Patient ID label

San Day Surgery Hornsby

# ADMISSION FORM

Family Name ..........................................................

Given Name(s) .......................................................

D.O.B. ....................................................................

**PATIENT TO COMPLETE BOTH SIDES of this form if an eAdmission cannot be completed**

Return to: San Day Surgery Hornsby 1a Northcote Rd Hornsby 2077 or email to sandaysurgeryhornsby@sah.org.au

## THIS HOSPITAL VISIT

| Date of Admission | Admitting Dr's Name | Initials |
|---|---|---|
| _ _ _ _ 2 0 _ _ | ........................................ | .............. |

## PERSONAL DETAILS

Have you attended The San Day Surgery Hornsby as a patient before? ☐ No ☐ Yes (under what name)..........................................

| Title | Family Name | Given Name(s) | |
|---|---|---|---|
| Preferred Name | Previous Family Name (if applicable) | Date of birth | Gender ☐ Male ☐ Female |

Marital Status ☐ Married (including defacto) ☐ Single ☐ Widowed ☐ Separated ☐ Divorced — Home Ph

| Unit No. | Street No. | Street Name | Work Ph |
|---|---|---|---|
| Suburb | P/code | Email address | Mobile |

Pre-operative Instructions ☐ Phone call - preferred number ☐ SMS/E-mail

| Postal address same as above ☐ Yes ☐ No | If No, postal address | | Sydney Contact No.(s) if not from Sydney |
|---|---|---|---|
| | Suburb | P/code | |

| Country of Birth | Country of Residence | Occupation | Religion |
|---|---|---|---|

Language spoken at home

☐ English ☐ Other .......................... Interpreter required ☐ Yes ☐ No

Are you (is the person) of Aboriginal or Torres Strait Islander Origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to answer

| Usual GP's name | Address | | Phone No. |
|---|---|---|---|
| | Suburb | P/code | Fax No. (if known) |

## PERSONS TO CONTACT

| Name | Relationship | Home Ph |
|---|---|---|
| Street address (if different to above) | | Work Ph |
| Suburb | P/code | Mobile |
| Name of other Emergency contact | Contact Phone No.(s) | |

*If you are claiming through the Department of Veteran's Affairs or Workers' Compensation please go to next page*

**Do you have private health insurance?** ☐ No ☐ Yes **If yes, please provide details below**

## PRIVATE HEALTH FUND

| Fund name | Client / membership No. | Table / type of cover | Relationship of patient to contributor |
|---|---|---|---|
| Contributor's Title | Family Name | Given Name(s) | Home phone No. |

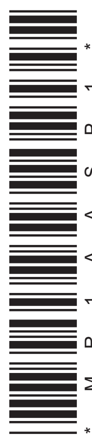
| Contributor's address if different from patient's personal street address? | P/code |
|---|---|

Have you been in this fund / table for over 12 months? ☐ Yes ☐ No

**If No,** have you transferred from another fund? ☐ No ☐ Yes If Yes, which fund?.........................................

ADMISSION FORM

MR 1AAS



| Family Name | Given Name(s) | D.O.B. | **OFFICE USE ONLY P2 OF MR 1AAS** MRN .................... |
|---|---|---|---|

**ENTITLEMENTS**
**Medicare / Veterans' Affairs**

**Medicare Card** Card No [ | | | | | | | | | | ] Medicare ID No Left of name [ ] Expiry ___ ___/___ ___

*If you do not intend to claim your hospitalisation costs through the DVA please complete Medicare Entitlement Section above*

**Veterans' Affairs** ☐Gold ☐Orange* ☐White DVA No [ | | | | | | | | ] * (Pharmaceutical benefits only) Expiry ___ ___/___ ___

*White cardholders only: Your doctor must obtain approval from the Department of Veterans' Affairs prior to day of admission*

**WORKERS' COMPENSATION / PUBLIC LIABILITY / THIRD PARTY PATIENTS ONLY**

**Type of claim** ☐ Workers' Compensation ☐ Third Party motor vehicle ☐ Public Liability

| Date of accident / / | Name of Insurer at time of accident | | Insurer's Claim No. |
|---|---|---|---|
| Insurer's address | P/code | Insurer's fax no. | Phone No. |
| **WCC Cases only** Name of employer | Contact person | | Phone no. |

**PERSON RESPONSIBLE FOR PAYMENT (if other than patient)**

Name

| Postal address for account (if different to above) | | | Home Ph |
|---|---|---|---|
| Suburb | P/Code | Work Ph | Mobile |

| | | | | |
|---|---|---|---|---|
| **ADVANCE CARE DIRECTIVE** *(If yes, a copy of this is required)* | Do you have an Advance Care Directive? | ☐Yes | | ☐No |
| **ENDURING GUARDIAN** *(If yes, a copy of this is required)* | Have you appointed an Enduring Guardian? | ☐Yes Name | Phone No. | ☐No |
| **POWER OF ATTORNEY** *(If yes, a copy of this is required)* | Have you appointed a Power of Attorney? | ☐Yes Name | Phone No. | ☐No |

**CONSENT TO USE PERSONAL INFORMATION**

I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the section on the San Day Surgery Hornsby Personal Information & Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital. I understand that my contact details may be given to the Sydney Adventist Hospital Foundation. I give consent to the use of my personal information as described in this Pre-Admission booklet. I understand that I may withdraw my consent at any time.

**Signature** ................................................................................. Print Name ....................................................... Date ........./............/20......

**ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES**

I have read and understand the section entitled *Patients' Rights and Responsibilities* in this Pre-Admission booklet and will discuss any queries with staff.

**Signature** ................................................................................. Print Name ....................................................... Date ........./............/20......

**CONFIRMATION OF COMPLETENESS OF FORM**

I certify the information on this form to be true & complete to the best of my knowledge.

**Signature** ................................................................................. Print Name ....................................................... Date ........./............/20......

*MR1AASP2*