



Complete all 3 pages and return to the hospital at least 7 days prior to admission

PATIENT ADMISSION DETAILS

Admitting Doctor:

General Practitioner (Name & Address):

Procedure details: Date: Time:

Have you been hospitalised anywhere in the last seven days? Yes No If yes, where:

Have you been a patient at RPHDPC in the past 7 years? Yes No

PATIENT DETAILS-Please print as your name appears on Medicare Card

Title: Surname: Previous Surname:

Given Names:

Address: Postcode

Phone (H) Phone (B) Phone (M)

Sex: Male Female Date of Birth: Marital Status:

Country of Birth : _____ Are you of Aboriginal/Torres Strait Island Descent?
If Australia which State: _____ Yes No

Are you an Australian Resident? Yes No Language spoken at home: _____

Medicare Number: Reference No: Expiry Date: Veteran's Affairs No:

Pension No: Full Part Expiry Date:
Health Care Card : Yes No

HEALTH FUND INSURER

Fund: Membership Number:

Level of Cover: Date joined:

Excess Amount: Confirmed by: Confirmed with: Date: Time:

PERSON RESPONSIBLE FOR ACCOUNT

Patient: Other: If another person please specify _____

ESCORT CONTACT DETAILS / PERSON TAKING YOU HOME

Surname: Given Name: Relationship:

Contact Number: Alternative contact number:

NEXT OF KIN / PERSON TO CONTACT IN CASE OF EMERGENCY

Surname: Given Name: Relationship:

Address:

Contact Number: Alternative contact number: