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08/2023





Please complete the following forms and send to the **hospital** as soon as possible.

Consent Form

(Specialist to complete and sign Part A)
(Patient to complete and sign Part B section)

Patient Registration Form

(Patient to complete and sign)

Patient Health History

(Patient to complete and sign)



PATIENT HEALTH HISTORY –
ADDITIONAL OBSTETRIC INFORMATION

It is preferable that this form is received by the hospital as soon as possible, or no later than 48 hours prior to admission.

TO BE COMPLETED BY MATERNITY PATIENT ONLY

Attach patient identification label

UR Number:

Surname:

Name:

Date of Birth:.....Gender:.....

Dr:

Patient Details

Grey shaded areas to be completed by nursing staff and initial all actions. Document as necessary ↓

OBSTETRIC ADMISSION DETAILS

Expected date of delivery: When was your last menstrual period?

Name of your Obstetrician:

How many weeks pregnant were you at your first antenatal visit?

What municipality / council area do you live in?

PREVIOUS PREGNANCIES (including miscarriages and terminations)

No.	Delivery Date	Duration of Pregnancy	Birth Weight	Baby's Sex	Any Pain Relief	Hours in Labour	Type of Delivery	Breast or Bottle	Where Born ie. hospital name
Eg.	30.05.93	39 weeks	3640g	Male	Epidural	9 hrs	Forceps	Breast 3 months	Sunnybank
1									
2									
3									
4									
5									
6									
7									

	NO	YES	Specify details below	Nursing Staff Use ONLY
Is this pregnancy a result of assisted conception?	☐	☐	☐ Clomid ☐ Pregnyl ☐ AI ☐ Mod IUI ☐ Embryo Transfer ☐ FET ☐ Other:	
Has anyone in your or your partner's family had Diabetes, Heart Disease, Twins or Congenital Abnormalities? (eg. Down's Syndrome, Cleft Palate)	☐	☐		
Were you induced in previous pregnancies? (if applicable)	☐	☐		
Did you have any problems or complications after the birth of your previous baby / babies? (if applicable)	☐	☐		
Were your previous baby / babies admitted to Special Care Nursery? (if applicable)	☐	☐		
Have you had any problems with this pregnancy?	☐	☐		
IMPORTANT INFORMATION	NO	YES	Specify details below	Nursing Staff Use ONLY
Do you have a Birth Plan?	☐	☐	Please attach	
Have you discussed your Birth Plan with your Doctor?	☐	☐		
Do you have any support person other than your partner? Have you discussed this with your Doctor?	☐	☐		

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Print Media Group Version 04/23



CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

Attach patient identification label
 MRN Number:
 Surname:
 Name:
 Date of Birth:
 Gender:
 Mobile Number:
 Dr:
 Patient Details

CERTIFICATION OF INABILITY TO GIVE CONSENT FOR EMERGENCY PROCEDURES (To be completed by Medical Practitioner)

The undersigned registered medical practitioner certifies that
 (Name of patient)
 is incapable of giving effective consent by reason of
 (State reason for inability to give consent, for example unconscious)
 their Next of Kin is unable to give consent due to
 (State reason for inability to give consent, for example uncontactable)
 for the procedure(s) stated:
 and that immediate treatment is necessary in order to avert a serious and imminent threat to the patient's life or physical or mental health. I / We have no knowledge of any prior written refusal to consent to the procedure(s) having been communicated to any medical practitioner.
 (Signature) (Print Surname) Date
 (Signature) (Print Surname) Date
 Second signature may not be available in extreme circumstances ie. second Medical Practitioner is not available

ADMISSION DETAILS (To be completed by Medical Practitioner)

Diagnosis
 Proposed Admission Date: Time (if known): AM / PM
 Proposed Procedure Date: Time (if known): AM / PM
 Estimated Length of Stay: Day Stay Overnight
 Pre Admission Clinic? * Yes No * If the service is provided by the hospital
 Referrals Required:
 Special Instructions / Past History
 Medical Practitioner's Signature Date



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PATIENT HEALTH HISTORY

Attach patient identification label
 MRN Number:
 Surname:
 Name:
 Date of Birth:
 Gender:
 Dr:
 Patient Details

DO YOU HAVE / HAVE YOU HAD ANY OF THE FOLLOWING?	NO	YES	DETAILS
Difficulty swallowing / eating / speech impairment	☐	☐	Specify:
High or Low Blood Pressure	☐	☐	Specify:
Heart disease / rheumatic fever / palpitations / irregular heartbeat / heart murmur / angina / heart attack	☐	☐	Specify:
Lung disease / Asthma / bronchitis / emphysema / shortness of breath / pneumonia	☐	☐	Specify: Do you use: ☐ Nebulisers ☐ Inhalers ☐ Home oxygen
Blood disorder / blood clot / DVT / PE	☐	☐	Specify:
Blood transfusion and/or blood products	☐	☐	Specify:
Cancer / Leukaemia	☐	☐	Specify:
Reflux / stomach ulcer / hernia	☐	☐	Specify:
Kidney or bladder problems / Stoma / Incontinence	☐	☐	Specify:
Bowel disease (eg. Crohns, diverticulitis) / Stoma / Incontinence	☐	☐	Specify:
Skin issues / Wound / Broken skin / Pressure sores	☐	☐	Specify:
Arthritis	☐	☐	Specify:
Gastric Band / Sleeve Gastrectomy / Gastric Bypass	☐	☐	Specify:
OTHER MEDICAL CONDITIONS:			

INFECTION CONTROL	NO	YES	DETAILS
Have you had recent contact (ie within the last 14 days) with a person/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness - Seasonal or Pandemic - e.g. Corona Virus (COVID 19)?	☐	☐	
Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or Pandemic e.g. Corona Virus (COVID-19), either overseas or in Australia within 14 days of onset of symptoms?	☐	☐	
Have you been identified as having a Multi Resistant Organism - MRSA, VRE, MRGN ie ESBL, CPE or Candida auris?	☐	☐	Site: Date identified:/...../..... ☐ Nose ☐ Throat ☐ Groin ☐ Wound ☐ Rectal swab ☐ Faeces ☐ Other: Hospital where identified:
Do you have a household contact with someone who has a Multi Resistant Organism MRSA, VRE, MRGN ie ESBL, CPE or Candida auris?	☐	☐	
Do you have a fever, cough, sore throat or acute respiratory illness?	☐	☐	Specify:
Have you ever had Tuberculosis (TB)?	☐	☐	

COVID-19	NO	YES
Do you currently meet the COVID-19 Public Health criteria for self-isolation or quarantine?	☐	☐
Have you been diagnosed as COVID-19 positive? Date of diagnosis: ____/____/____ Date of clearance by Public Health: ____/____/____	☐	☐
Have you been vaccinated for COVID-19? Dose 1 date: ____/____/____ Dose 2 date: ____/____/____ Brand of vaccine: _____ Booster date/s: ____/____/____	☐	☐

CJD RISK SCREENING	NO	YES
Do you have a family history of two or more first or second-degree relatives with CJD (Creutzfeldt-Jakob disease)?	☐	☐
Have you had an unexplained progressive neurological illness of less than 12 months?	☐	☐
Have you ever received human pituitary hormone for infertility or human growth hormone for short stature prior to 1986?	☐	☐
Have you had surgery on the brain or spinal cord that included a dura mater graft (prior to 1990)?	☐	☐
Have you been involved in a 'look-back' for CJD or shown a 'medical in confidence letter' regarding your risk for CJD?	☐	☐

If the patient answers YES to CJD questions, clarification / advice must be sought from the Infection Control Manager



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MRN Number:

Surname:

Name:

Date of Birth:..... Gender:.....

Dr.

Patient Details

<i>Please tick (✓) No or Yes to all of the following questions</i>			<i>Provide details if requested below</i>
GENERAL HEALTH / PRE-SURGICAL INFORMATION	NO	YES	DETAILS
Do you have any allergies / sensitivities? ☐ Medication ☐ Tapes ☐ Latex ☐ Food ☐ Other.....	☐	☐	Please identify:.....
Have you had any recent blood or urine tests / pathology?	☐	☐	Specify: Which pathology company?.....
Have x-rays / CT Scans / MRI been taken for this admission?	☐	☐	Please bring with you.
Females – are you pregnant or are you breastfeeding?	☐	☐	Due date if pregnant:
Have you, or a blood relative, had a problem with an anaesthetic?	☐	☐	Please describe:
Do you have sleep apnoea?	☐	☐	Please bring your machine in with you.
Do you use a CPAP machine?	☐	☐	
Special diet / Cultural Needs	☐	☐	Specify:
Do you drink alcohol?	☐	☐	How many standard drinks a week?
Have you smoked in the past month?	☐	☐	Ex smoker ☐ Date ceased:...../...../.....
Have you ever used recreational drugs?	☐	☐	Specify:
Prosthesis / artificial joints / metal pins or plates / stent or valve / Pacemaker / Defibrillator?	☐	☐	Specify:
Broken / loose / chipped teeth / dentures / crowns / plates or caps?	☐	☐	Specify:
Mobility issues	☐	☐	☐ Stick ☐ Walking Frame ☐ Wheelchair ☐ Bed bound ☐ Other
Fainting or dizzy spells / recent falls?	☐	☐	Specify:
DO YOU HAVE / HAVE YOU HAD ANY OF THE FOLLOWING?	NO	YES	DETAILS
Frequent headaches / migraines / neurological issues	☐	☐	Specify:
Stroke / TIAs / Head Injury	☐	☐	Specify:
Epilepsy / seizures	☐	☐	Specify:
Parkinson's / Multiple Sclerosis / Motor Neurone Disease	☐	☐	Mobility issues:
Short term memory loss / confusion / Alzheimer's / Dementia	☐	☐	Specify:
Had or having treatment for mental health condition	☐	☐	Current treatment: ☐ Yes ☐ No Specify:
Previous Suicide attempt or Suicidal / Self Harm Ideation	☐	☐	Specify:
Aggressive tendency or behaviour	☐	☐	Specify:
Thyroid problems	☐	☐	Specify:
Diabetes ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes	☐	☐	Managed by: ☐ Diet ☐ Tablets ☐ Insulin Complications:

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MRN Number:

Surname:

Name:

Date of Birth:..... Gender:.....

Dr:

Patient Details

TO BE COMPLETED BY PATIENT

ADMISSION DETAILS					
Admission Date:			☐ Day Stay or ☐ Overnight Stay		
Operation Date (if different from admission date):			Preferred Accommodation: ☐ Luxe Room ☐ Private Room ☐ Shared Room (subject to avail)		
Procedure / Reason for Admission:					
Admitting Doctor:			Have you been to this hospital before? ☐ Yes ☐ No		
How did you find out about this hospital? ☐ Specialist ☐ GP ☐ Newspaper ☐ Internet ☐ Social Media ☐ Other _____					
Have you been in ANY hospital within the past 28 days? ☐ Yes ☐ No If yes, which hospital? _____					
Is this admission related? ☐ Yes ☐ No			Date of hospitalisation: From _____ To _____		
METHOD OF PAYMENT FOR THIS ADMISSION					
☐ Private Health Insurance ☐ Self Funded ☐ Workcover ☐ TAC / MVA ☐ DVA ☐ Public Patient ☐ Other _____					
PATIENT DETAILS					
Title:			Residential Address:		
Surname:					
Given Name:			Suburb:		
Middle Name:			State:		Postcode:
DOB:		Sex: ☐ Male ☐ Female ☐ Other	Home Ph:		Work Ph:
Previous Surname:			Mobile Ph:		
Preferred / Identifying Name:			Email:		
Gender: Identifying Pronoun:					
Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Widowed ☐ Separated ☐ Divorced			☐ I do NOT wish to receive SMS reminders ☐ I do NOT wish to receive a patient satisfaction survey		
Religion:			Religious Visit: ☐ Yes ☐ No		☐ Australian Resident ☐ Non Resident
Country of Birth:			Preferred Language: Interpreter: ☐ Yes ☐ No		
Indigenous Status: ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Decline to answer			Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Pensioner ☐ Retired ☐ Child ☐ Other: _____		
GENERAL PRACTITIONER DETAILS					
General Practitioner:			Phone: Fax:		
Name of Practice:			☐ I do NOT wish for my GP to be notified of my admission & discharge		
Address:			☐ I do NOT wish for my admission information to be uploaded to the My Health Record		
Suburb:		State: Postcode:			
REFERRING DOCTOR DETAILS					
Is the doctor that referred you to your Admitting Doctor the same as the GP above? ☐ Yes ☐ No If no please complete the below details:					
Referring Doctor:			Address:		
Name of Practice:			Suburb:		State: Postcode:
Phone:			Fax:		
MEDICARE / CONCESSION CARD DETAILS These cards may entitle patients to medicines at the concession rate & may be requested as proof of eligibility for subsidised medicine					
Medicare Card No.:			Healthcare Card No.:		Expiry
Medicare Reference No.:			Safety Net Card No.:		Expiry
DVA Card No.:			Pension Card No.:		Expiry
DVA Card Colour: ☐ Gold ☐ White ☐ Orange			Ambulance Membership No.:		Expiry
PRIVATE HEALTH INSURANCE					
Health Fund:			Level of Cover / Table:		
Membership No.:			Have you confirmed your level of cover with your fund? ☐ Yes ☐ No		

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PATIENT REGISTRATION FORM

It is preferable that this form is received by the hospital as soon as possible, or no later than 72 hours prior to admission.

TO BE COMPLETED BY PATIENT

Attach patient identification label

MRN Number:

Surname:

Name:

Date of Birth: Gender:

Dr:

Patient Details

NEXT OF KIN / EMERGENCY CONTACT 1		EMERGENCY CONTACT 2	
Title:	Relationship:	Title:	Relationship:
Surname:		Surname:	
Given Name:		Given Name:	
Address:		Address:	
Suburb:		Suburb:	
State:	Postcode:	State:	Postcode:
Home Ph:	Work Ph:	Home Ph:	Work Ph:
Mobile Ph:		Mobile Ph:	

LEGAL INFORMATION *If yes to any of the below marked with a star (*) please provide a copy to the hospital*

Enduring Power of Attorney (Financial Decisions)	☐ Yes ☐ No	Name:	Ph:
Enduring Power of Guardianship (Personal Decisions)	☐ Yes ☐ No	Name:	Ph:
Medical Power of Attorney (Medical Decisions) *	☐ Yes ☐ No	Name:	Ph:

Do you have an Advanced Care Directive? ☐ Yes ☐ No If Yes, please bring a copy with you to hospital and give to the Nursing Staff during Admission.

PATIENTS POSTAL ADDRESS

☐ Same as residential address *If different please complete the details below:*

Postal Address:	Suburb:	
	State:	Postcode:

PERSON RESPONSIBLE FOR ACCOUNT *For any out of pocket expenses not covered by your insurer / fund*

☐ Self ☐ Emergency contact 1 ☐ Emergency contact 2 ☐ Other *If other please complete the details below:*

Surname:	Given Name:	
Address:	Relationship:	
Suburb:	Home Ph:	Work Ph:
State:	Postcode:	Mobile Ph:

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY DETAILS *Written approval will be required prior to admission*

☐ Workcover ☐ Third Party ☐ Motor Vehicle ☐ Public Liability

Name of Insurer:	Employer:	
Date of Accident:	Contact Person:	
Location of Accident:	Employer Address:	
Cause of Injury:	Suburb:	
Claim Number:	State:	Postcode:
Claim Approved? ☐ Yes ☐ No	Ph:	Fax:

COLLECTION, MANAGEMENT AND RELEASE OF INFORMATION

It may be necessary for parts of your medical record to be disclosed to other medical professionals to provide your treatment, or during activities necessary to operate our hospital (e.g. to your health fund, DVA, third party insurers such as Workcover, TAC, State Governments for public contract patients, the supplier / manufacturer of your prosthesis, to our insurer, to an external company contracted to evaluate customer satisfaction, your local doctor).

It may also be necessary for The George Centre to collect information about you from third party health care providers about your health. If you do not wish for us to collect certain information about you please tell us and we will discuss any consequences that this may have on your health care.

I authorise the release and collection of information about this admission. I certify that the information provided on this form is true and accurate to the best of my knowledge and I have read and understand the Admission Information brochure available on the hospital website, or provided with these forms.

I also consent to the collection, management and use of my personal and health information in accordance with The George Centres Privacy Policy.

Patient or Guardians Signature

Patient or Guardians full name

Date

[illegible]