



St Vincents & Mercy Private
 Phone: 9411 7111 Fax: 9419 6585
 Booking Office: 59-61 Victoria Parade Fitzroy 3065
 hospital.bookings@stvmph.org.au

PATIENT REGISTRATION FORM

St Vincents Mercy Vimy

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: _____ ADM No: _____
 SURNAME: _____
 GIVEN NAMES: _____ SEX: _____
 DATE OF BIRTH: _____ PHONE No: _____
 ADDRESS: _____

TO BE COMPLETED BY CONSULTING ROOMS

Admission Date _____ Admission Time _____ Overnight + Day Stay Only
 Procedure/Operation _____ Date _____
 Admitting Doctor _____
 Anaesthetist _____ Other Medical Practitioners _____

PERSONAL DETAILS TO BE COMPLETED BY PATIENT

Have you previously been a patient at St Vincents Private, Mercy Private or Vimy Private? Yes No
 Have you been a patient in any other hospital within the last 28 days: Yes No Which Hospital _____
 Preferred Accommodation: Shared Private
 Title: Mr Mrs Miss Ms Sr Fr Br Dr Other _____
 Surname _____ Previous Surname _____
 Given Names _____
 Address _____ Suburb _____ Postcode _____
 Phone No (Home) _____ (Work) _____ (Mobile) _____
 Sex Male Female Date of Birth ____/____/____ Age _____ Marital Status _____
 Religion _____ Country of Birth _____ Which state? _____
 Aboriginal/Torres Strait Islander Yes No Language Spoken _____
 Medicare Number - - Reference number (left of patient name)
 Medicare Expiry Date ____/____/____ Pension/Health Care Card No. _____
 DVA - Veterans Affairs No. _____ Gold White Safety Net No. _____
 Ambulance Membership Yes No Membership No. _____

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for your account?
 Private Health (see below) Uninsured DVA
 Workcover (see over) TAC (see over)

PRIVATE HEALTH INSURANCE

Fund _____ Membership No. _____

DOCTOR DETAILS

Name of GP _____
 GP Address _____
 GP Phone _____ GP Fax _____

TO ENSURE WE RECEIVE YOUR PAPERWORK PROMPTLY, PLEASE SUBMIT AT LEAST TWO WEEKS PRIOR TO ADMISSION

PLEASE DO NOT PULL APART

PATIENT REGISTRATION

MR1

PLEASE TURN OVER

NEXT OF KIN - FIRST CONTACT

Surname _____ Given Name _____ Relationship to patient _____
 Address _____ Suburb _____ Postcode _____
 Phone No (Home) _____ (Work) _____ (Mobile) _____

ADDITIONAL CONTACT PERSON

Surname _____ Given Name _____ Relationship to patient _____
 Address _____ Suburb _____ Postcode _____
 Phone No (Home) _____ (Work) _____ (Mobile) _____

MEDICAL POWER OF ATTORNEY

Surname _____ Given Name _____
 Address _____ Phone _____
 Do you have an Advanced Care Directive? Yes No

WORKCOVER

Name of Employer _____
 Address _____ Suburb _____ Postcode _____
 Phone _____ Date of Accident _____
 Has Employer accepted liability? Yes No If yes, attach acceptance letter
 Has an insurance Company accepted liability for admission? Yes No
 Name of Insurance Company _____ Claim Number _____
 Case Manager _____ Phone _____

TRANSPORT ACCIDENT COMMISSION (TAC)

Date of accident _____ TAC Claim No _____
 Support Co-ordinator / Rehabilitation Officer _____

If you have ticked Work Cover or TAC please note:

Approval of your application is necessary prior to admission. The TAC or Work Cover will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and they have accepted liability for your hospitalisation, treatments and other associated costs.
 If TAC or Work Cover do not accept liability for your hospitalisation, treatments and other associated costs, then you may be admitted under your private insurer.

DECLARATION CONCERNING CLAIM (The accurate answers to these questions are an essential part of this claim)

Patient/Guardian to complete (please tick (✓) below)	Yes	No
Do you have entitlement to claim compensation or damages (including previous settlements)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lodged a claim for compensation or damages?	<input type="checkbox"/>	<input type="checkbox"/>
Did the injury or condition occur at work, going to or from work or as a result of being at work?	<input type="checkbox"/>	<input type="checkbox"/>
Did the hospitalisation result from a motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>
Did the hospitalisation result from any other type of accident?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient a full-time student dependant over 17 years and under 25 years?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, name of educational institution: _____
 Date patient was first aware of symptoms: / / Date patient first consulted a doctor for symptoms: / /

- I hereby declare and warrant that all the above information provided in connection with this claim is true and correct.
- I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.
- I authorise my health fund to pay benefits directly to the hospital.

Patient's/
 Guardian's Signature: _____ Date: / /



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INFORMED CONSENT TO TREATMENT

St Vincents Mercy Vimy

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: _____ ADM No: _____
 SURNAME: _____
 GIVEN NAMES: _____ SEX: _____
 DATE OF BIRTH: _____ PHONE No: _____
 ADDRESS: _____

PLEASE READ THIS CAREFULLY BEFORE SIGNING

- This document should be read and signed by the patient provided he/she is an adult who is not suffering from any disability which renders them incapable of consenting, ie. not "competent" (in the legal sense).
- If the patient is a child or an adult person who is unable to consent, this document must be read and signed by the person legally responsible for making decisions about medical/surgical treatment of the patient.
- You should only sign this document if you are satisfied that it accurately records your discussions with the responsible doctor. If you have any questions about the operation or procedure, you must seek guidance before signing this document.

NAME & DATE OF BIRTH OF PATIENT

NAME _____ DATE OF BIRTH: _____

OPERATION/S OR PROCEDURE/S (include side if relevant) _____

I HEREBY CONSENT to the performance of operation/s or procedure/s listed above as recommended by Dr _____ The doctor has explained the nature and effect of the procedure/s or treatment/s and agreed to perform them. The doctor has also explained the form of anaesthesia (eg. general, spinal, regional, local) which may be required. I am satisfied that the indications, benefits, risks, complications and alternatives (if any) have been explained to me. I also consent to additional operation/s and or procedure/s which may be found to be necessary during the course of the aforementioned operation/s or procedure/s. I understand that a sample of my blood may need to be tested for infectious agents such as Hepatitis B, Hepatitis C and HIV in the event of its exposure to another person; for example my doctors or a hospital staff member. I specifically do NOT consent to the following (complete if required e.g. blood transfusion, or enter N/A if not applicable) _____

To be signed by the person who is consenting to the operation/s or procedure/s

DATE: _____ SIGNATURE: _____ PRINT NAME: _____

This section is to be completed only where the patient is not able to consent and the person signing is legally authorised to consent on the patient's behalf (eg. parent, guardian)

NAME, ADDRESS & STATUS OF PARENT, GUARDIAN, OR OTHER

NAME: _____ ADDRESS: _____

STATUS: Mother Father Guardian Other, specify _____

To be completed by the treating Doctor

DOCTOR'S ACKNOWLEDGEMENT

I certify that I have personally explained the nature of the patient's condition, the need for treatment, the operation to be performed and the material risks and alternatives (if any) to:

- the patient, or
- the person who has authority to make treatment decisions for and on behalf of the patient, and have provided an opportunity for questions to be asked.

DATE: _____ DOCTOR'S SIGNATURE: _____ PRINT NAME: _____

INFORMED CONSENT TO TREATMENT

M/R3



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INFORMED CONSENT TO TREATMENT

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FIX PATIENT IDENTIFICATION LABEL HERE

UR No: _____ ADM No: _____

SURNAME: _____

GIVEN NAMES: _____ SEX: _____

DATE OF BIRTH: _____ PHONE No: _____

ADDRESS: _____

Consent to Anaesthetic Procedure

I have informed _____ and/or _____
Print name of patient/person responsible Guardian/person responsible/relationship to patient

Name of treating STVMP Accredited Practitioner

- I have read/seen/heard and understand the following information sheet(s)/video(s)/audio presentation(s) which explains the anesthetic procedure(s) and the risks involved _____

Insert the name(s) of information sheet(s)/video(s)/audio presentation(s)

_____ (Delete this section if not applicable)

- I understood and am satisfied with the explanations I have been given. I consent to undergo the anesthetic procedure but do not consent to the following type of anesthetic (if applicable).

Signature of patient/person responsible

Signature of treating STVMP Accredited Anesthetist
who has obtained the consent

Date: _____

INFORMED CONSENT TO TREATMENT

MR3

DOCTORS USE ONLY



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PRE-ADMISSION HEALTH QUESTIONNAIRE

St Vincents Mercy Vimy

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UR No: _____ ADM No: _____
 SURNAME: _____
 GIVEN NAMES: _____ SEX: _____
 DATE OF BIRTH: _____ PHONE No: _____
 ADDRESS: _____

TO BE COMPLETED BY PATIENT

Interpreter required No Yes Language _____
 Form Completed by Patient Parent Relative/Carer, specify _____ Staff member
 Have you been in hospital in the last 2 months? Yes No
 Reason? _____ How long? _____

Reason for this admission and history or presenting illness:

If reason for admission is the result of an accident, please state:

When injury occurred: _____ Where injury occurred (eg. Football Field): _____

How injury occurred: _____

Medical/Surgical History List the medical conditions/operations performed and date (attach list if insufficient space)

ALLERGIES

Staff use

Do you have any allergies? Yes No (If yes please tick appropriate box and name allergies and give details)

Entered on IBA

 ___/___/___

Medication or natural remedy Allergy Latex / Rubber Allergy

Adhesive Tapes Allergy Food Allergy

Lotions Allergy Other Allergy

PATHOLOGY / X-RAYS OR OTHER TEST RESULTS

Staff use

Have blood tests / pathology / autologous blood been taken for **THIS admission** Yes No

Results available?
 In File
 Online
 Not available
 With Patient
 With Doctor

Which company? _____ When? _____

Have you had a recent ECG / Echocardiogram? Yes No

Have X-rays been taken for this admission? Yes No

If Yes – please make sure you bring them with you

MEDICATIONS

Staff use

Do you take or have you recently taken blood thinning medication (*Please Circle*) eg. Aspirin, Warfarin, Coumadin, Clopidogrel, Iscover, Plavix or natural blood thinning medication? Yes No

Patient aware of management plan
 Notified required and completed
 Surgeon
 Anaesthetist
 Theatre
 Ward
 DPU

Have you been told to cease this? Yes No
 Date to cease ___/___/___ Date last taken ___/___/___

Have you been told to start any other treatment eg clexane? Yes No

Have you taken any steroids or cortisone tablets/injections in the last 6 months? Yes No

If yes. specify _____ Date last taken ___/___/___

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

Name: _____

Date of Birth: ____ / ____ / ____



St Vincents & Mercy Private

CURRENT MEDICATIONS

Current medications – please list ALL medications including complementary medications and bring these to hospital in their original containers (attach a list if insufficient space)

DRUG NAME	DOSE	FREQUENCY / TIME	Staff use

GENERAL MEDICAL HISTORY	YES (Please Tick)	NO (Please Tick)	Comments & Further Information	
Heart Disease including Heart Attack / Angina			Details/Date	
(Please circle) High Blood Pressure High Cholesterol			Details Name of treating DR	
(Please circle) Peripheral Vascular Disease Palpitation, irregular heart beat / heart murmur				
(Please Circle) Implanted devices / prosthesis (eg joint / heart valve / lapband / stents / stimulators/ shunts/eye lens/other? Pacemaker – last checked ____ / ____ / ____			Specify Is surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No Bring ID information if applicable	Ward / Theatre Notified <input type="checkbox"/> ____ / ____ / ____
Diagnosed Sleep Apnoea CPAP <input type="checkbox"/> Mouth Guard <input type="checkbox"/>			Bring CPAP Machine to hospital Mouth Guard <input type="checkbox"/>	
(Please Circle) Asthma / bronchitis / emphysema / shortness of breath / hay fever / Pneumonia / TB			Treatment (Please Tick) <input type="checkbox"/> Oral Steroids <input type="checkbox"/> Puffers <input type="checkbox"/> Nebulisers <input type="checkbox"/> Home Oxygen	Please bring all Asthma medications
Anaesthetic Reactions			Details	Anaesthetic referral <input type="checkbox"/>
Family history of anaesthetic reactions				
Problems with extending neck fully?				____ / ____ / ____
Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>			Controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin <input type="checkbox"/> Pump	
Do you have instructions how to manage your diabetes before surgery?			Specialist details	
(Please Circle) Blood Disorders / bleeding problems / bruise easily / Anaemia			Details	
Blood clots in legs			Specify	VTE Assessment <input type="checkbox"/> PAC
Blood clots in lungs?			Is Surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> On Admission
Blood Transfusion Blood Transfusion reaction			Date of last transfusion ____ / ____ / ____ Type of reaction	
Epilepsy / fits / seizure			Last Seizure Treatment	
Arthritis			Details	

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7



Name: _____

Date of Birth: ____ / ____ / ____

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GENERAL MEDICAL HISTORY	YES (Please Tick)	NO	Comments & Further Information	Staff use
(Please Circle) Strokes / mini strokes / MS / Motor Neurone Disease			Any residual weakness or symptoms?	
Do you have Parkinson's Disease?			Treatment	
Short Term Memory loss / confusion			Details	
(Please Circle) Mental illness / nervous breakdown / anxiety attacks / depression / psychosis			Details	
Have you ever been treated for pain? Was this medication effective?			Specify	
Faints / Black outs / dizzy spells / Migraine			Details	
Fall in the past 12 months			Details	Falls Risk Assessment <input type="checkbox"/> By PAC <input type="checkbox"/> On Admission
Physical Disability – Mobility aids			Specify Please bring to hospital	Infection Control <input type="checkbox"/> __ / __ / __
Infectious diseases: HIV / sexual / hepatitis or other infections?			Specify Treatment	
Elimination issues: bowel or bladder problems / incontinence / stoma therapy			Specify	
Reflux / hiatus hernia / gastric ulcers				
Cancer			Location Date diagnosed ____ / ____ / ____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy	
(Please Circle) Skin conditions – existing wounds / fistula / pressure areas / ulcers / broken skin or reddened due to friction or pressure			Details and current treatment	Pressure Ulcer Assessment <input type="checkbox"/> By PAC <input type="checkbox"/> On Admission
Pregnant N/A			Due date ____ / ____ / ____	If yes, advise anaesthetist
Last menstrual period			Date ____ / ____ / ____	
Breastfeeding N/A				
Impairment <input type="checkbox"/> Vision <input type="checkbox"/> Hearing			Aids used	
Do you have Glaucoma?			Treatment	
Dental problems			Specify	
Do you have dentures			Specify	
Limited jaw movement			<input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Loose teeth	
INFECTION CONTROL ASSESSMENT				Staff use
(Please Circle) Have you had a cough/cold/ chest infection recently?			Currently taking antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeon aware? <input type="checkbox"/> Yes <input type="checkbox"/> No	Infection Control notified <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any illnesses such as gastroenteritis, or been in contact with someone who has had chicken pox within the last 14 days			Specify	__ / __ / __
CREUTZFELDT JACOB DISEASE				Staff use
Do YOU have acute dementia or progressive neurological disorder of less than 12 months duration?				Infection Control notified <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a FAMILY HISTORY of CJD or progressive neurological disorder of less than 12 months duration?				__ / __ / __
Were you a recipient of a dura mater graft prior to 1990?				Infection Control to manage <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been a recipient of human pituitary-derived hormones for infertility or short stature (prior to 1985)?				__ / __ / __
Have you been involved in a "Look Back" study for CJD or are in the possession of a "Medical in Confidence Letter" regarding risk of CJD?				No further action required as per plan <input type="checkbox"/> Yes <input type="checkbox"/> No __ / __ / __



Name: _____

Date of Birth: ____ / ____ / ____

St Vincents & Mercy Private

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

LIFESTYLE	Yes	No	Staff use
Do you smoke?			Consider Nicotine patches
Have you ever smoked regularly?			
Have you discussed nicotine replacement therapy or cessation with your Doctor?			
Alcohol intake			Amount Frequency
Recreational Drug use?			Type Frequency

NUTRITIONAL ASSESSMENT	Staff use
Height _____ cms Weight _____ kgs	BMI = Hovermat in IBA □ ____ / ____ / ____
Have you lost weight recently without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No = 0 <input type="checkbox"/> Unsure = 2	
If yes to weight loss: <input type="checkbox"/> 1-5kg = 1 <input type="checkbox"/> 6-10kg = 2 <input type="checkbox"/> 11-15kg = 3 <input type="checkbox"/> >15kg = 4	Nutritional Assessment Score of 2 or above – refer to dietician □ ____ / ____ / ____
Have you been eating poorly due to a decrease in appetite? <input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	
Food intolerance or allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Describe exact food and response	
Special dietary needs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetic <input type="checkbox"/> Kosher <input type="checkbox"/> Thickened Fluids <input type="checkbox"/> Texture Modified <input type="checkbox"/> Other – specify	
Do you require assistance with meals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cut up <input type="checkbox"/> Packets Opened <input type="checkbox"/> Special utensils <input type="checkbox"/> Assistance with eating	

Day Surgery Patients Discharge Plan
ALL PATIENTS UNDERGOING DAY PROCEDURES MUST HAVE AN ESCORT HOME AND A CARER OVERNIGHT

Who is taking you home? Name _____ Phone _____
 Who is staying with you overnight? Name _____ Phone _____

Overnight Patient Discharge Plan (NOTE – DISCHARGE TIME IS 9.30AM)	Staff use
Living arrangements <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner with Carer <input type="checkbox"/> With Family <input type="checkbox"/> Other, specify	Issues identified Referred <input type="checkbox"/> Home Health <input type="checkbox"/> Social Work ____ / ____ / ____ <input type="checkbox"/> N/A
Home environment <input type="checkbox"/> House/flat/apartment <input type="checkbox"/> SRS <input type="checkbox"/> Nursing Home <input type="checkbox"/> Retirement Village <input type="checkbox"/> Hostel <input type="checkbox"/> Other, specify	
At home there are <input type="checkbox"/> Steps <input type="checkbox"/> Stairs <input type="checkbox"/> Ramps/rails <input type="checkbox"/> External toilet <input type="checkbox"/> Separate shower <input type="checkbox"/> Shower over bath <input type="checkbox"/> Bathroom Handrails <input type="checkbox"/> Toilet Handrails	
Activity assessment – Do you cope independently with daily living activities eg showering, dressing? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify assistance required _____	
Support services at home <input type="checkbox"/> No services <input type="checkbox"/> Family / Friends <input type="checkbox"/> Personal carer <input type="checkbox"/> Delivered meals <input type="checkbox"/> Shopping <input type="checkbox"/> Home Nursing <input type="checkbox"/> Home Help <input type="checkbox"/> Personal alarm <input type="checkbox"/> Care package Case Manager _____ Phone _____	
Name of GP _____ Phone _____ Fax _____	
Do you plan to return to your current accommodation directly from hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, specify plans _____	
Are you a carer for others at home? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____	
Any additional patient information _____ _____ _____	
Signature _____ Date ____ / ____ / ____ Time _____	
Pre-Admission Form Sighted / Triage <input type="checkbox"/> Green No - Further Action Required <input type="checkbox"/> Orange <input type="checkbox"/> Red <input type="checkbox"/> Refer to MR2B Signed _____ Date ____ / ____ / ____	
Unit Nurses Signature _____ Date ____ / ____ / ____ Time _____	