Sydney Adventist Hospital

ADMISSION FORM

OFFICE USE ONLY

MRN | ACN

Form	Date received
☐ MR1AB HBL	/ /20
☐ MR26A Patient History	/ /20
☐ MR1C Consent	/ /20
☐ MR1AA Admission form	/ /20

THIS HOSPITAL VISIT

Date of Admission

Date of Procedure

Preferred accommodation (please tick)
☐ Single Room ☐ Shared Room (***Not available for Maternity or Day patients Only***)

SAH cannot guarantee that your accommodation preference will be granted as room allocations are based on availability and clinical need. Gap payments will apply for private rooms if your insurance does not cover private room fees. This also applies if your preference is for a shared room and you are allocated a private room.

Admitting Dr's Surname | Initials | Suburb

PERSONAL DETAILS

Have you attended this Hospital as a patient before? ☐ No ☐ Yes (under what name).....

If this admission is for a child, was the child born at this hospital? ☐ No ☐ Yes Mother's 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

Postal address same as above ☐ Yes ☐ No

If No, postal address | Sydney contact No.(s) if not from Sydney

Suburb | P/code | Preferred contact No. for pre-operative phone call

Country of Birth | Country of Residence | Occupation | Religion

Language spoken at home ☐ English ☐ Other ..... Interpreter required ☐ No ☐ Yes

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)

PRIVATE HEALTH FUND

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

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?.....

Patients with less than 12 months membership in their fund / table may not be eligible for any benefits.

Return address: Sydney Adventist Hospital
Admitting Officer, Freepost 6, 185 Fox Valley Rd,
Wahroonga NSW 2076

ADMISSION FORM

MR 1AA

MR1AAP1

Family Name	Given Name(s)	D.O.B.	**OFFICE USE ONLY P2 OF MR 1AA**
			MRN ..... ACN .....

ENTITLEMENTS
Medicare / Safety Net / Veterans'Affairs

Medicare Card Card No | | | | | | | | | | Medicare ID No Left of name | | . Expiry ___ ___/___ ___

Other Card Type
- ☐ Pensioner Card
- ☐ Health Care Card
- ☐ C'wealth Senior Card

| | | | | | | | | | | Expiry ___ ___/___ ___/____ ____

Safety Net Card
- ☐ Safety Net Entitlement
- ☐ Safety Net Concession

| | | | | | | | | | |

If you have a current Prescription Record Form, please bring this with you to the hospital as you may be eligible for benefits under the Medicare Safety Net Scheme.

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 Do you have an Advance Care Directive? ☐ Yes (**If Yes**, a copy of this is required) ☐ No

ENDURING GUARDIAN Have you appointed an Enduring Guardian? ☐ Yes (**If Yes**, a copy of this is required) ☐ No
Name Phone No.

POWER OF ATTORNEY Have you appointed a Power of Attorney? ☐ Yes (**If Yes**, a copy of this is required) ☐ No
Name Phone 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 Sydney Adventist Hospital 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 also 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 ...../...../.....

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 ...../...../.....

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 ...../...../.....

Hospital admission in the last 6 months (including SAH) ☐ Yes ☐ No

If Yes, which hospital? .....

Reason .....

From ...../...../..... to ...../...../.....

If SAH, planned admission ☐ Yes ☐ No