ADMISSION REGISTRATION FORM

Pages 1-4 to be completed by patient

Completed forms must be returned to the hospital 7 days prior to admission

Have you been a patient of Vermont Private Hospital before? Yes ☐ No ☐

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐
Surname:
Given Name:
Preferred Name:

Level 2, 645 Burwood Highway
Vermont South Vic 3133
Phone: (03) 8547 1111 Fax: (03) 8414 2877
Email: reception@vermontprivate.com.au
www.vermontprivate.com.au

Surgeon Name:	Date of Procedure:	
Date of Birth:	Address:	
Gender: M ☐ F ☐		
Marital Status:	Suburb:	Post Code:

	Please mark preferred contact	☒
Religion:	Home Phone:	☐
Country of Birth:	Business Phone:	☐
Occupation:	Mobile:	☐
Resident of Australia? Yes ☐ No ☐	Email:	☐
Torres Strait Islander or Aboriginal? Yes ☐ No ☐	I agree to receive a feedback survey post discharge	☐

Name of General Practitioner:	Phone Number:
Address of GP Practice:	

Next of Kin (NOK)		**Emergency Contact** Same as NOK ☐	
Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐		Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐	
Full Name:		Full Name:	
Relationship:		Relationship:	
Home Tel No:		Home Tel No:	
Mobile No:		Mobile No:	
Address		Address	
Suburb:	Post Code:	Suburb:	Post Code:

Medicare No: ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___ Your Reference No. (___) *The number in front of your name*

Expiry Date: __ __/__ __ __ __

Pension Card No: ___ ___ ___-___ ___ ___ - ___ ___ ___ ___ Expiry Date: __ __/__ __/__ __ __ __

Health Care Card No: ___ ___ ___-___ ___ ___ - ___ ___ ___ ___ Expiry Date: __ __/__ __/__ __ __ __

Are you a member of Ambulance Victoria? Yes ☐ No ☐	Membership No:

Please contact your health insurance fund to confirm that you are covered for your hospital admission

Private Health Insurance	
Insurance Fund:	Policy Name:
Membership Number:	Date Joined:
Do you have an excess: Yes ☐ No ☐	Amount: $

Department of Veteran Affairs	**WorkCover ☐ TAC ☐**
Card: Gold ☐ White ☐ (Blue ☐ no treatment entitlement)	Insurance Company:
Card Number:	Claim Number:

Payment on admission may be made by cash, bank cheque, credit card (Visa, MasterCard) or EFTPOS.
Personal and business cheques are not accepted. Thank you for your understanding.

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PATIENT MEDICAL HISTORY

Title:	
Surname:	
Given Name:	
Date of Birth:	**Gender: M☐ F ☐**

Name of the person completing this form: _____ Phone: _____

DISCHARGE PLANNING			
You must have someone to escort you home and stay with you overnight, please provide the name & contact details of the person escorting you home from the hospital			**Name:** **Contact No:**
Do you have Ambulance Cover?	**Yes ☐**	**No ☐**	**Membership Number:**
Please provide the name & contact details of your carer staying with you overnight after your procedure			**As Above: ☐** **Name:** **Contact No:**
Are you a resident of an aged care facility / hostel?	**Yes ☐**	**No ☐**	**If yes, please bring the original medication chart from the aged care facility/hostel**

GENERAL INFORMATION	**YES**	**NO**	**Comments or Further Information**
Are you able to lie flat on your back for a length of time?			
Can you easily roll over in bed?			
Can you walk unaided?			**If no, what aid do you use?**
Have you had a recent fall?			**Were you injured? Yes ☐ No ☐**
Do you have compromised skin integrity? (e.g. ulcers, wounds, cuts, tears, bruising, burns, skin disorders)			
Do you have an advanced care directive or treatment limiting order?			**If yes, please bring a copy on admission**
Do you have a nominated medical power of attorney (POA)?			**If yes:** **Name of POA:** **Phone No. for POA:** **Please bring the original POA with you to the hospital**
Please provide your approximate **height** and **weight**?	Height:		Weight:

MEDICAL INFORMATION	**YES**	**NO**	**Comments or Further Information**
Cancer			Chemotherapy ☐ Radiotherapy ☐
High Blood Pressure			
Heart Condition: palpitations/irregular/heart attack/ surgery/stents/Rheumatic Fever			
Do you have a pacemaker or any prosthetic devices?			
Tendency to bleed/blood clots/bruise easily			
Stroke/Epilepsy			
Migraines/Fainting/Dizziness			
Physical disability			Details:
Depression/ Diagnosed Psychiatric illness			
Dementia/Alzheimer disease/Cognitive impairment/ Intellectual disability			Details:
Asthma/Bronchitis/Pneumonia/Sleep Apnoea/COAD/TB			Do you use a CPAP machine?
Recent Cold or Flu			
Hiatus Hernia/Gastrointestinal disorders/Reflux			
Diabetes (please indicate)			Insulin ☐ Diet ☐ Tablet ☐
Thyroid problems			
Kidney/Bladder problems/Incontinence			
Arthritis			
Female Patients: Could you be pregnant?			Number of weeks:

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PATIENT MEDICAL HISTORY

Title:	
Surname:	
Given Name:	
Date of Birth:	**Gender: M☐ F ☐**

LIFESTYLE	**YES**	**NO**	**Comments and Further Information**
Have you ever smoked?			**Frequency** **Date ceased**
Do you drink alcohol?			**Frequency** **Date ceased**
Do you use recreational drugs?			**Frequency** **Date ceased**
Do you require an interpreter?			**Frequency** **Date ceased**

MEDICATIONS	**YES**	**NO**	**Comments or Further Information**
Have you recently taken blood thinning/arthritis medication (Aspirin based)?			
Have you taken any steroids or cortisone tablets/injections in the last 6 months?			
If you are on Warfarin what was the date and result of your last INR?	**Date of test:**		
Have you been advised to cease your blood thinning medication? Yes ☐ No ☐ If so, by whom: What date did you cease:			
Are you taking any other prescription or non-prescription medication including sedatives? Yes ☐ No ☐			
If yes, please list the dose for **all** medication taken including herbal supplements and vitamins:			

If the space below does not accommodate your medication details, please send additional information along with this form

Medication	**Frequency**	**Dose**	**Medication**	**Frequency**	**Dose**

ALLERGIES

Are you allergic to: Medications ☐ Foods☐ Tapes ☐ Latex ☐ Nil known allergies ☐
Details:

INFECTION PREVENTION & CONTROL	**YES**	**NO**	**INFECTION PREVENTION & CONTROL**	**YES**	**NO**
Have you had a dura mater graft prior to 1990?			Have you been tested positive for HIV?		
Liver condition e.g. Hepatitis (specify type)			Have you suffered from an unexplained recent progressive neurological illness?		
Have you or a family member been exposed to an infectious disease in the last 2 weeks (shingles, chicken pox, measles, whooping cough etc.)? Have you had viral symptoms over the last 4 weeks (i.e. flu like symptoms)?			Have you had an infection or colonisation with a multi-drug resistant organism, for example MRSA, VRE, CRE and/or have you had any other type of infection that affects your health status?		
Have you received human pituitary hormones (growth hormones, gonadotropins) prior to 1985?			Have you ever been involved in a 'look-back' investigation for CJD or have a 'medical in confidence letter' regarding your CJD risk?		

Within the last 12 months have you; (please tick if applicable) Travelled overseas ☐ Been admitted to a hospital ☐
Had an overnight stay or admission in an overseas hospital or residential aged care facility ☐

PREVIOUS OPERATIONS/PROCEDURES/ANAESTHETIC DETAILS

If the space below does not accommodate your surgical history, please send additional information along with this form

Date: / /	
Date: / /	
Date: / /	
Have you or your family ever had a bad reaction to an anaesthetic? Yes ☐ No ☐ Details:	
Have you ever had a blood transfusion? Yes ☐ No ☐ Details:	

PATIENT ID LABEL

CONSENT FORM

DECLARATION TO BE COMPLETED BY THE PATIENT OR PARENT/GUARDIAN

I .....

of .....

hereby confirm that I have given consent to .....
(Name of specific surgeon performing procedure)

and any assistant, deemed necessary to perform the operation(s) / procedure(s) of:

.....

.....
(The site and side of the operation must be recorded in full (i.e. RIGHT or LEFT) and not abbreviated to L or R, whenever the side is recorded.)

on.....
(Insert either 'myself' or in the case of parent or guardian, the name of the patient.)

I also confirm that I have consented to such further or alternative measures as the person performing the procedure may find necessary during the course of such procedures and to the administration of a local or other anaesthetic for any of the foregoing purposes.

I **do / do not** consent to the administration of blood or blood products and I have notified my doctor and am aware of the risks, benefits and alterative options. (please circle the correct response)

Dated this.....day of.....20.....

Signature of patient or parent / guardian.....

SURGEON CONFIRMATION

I.....have explained to the patient / person legally responsible for the patient,
(Name of specific surgeon performing procedure)
the nature of the above operation(s) / procedure(s).

		Arranged Prior to Admission	Provider	Required on Admission
Pathology				
Xray				
ECG				

Dated this .....day of .....20.....

.....

.....

.....

Signature of doctor.....

MEDICATION ORDERS ON ADMISSION

Date	Drug	Dose	Route	Frequency & Duration	Doctor's Signature	Record of Administration		
						Date Given	Time Given	Given By

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DOCTORS REFERRAL

To be completed by surgeon

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐	
Surname:	
Given Name:	
Date of Birth:	Gender: M ☐ F ☐

ADMITTING SURGEON:	

PROCEDURE	
Proposed procedure	
Indicate correct side	Left ☐ Right ☐
Proposed Item numbers	
Date of procedure	
Type of Anaesthetic	GA ☐ Regional & Sedation ☐ LA & Sedation ☐ Topical & Sedation ☐ LA ☐ Topical ☐

CLINICAL DETAILS
Principal diagnosis (i.e. the condition which best accounts for patient's stay in VPH):
Other conditions present Asthma ☐ IHD ☐ CVA ☐ Obesity ☐ Diabetes ☐
Medications
Allergies

SPECIFY PRE-OPERATIVE INSTRUCTIONS (including tests required)	
☐ Preadmission nursing assessment	☐ Anaesthetic consultation
☐ Pathology	☐ Investigations
☐ Special Instructions	

DRUG ORDERS

☐ Drug orders on admission

Drug	**Route**	**Frequency**	**Time Given**				

Signature: _____ Date:_____/_____/_____