ADMISSION & MEDICAL REGISTRATION FORM

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

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐	**Level 2, Vermont South Medical Centre** **645-647 Burwood Highway** **Vermont South Vic 3133** **Phone: (03) 8547 1111 Fax: (03) 8414 2877** **Email: reception@vermontprivate.com.au**
Surname:	
Given Name:	
Preferred Name:	
Have you been a patient of Vermont Private Hospital before? Yes ☐ No ☐	

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:	☐
Are you a resident of Australia? Yes ☐ No ☐	Mobile:	☐
Occupation:	Email:	☐
Language Spoken at home:		
Do you require an interpreter? Yes ☐ No ☐	I agree to receive an electronic feedback survey post discharge	☐
Are you of Aboriginal or Torres Strait Islander decent? Yes ☐ No ☐		
Do you have any religious / cultural needs? Yes ☐ No ☐ If yes, please specify;		

Name of General Practitioner:	Phone Number:
Medical Centre Name:	
Address:	
Suburb:	Post Code:

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 Phone:		Home Phone:	
Mobile:		Mobile:	
Address:		Address:	
Suburb:	Post Code:	Suburb:	Post Code:

Account Information	
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 Number:

Private Health Insurance	
Have you contacted your health insurance fund to confirm you are covered for your hospital admission? Yes ☐ No ☐	
Insurance Fund:	Policy Name:
Membership Number:	Date Joined:
Do you have an excess? Yes ☐ No ☐	Excess amount: $

Department of Veteran Affairs (DVA)	**WorkCover ☐ TAC ☐ Not applicable ☐**
DVA 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.

DISCHARGE PLANNING	
Do you live alone?	Yes ☐ No ☐
Who will pick you up upon discharge?	**Name:** **Contact No:**
Please provide the name & contact details of your carer staying with you overnight after your procedure:	**As Above:** ☐ **Name:** **Contact No:**
Are you solely responsible for the care of another person at home?	Yes ☐ No ☐
Do you live in supported accommodation? Hostel ☐ Retirement village ☐ Nursing home ☐ **If you are a resident of a hostel or nursing home, please bring your original medication chart from the facility.**	

PREVIOUS SURGERY/PROCEDURES – Please list all your previous surgical procedures below. *Please attach additional information along with this form if the space provided is not enough.*	
OPERATION	APPROX YEAR

ALLERGIES – Please list all your known allergies below. *Please attach additional information along with this form if the space provided is not enough.*	
Do you have any allergies? (e.g. medications, tapes, latex, food) Yes ☐ Nil known ☐	
ALLERGY	REACTION
Do you require a special diet? Yes ☐ No ☐ If yes, please specify:	

CURRENT MEDICATIONS TAKES (please bring your medications with you on admission)		
Do you take blood thinning medication? Yes ☐ No ☐ If yes, please select: Aspirin ☐ Clopidogrel ☐ Plavix ☐ Warfarin ☐ Other ☐ ..... Date of most recent INR test: Most recent INR result: Pathology service that conducted your INR testing:		
Have you been advised to cease your blood thinning medication? Yes ☐ No ☐ If so, by whom? What date did you cease?		
Please list all medications you currently take below (including non-prescription medications such as herbal supplements and vitamins). If you have a medication list, please attach it to this form		
Medication Name	Frequency	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
Have you taken or are you taking Flomax? Yes ☐ No ☐		
Have you taken any steroids or cortisone tablets/injections in the last 6 months? Yes ☐ No ☐		

PLANNING FOR YOUR CARE		Comments or Further Information
Do you have an advanced care plan or directive?	Yes ☐ No ☐	If yes, please bring a copy on admission
Do you have a nominated medical power of attorney (POA) or substitute decision maker?	Yes ☐ No ☐	If yes; Name: Contact No.: Please bring the original POA on admission
Are you able to lie flat on your back for a length of time?	Yes ☐ No ☐	
Can you easily roll over in bed?	Yes ☐ No ☐	
Can you walk unaided?	Yes ☐ No ☐	If no, what aid do you use?
Have you had a recent fall?	Yes ☐ No ☐	If yes, were you injured?
Do you have any skin conditions? (e.g. ulcers, wounds, cuts, tears, bruising, burns, skin disorders)	Yes ☐ No ☐	Details:
Goals of Care – Is there anything we can do during your admission to assist you further?		

INFECTION PREVENTION & CONTROL	
Have you had any of the following?	
A dura mater graft prior to 1990?	Yes ☐ No ☐
Suffered from an unexplained recent progressive neurological illness?	Yes ☐ No ☐
You or a family member been exposed to an infectious disease in the last 2 weeks (e.g. shingles, chicken pox, measles, whooping cough etc.)?	Yes ☐ No ☐
Had viral symptoms over the last 4 weeks (e.g. flu like symptoms)?	Yes ☐ No ☐
Had vomiting or diarrhoea in the past 48 hours?	Yes ☐ No ☐
Ever been involved in a 'look-back' investigation for CJD or have a 'medical in confidence letter' regarding your CJD risk?	Yes ☐ No ☐
Received human pituitary hormones (growth hormones, gonadotropins) prior to 1985?	Yes ☐ No ☐
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?	Yes ☐ No ☐
Have you tested positive for HIV?	Yes ☐ No ☐
Within the last 12 months have you; (please tick if applicable) Been admitted to a hospital ☐ Travelled overseas ☐ Been admitted to an overseas hospital or residential aged care facility ☐	

HEALTH QUESTIONNAIRE		
Do you have, or have you ever had, any of the following? (If yes, please provide further details)		
1. Have you or any of your blood relatives ever had a problem with anaesthetic?	Yes ☐ No ☐	Details:
2. Please provide your approximate height and weight		Height: Weight:
3. Difficulty swallowing, opening your mouth or moving your neck	Yes ☐ No ☐	Details:
4. Difficulty walking up more than two flights of stairs	Yes ☐ No ☐	What stops you walking further?
5. Dentures	Yes ☐ No ☐	Upper only ☐ Lower only ☐ Both upper and lower ☐
6. Hearing aids	Yes ☐ No ☐	Right ☐ Left ☐ Both ☐
7. High blood pressure	Yes ☐ No ☐	Is it controlled by medications? Yes ☐ No ☐
8. Angina / chest pain	Yes ☐ No ☐	How frequently?
9. Arrhythmias or palpitations	Yes ☐ No ☐	Details:
10. Heart attack	Yes ☐ No ☐	Date:
11. Heart surgery / pacemaker / defibrillator inserted	Yes ☐ No ☐	Date and type:
12. Other heart problems	Yes ☐ No ☐	Details:
13. Heartburn or acid reflux	Yes ☐ No ☐	Is it controlled by medications? Yes ☐ No ☐
14. Liver disease / hepatitis / jaundice	Yes ☐ No ☐	Details:
15. Kidney disease	Yes ☐ No ☐	Dialysis: Yes ☐ No ☐
16. Diabetes	Yes ☐ No ☐	Pre diabetic ☐ Diet controlled ☐ Tablets ☐ Insulin ☐ Medication ☐ please specify: Usual blood sugar levels:
17. Asthma	Yes ☐ No ☐	How frequent are your attacks? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Less frequent ☐ please specify:

18. COPD / Emphysema / Lung disease	Yes ☐ No ☐	Please specify:
19. Sleep apnoea	Yes ☐ No ☐	Do you have a CPAP machine? Yes ☐ No ☐
20. Stroke or TIA / MS / Motor Neuron Disease	Yes ☐ No ☐	Please specify:
21. Epilepsy or fits	Yes ☐ No ☐	How frequent are your attacks? Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Less frequent ☐ please specify: Date of last fit:
22. Arthritis	Yes ☐ No ☐	Are you taking steroids? Yes ☐ No ☐
23. Bleeding / bruising disorders	Yes ☐ No ☐	Blood clots in the legs or lungs? Yes ☐ No ☐
24. Anaemia / Previous blood transfusion	Yes ☐ No ☐	Please specify:
25. Have you ever smoked tobacco?	Yes ☐ No ☐	Number per day: If stopped, when did you stop?
26. Do you drink alcohol?	Yes ☐ No ☐	How many drinks per week?
27. Do you take recreational (party) drugs?	Yes ☐ No ☐	What do you take and how often?
28. Do you or have you ever suffered from anxiety, depression or emotional disorders?	Yes ☐ No ☐	Please specify: Have you ever seen a psychologist or psychiatrist? Yes ☐ No ☐
29. Have you ever been diagnosed with a spectrum disorder?	Yes ☐ No ☐	Please specify:
30. Female patients: Could you be pregnant?	Yes ☐ No ☐	If yes, number of weeks?
31. Other medical conditions or disabilities not already mentioned	Yes ☐ No ☐	Please specify:

I (patient / substitute decision maker) consent for my General Practitioner to disclose my / the patient's medical record and medications for the purpose of my care and treatment at Vermont Private Hospital.

Signature:	**Date:**

Office use only (staff to complete)	
Reviewed by nursing/medical staff; Name (print): Designation: Date:	Suitable for anaesthetic at VPH? Yes ☐ No ☐ Requires further assessment? Yes ☐ No ☐ Action taken: