ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT DETAILS FORM

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT TO COMPLETE

To be completed by patient. Please PRINT clearly. Your responses are valuable in planning your admission and stay.

ADMISSION DETAILS

Admitting Doctor:

Date of Admission: / / Date of Operation: / /

Admission Type: ☐ Overnight ☐ Day Patient

PERSONAL DETAILS

Title: Given Names: Preferred Name:

Surname: Previous Surname (if applicable):

Date of Birth: / /

Residential Address:

Postal Address:

Telephone (Wk/Day): (Home): (Mobile):

Email:

Gender: ☐ Male ☐ Female ☐ Non-binary or ☐ Preferred term

Country of birth: Are you an Australian resident? ☐ Yes ☐ No

Language spoken at home: Religion:

Do you require an interpreter? ☐ Yes ☐ No If yes, language:

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Both

EMERGENCY CONTACT

Name: Relationship to Patient:

Address:

Telephone (Wk/Day): (Home): (Mobile):

Second Contact/Power of Attorney: Telephone:

DETAILS OF GP

Name:

Address:

Telephone: Fax: Email:

DETAILS OF COMMUNITY PHARMACY

Name:

Telephone: Email:

PAEDIATRIC PATIENTS

Name of Parent/Carer staying with child:

DETACH FROM BOOKLET

TAE - SLC 060123

PATIENT TO COMPLETE

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT DETAILS FORM

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Doctor:

PERSON RESPONSIBLE FOR ACCOUNT

☐ Self ☐ Next of Kin ☐ Workers Compensation ☐ DVA ☐ Third Party ☐ Defence ☐ Other:

Title: Surname: Given Names:

Address:

Telephone (Wk/Day): (Home): (Mobile):

By signing below, I declare that I am the person responsible for this account and acknowledge that I have read, understood and agreed to the financial information as outlined in the Pre-Admission Information.

Name: Signature: Date: / /

MEDICARE DETAILS

Medicare No: Medicare Reference Number: Expiry Date: /

CONCESSIONAL BENEFITS

Do you hold any of the following cards:

☐ Health Care Card ☐ Pension Card ☐ Pharmaceutical Benefits Card

Name of Pension/Benefit: Benefit Card No:

Have you reached the Safety Net for Pharmaceuticals? ☐ Yes ☐ No Safety Net No:

HEALTH INSURANCE DETAILS

Insurance Type: ☐ Private Health Fund ☐ Workers Compensation ☐ Third Party ☐ DVA ☐ Self Funded ☐ Defence

Name of Health Fund: Type of Cover:

Membership No: Do you have an excess? ☐ Yes ☐ No

Has this cover changed in the last 12 months? ☐ Yes ☐ No

Workers Comp Fund Name:

Address:

Claim Number: Date of Accident: / /

Employer Name: Telephone:

HR Manager: Fax Number:

Third Party Name: Details: Policy Number:

Serving Member of: DVA No.: DVA Card Colour:

Details of cover (white card only):

PATIENT RESPONSIBILITY

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following sections of the Pre-Admission Booklet:

☐ Pre-Admission Information ☐ Responsibilty of Personal Items ☐ Privacy Information

Name: Signature: Date: / /

PATIENT DETAILS FORM

MR3

DETACH FROM BOOKLET

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT HISTORY FORM

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT TO COMPLETE

ADMISSION DETAILS

Please specify the reason for admission:

Have pathology (blood tests) been taken for this admission? ☐ No ☐ Yes Pathology provider:

Have x-rays/scans been taken for this admission? ☐ No ☐ Yes ☐ With Patient ☐ With Doctor

What is your: Height: cm Weight: kg Blood group (if known)

Are you coming from an aged care facility? ☐ No ☐ Yes

If Yes, name of facility: Telephone:

MEDICATION Shaded areas for staff only

ALLERGIES AND SENSITIVITIES

☐ No known allergies or reactions.

☐ **YES - Please document all known allergies or sensitivities e.g medications, foods, plants, tapes and dressings.**

Medicine or substance	Details and reaction

MEDICATIONS Tablets, capsules, puffers, patches, insulin, eye drops and creams

- include any complementary therapies , vitamins or over the counter preparations.

Medication	Strength	Dose	Frequency	Medication plan/review?
Does someone assist you to manage your medications at home? ☐ No ☐ Yes If yes, who?				

RECENTLY CEASED OR CHANGED MEDICATIONS

- include any complementary therapies , vitamins or over the counter preparations.

Medication	Strength	Dose	Frequency

PATIENT HISTORY FORM

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TAE - SLC 011020

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT HISTORY FORM

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT MEDICAL ADMISSION **Shaded areas for staff only**

Please tick the relevant box and if YES, specify details where applicable.

ENDOCRINOLOGY Name of Specialist/s:

Do you have diabetes?	N	Y	☐ Type 1 ☐ Type 2 Controlled by ☐ diet ☐ insulin ☐ tablets
If you have diabetes, are your blood sugar levels well controlled?	N	Y	
Do you have low blood sugar?	N	Y	
Do you have thyroid problems?	N	Y	

CARDIOVASCULAR Name of Specialist/s:

Do you have a history of high blood pressure /hypertension?	N	Y	
Do you have a history of chest pain/angina?	N	Y	
Do you have a history of a heart attack/s?	N	Y	
Do you have a history of palpitations/heart murmur/ irregular heart beat/AF?	N	Y	
Do you have a history of deep venous thrombosis/ pulmonary embolism?	N	Y	
Do you have a history of cardiac implants or grafts?	N	Y	
Do you have a history of pacemaker and/or defibrillator?	N	Y	
Do you have a history of heart failure/congestive cardiac failure?	N	Y	
Do you have a history of rheumatic fever/valve disease?	N	Y	
Do you have a history of other cardiac problems?	N	Y	

RESPIRATORY Name of Specialist/s:

Do you have a history of recent cold – cough, fever, sore throat, or runny nose?	N	Y	
Do you have a history of bronchitis/asthma/emphysema/ chronic obstructive pulmonary disease/shortness of breath/bronchiectasis or hay fever?	N	Y	Do you use - ☐ nebulisers ☐ puffers ☐ home oxygen
Do you have a history of sleep apnoea?	N	Y	Do you use a CPAP Machine? ☐ No ☐ Yes

GASTROINTESTINAL Name of Specialist/s:

Do you have a history of any gastrointestinal ulcer /reflux/hiatus hernia?	N	Y	
Do you have a history of any bowel disorders?	N	Y	
Do you have a history of any liver disorders?	N	Y	
Do you have a history of hepatitis?	N	Y	Type of hepatitis?
Do you have a stoma?	N	Y	

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT HISTORY FORM

UR No.: Admission No.:

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Doctor:

PATIENT TO COMPLETE

PATIENT MEDICAL ADMISSION **Shaded areas for staff only**

Please tick the relevant box and if YES, specify details where applicable.

HAEMATOLOGY Name of Specialist/s:

Do you have a history of anaemia/iron deficiency?	N	Y	
Do you have a history of blood disorders/bleeding problems/clotting disorder or bruise easily?	N	Y	
Do you take blood thinners/arthritis tablets/ aspirin based medication/warfarin?	N	Y	If yes, what date have you been advised to stop taking this medication? ____ / ____ / ____ If you have not been given specific instructions regarding this medication, please contact your admitting doctor for instructions.
Do you have a history of previous blood transfusion/s?	N	Y	Date last given: ____ / ____ / ____ Reason: Any adverse reactions? Advised of any special requirements for future transfusions?

NEUROLOGY Name of Specialist/s:

Do you have a history of any neurological condition? e.g MS or Parkinson's?	N	Y	
Do you have a history of seizures/epilepsy /fainting/febrile convulsions?	N	Y	
Do you have a history of stroke/TIA?	N	Y	Any residual weakness?
Do you have any limb deficits?	N	Y	☐ right leg ☐ left leg ☐ right arm ☐ left arm
Do you have any speech or swallowing difficulties?	N	Y	
Do you have a history of delirium, dementia or cognitive impairment?	N	Y	☐ Screen
Do you have a history of depression/anxiety or mental health disorder?	N	Y	
Do you have a history of developmental delay?	N	Y	
Do you have a history of neurological or developmental disorder? e.g ADHD, Autism	N	Y	

GENITO-URINARY / RENAL Name of Specialist/s:

Do you have a history of kidney or renal disorder/dialysis?	N	Y	
Do you have a history of bladder issues? e.g urinary frequency/incontinence.	N	Y	
Do you have a catheter or stoma?	N	Y	

MUSCULOSKELETAL Name of Specialist/s:

Do you have a history of arthritis?	N	Y	
Do you have a history of back or neck problems?	N	Y	
Do you have a history of joint replacement/s?	N	Y	☐ right ☐ left : ☐ right ☐ left :
Do you have any pins/plates?	N	Y	
Other implants or devices?	N	Y	

PATIENT HISTORY FORM

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PATIENT TO COMPLETE

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT HISTORY FORM

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

PATIENT MEDICAL ADMISSION Shaded areas for staff only

Please tick the relevant box and if YES, specify details where applicable.

GENERAL HEALTH AND LIFESTYLE

Name of Specialist/s:

Do you have a special diet?	N	Y		☐ Notify diet aide
Have you lost weight recently without trying?	N	Y	☐ Unsure If yes ☐ 1-5kg ☐ 6-10kg ☐ >15kg ☐ Unsure	☐ Screen
Have you been eating poorly because of decreased appetite?	N	Y		☐ Screen
Have you ever smoked?	N	Y	Daily amount? Or date ceased?	
Do you drink alcohol?	N	Y	Standard drinks per/day:	
Do you have a history of drug dependency?	N	Y		
Do you use recreational drugs?	N	Y		
Do you exercise regularly?	N	Y		
Female patients, are you pregnant?	N	Y		
Do you suffer from chronic pain?	N	Y	Pain specialist?	
Do you currently have any areas of broken skin? e.g scratches or wounds.	N	Y		
Do you currently have any bruising?	N	Y		
Do you have a history of falls or being unsteady on your feet?	N	Y	Date of last fall: / /	☐ Screen
Do you have a history of previous or current pressure injuries?	N	Y		☐ Screen

CANCER TREATMENT

Have you been diagnosed with cancer?	N	Y	Specify: Site: Date: / / Treatment ☐ surgery ☐ chemotherapy ☐ radiotherapy

SURGICAL HISTORY/ TRANSPLANTS/ CHEMOTHERAPY OR RADIOTHERAPY

Please list dates and proceedures performed.

DATE	SURGERY

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PATIENT TO COMPLETE

PATIENT MEDICAL ADMISSION **Shaded areas for staff only**

Please tick the relevant box and if YES, specify details where applicable.

PROBLEMS WITH ANAESTHETICS (Self or Family)

Malignant Hyperthermia?	N	Y	☐ Self ☐ Family
Have you or anyone in your immediate family had a reaction to an anaesthetic?	N	Y	Details and reaction

PROSTHETICS / AIDS / OTHER

Visual aids?	N	Y	☐ Glasses ☐ Contact lenses ☐ Sight impaired ☐ Eye prosthesis ☐ Other implants e.g. lens
Hearing aids?	N	Y	☐ Left ☐ Right
Walking aids?	N	Y	
Dentures?	N	Y	

ANY OTHER MEDICAL CONDITIONS

Please document any additional medical conditions below.

PREVIOUS HOSPITALISATION

Have you been treated at this hospital before?	N	Y	Year:
Have you been hospitalised for more than 48 hours within the last 3 months?	N	Y	Dates: Hospital:
Have you been admitted to any hospital or aged care facility outside Australia within the last 12 months?	N	Y	Dates: Hospital:

INFECTION CONTROL

If YES, please specify

Have you travelled to a country with a current health alert in the last month?	N	Y		If Yes, refer to Infection Control Co-ordinator for review.
Do you have a history of infectious disease? HIV, Tuberculosis?	N	Y		
Have you ever had a multi resistant organism? MRSA, VRE, ESBL?	N	Y		
Do you have or have you recently had a fever with or without respiratory symptoms? Cough, sore throat, or runny nose?	N	Y		
Have you had vomiting and/or diarrhoea in the last 48hrs?	N	Y		

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PATIENT MEDICAL ADMISSION **Shaded areas for staff only**

QUESTIONS RELATED TO CREUTZFELDT JAKOB DISEASE (CJD)

Have you had surgery on the brain or spinal cord that may have included a dura mater graft prior to 1990?	N	Y	If Yes, refer to Infection Control Co-ordinator for review.
Have you had two or more first degree relatives who have been diagnosed with CJD or other Prion Disease, where genetic cause has not been excluded?	N	Y	
Have you received pituitary hormone treatment for fertility or human growth hormone for short stature prior to 1990?	N	Y	
Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been identified?	N	Y	
Have you been involved in a "look back" study for CJD, or are you in possession of a "medical in confidence letter" regarding the risk of CJD?	N	Y	

ADVANCED CARE DIRECTIVE

Do you have an Advanced Care Directive or treatment limiting order?	N	Y	If yes, please provide a copy on admission.
If No, would you like more information about Advanced Care Directives?	N	Y	Contact Name: Telephone:

DISCHARGE PLANNING (Day Patients only)

Who will be taking you home and be with you for 24 hours?

Name:	Relationship:
Best contact number:	

DISCHARGE PLANNING (Day and Overnight Patients)

Are you over 80 years of age?	N	Y	
Do you live alone?	N	Y	
Do you have someone to care for you after discharge?	N	Y	Name: Relationship:
Are you solely responsible for the care of another person at home?	N	Y	
Do you currently receive community support services?	N	Y	Name of provider:
Do you have difficulty walking?	N	Y	
Do you require assistance with any aspects of daily living?	N	Y	
Where do you plan to go after discharge?			
How do you plan to get there?			

NAME OF PERSON COMPLETING THE FORM

Name:	Signature:
Relationship:	Date:

ST LUKE'S CARE
— PRIVATE HOSPITAL —

PATIENT HISTORY FORM

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NURSE'S USE ONLY **Shaded areas for staff only**

ADDITIONAL SCREENING REQUIRED

Medication review or plan?	N	Y	
Cognitive impairment screening?	N	Y	
Malnutrition screening?	N	Y	
Infection control review?	N	Y	

PATIENT HISTORY REVIEWED BY

☐ **Pre-admission Nurse**	Print name:	
	Signature:	
	Designation:	Date:

☐ **Admitting Nurse**	Print name:	
	Signature:	
	Designation:	Date:

☐ **Ward Nurse**	Print name:	
	Signature:	
	Designation:	Date:

ADDITIONAL NOTES

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ST LUKE'S CARE
PRIVATE HOSPITAL

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ADDITIONAL NOTES