THE GEORGE CENTRE™

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

Patient Details

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

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	Please inform administration staff if you have a preferred method of communication other than SMS.
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:	
Address:	
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.: ☐ Expiry:	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

BINDING MARGIN – DO NOT WRITE IN THIS AREA

PATIENT REGISTRATION FORM

TGCMR120

Print Media Group Version 05/24

THE GEORGE CENTRE™

PATIENT REGISTRATION FORM

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Patient Details

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

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	Employer:	
Name of Insurer:	Contact Person:	
Date of Accident:	Employer Address:	
Location of Accident:		
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 _____

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THE GEORGE CENTRE™

PATIENT HEALTH HISTORY

Attach patient identification label

Patient Details

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

Please complete this form and forward to your admitting hospital at least 3 days prior to admission

Admission Date: ...../...../.....

State reason for admission: .....

What are your goals of care? .....

(Goals of care describe what a patient wants to achieve during an episode of care) .....

DATE	PREVIOUS PROCEDURES

Height.....cm Weight.....kg BMI.....

Do you have an Advanced Care Directive? ☐ YES ☐ NO If yes, please provide a copy on admission

MEDICATION MANAGEMENT	NO	YES	DETAILS
Do you take or have you recently taken blood thinning medications (eg. aspirin / warfarin / clopidogrel)?	☐	☐	Specify: ....
If yes, and attending for surgery have you been told to stop this?	☐	☐	When were they ceased?.....
Have you had any steroid or cortisone injections in the last 12 months?	☐	☐	Specify: .....
Do you require assistance with taking medications? ie. dosette / crushed / webster packs	☐	☐	Specify: .....
Are you taking any prescription / non prescription or complimentary medicines?	☐	☐	***If YES, please bring these with you in original packaging***
Have you been asked to cease any medications?	☐	☐	Specify: .....

Please list all medications below, or provide your Pharmacy card or a Medication list from your doctor.

Medication Name	Dose	Frequency	If known, I'm taking this for... (eg. blood pressure, Diabetes, etc)

PATIENT HEALTH HISTORY

TGCMR121

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Print Media Group Version 05/24

THE GEORGE CENTRE™

PATIENT HEALTH HISTORY

Attach patient identification label

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

Patient Details

Please tick (✓) No or Yes to all of the following questions			***Provide details if requested below***
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? Do you use a CPAP machine?	☐ ☐	☐ ☐	***Please bring your machine in with you.***
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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THE GEORGE CENTRE™

PATIENT HEALTH HISTORY

Attach patient identification label

Patient Details

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

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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PATIENT HEALTH HISTORY

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Patient Details

MRN Number: .....

Surname: .....

Name: .....

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

Dr: .....

DISCHARGE PLANNING	NO	YES	DETAILS
Do you live: ☐ with Family ☐ Alone ☐ High Care ☐ Low Care	☐	☐	Care Facility details: .....
Do you anticipate any difficulties returning to your place of residence?	☐	☐	Specify: .....
Do you have a responsible adult to collect you from hospital and to remain with you for 24 hours post anaesthetic? (All surgical & procedural patients)	☐	☐	Specify: .....
Are you the sole or designated carer of someone?	☐	☐	Specify / Alternative arrangements: .....
Are you already receiving assistance at home?	☐	☐	Specify: .....
Do you require additonal service adjustments during / for your admission?	☐	☐	Specify: .....
Do you understand the importance of following the instructions regarding your ongoing care?	☐	☐	Specify: .....
Are you aware of the danger to yourself / others and not drive a motor vehicle or operate machinery for 24 hours following any sedation, Anaesthetic or strong pain medication?	☐	☐	Specify: .....
Do you attend a day centre or recieve assistance from a community service for meals, home help or personal care?	☐	☐	Please advise your service of your intended absence.
Is there any other information that would help us to support you for dishcharge?	☐	☐	Specify: .....

TO THE BEST OF MY KNOWLEDGE, THE ABOVE DETAILS ARE TRUE AND CORRECT

Patient / carer / relative / guardian signature: Please print name:

NURSES TO COMPLETE ON ADMISSION

HANDOVER OF CARE: *Nursing staff to check and complete this form and initiate referrals if considered appropriate*

All alerts / allergies documented and communicated on Alert Sheet TGCMR000	☐ YES		☐ N/A
ID Band/s and identity confirmed (as per Site policy)	☐ YES		
Valuables stored according to local policy / sent home with relatives / carers?	☐ YES	☐ NO	☐ N/A
The VMO, Surgeon and Anaethetist have been notified of any clinical or medication issues.	☐ YES	☐ NO	☐ N/A

INFECTION SCREENING

Confirm the COVID-19 Patient Screening Questionnaire has been completed	☐ YES	☐ NO
Have you had a fever, cough, cold or acute respiratory infection in the last 2 days?	☐ YES	☐ NO
Have you had a fever associated with a rash in the last week?	☐ YES	☐ NO
Have you had a sudden onset of vomiting and/or diarrhoea in the past 2 days?	☐ YES	☐ NO
Do you meet the current COVID-19 Public Health criteria for self-isolation or quarantine?	☐ YES	☐ NO

INTERSTATE / OVERSEAS HEALTHCARE / TRAVEL

Have you returned from any interstate / overseas travel in the last 14 days?	☐ YES	☐ NO
Have you been admitted to, transferred from or stayed overnight in any interstate / overseas health care facility in the past 12 months?	☐ YES	☐ NO
Have you resided in an interstate / overseas Residential Aged Care Facility in the past 12 months?	☐ YES	☐ NO

If an infection risk noted, staff must contact Department Manager / After Hours Manager or Infection Control Manager to report this information and gain advice on their care in the clinical area.

I have reviewed the Patient Health History and taken necessary actions

Admitting nurse Signature / Print name: Designation: Date: Time:

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THE GEORGE CENTRE™

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.

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

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

Dr: .....

TO BE COMPLETED BY MATERNITY PATIENT ONLY

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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PATIENT HEALTH HISTORY – ADDITIONAL OBSTETRIC INFORMATION TGCMR4.5D

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