Are you a permanent Australian Resident: Yes ☐ No ☐

Country of Birth: _____________________________________

Religion: ____

Are you of Aboriginal Descent Yes ☐ No ☐ Torres Strait Islander Descent Yes ☐ No ☐

Would you consent to a Blood / blood product transfusion if required? Yes ☐ No ☐

Do you require an interpreter: No ☐ Yes ☐ Language:_____________________

Do you have an Advanced Health Directive: No ☐ Yes ☐ certified copy supplied - Yes ☐ No ☐

Do you have an Enduring Power of Attorney: No ☐ Yes ☐ certified copy supplied - Yes ☐ No ☐

Have you read the 'Australian Charter of Health Care Rights?' Yes ☐ No ☐ (Please read your Patient Information Guide)

Next of Kin:

Name:____Relationship:___________________

Address: ____

Home Number:________________________________Mobile________________________________

Please complete details over page

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Medicare No: ______________________________ Expiry Date ________________ Patient Ref Number ____

DVA File No ______________________________ Expiry Date _________________ Gold ☐ White ☐

Private Health Fund ______________________ Membership Number _____________________________

☐ Top Cover ☐ Budget / Saver ☐ Nil Cover

Do you have an:

Excess: Yes ☐ No ☐ Amount: $__________ Co-Payment Yes ☐ No ☐ Amount: $___________

***This is payable on admission.**

Do you have exclusions on your level of cover? Yes ☐ No ☐

Pension/Healthcare Card _____________________ Expiry Date _________________________

Safety Net Card _____________________ Expiry Date _________________________

Transport Contact Details:

Full Name: __________________________ Phone: ________________ Mobile: _____________________

Overnight Carer: (if different from above)

Name: _________________________ Phone: _________________ Mobile: _____________________

ATTENTION: (please read and sign)

Property and Valuables

The hospital does not take any responsibility for the loss of any items that you bring into hospital with you. We recommend that you do not bring any items of value with you to hospital.

Personal Information

Each person has the right to the privacy of their personal information. Your personal information may be disclosed to: those providing medical treatment eg. Medical, nursing and other healthcare workers at the hospital and for on-going care after discharge, your health fund, DVA, Medicare as requested by law, eg.Queensland Health. To assist in health care planning, quality and safety reviews.

Important Notice For Day Surgery:

You will receive medication that may interfere with your ability to drive and make decisions. You MUST have a responsible carer to drive you home and care for you immediately following your discharge. You must have a responsible adult to care for you overnight. If you do not have a carer your procedure may have to be cancelled, and re-booked. Children must have a driver as well as a carer for the journey home.

The information provided by me is accurate to the best of my knowledge, I have read and understood the information provided. I understand I will be liable for all charges, associated with the procedure to be performed and will be expected to pay all costs not reimbursed by Private Health Insurance, QLD Workers' Compensation, Third Party Debtor or the Department of Veterans' Affairs, on the day of the surgery.

Signature:.. Date:.......................................