

# ADMISSION FORM

## Rockhampton

Ward St  
PO Box 924  
Rockhampton, 4700  
Tel: 07 4931 3313  
Fax: 07 4931 3477

## Mackay

76 Willetts Rd  
PO Box 214  
Mackay, 4740  
Tel: 07 4965 5666  
Fax: 07 4965 5600

## Bundaberg

313 Bourbong St  
PO Box 715  
Bundaberg, 4670  
Tel: 07 4153 9539  
Fax: 07 4153 9496

## Gladstone

Rossella St  
Gladstone, 4680  
Tel: 07 4971 3713  
Fax: 07 4971 3703

## Yeppoon

Cliff St,  
Yeppoon, 4703  
Tel: 07 4939 4611  
Fax: 07 4939 4787

## MERCY HEALTH AND AGED CARE CENTRAL QUEENSLAND LIMITED MATER MISERICORDIAE HOSPITALS

Item Number: \_\_\_\_\_ AHS/ MIMS Admitting Doctor: (Mackay only) \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO THE HOSPITAL WHERE YOU WILL BE ADMITTED AT LEAST 7 DAYS BEFORE ADMISSION OR AS SOON AS POSSIBLE.**

### ADMISSION INFORMATION

Proposed Admission Date:		Proposed Time:		
Admitting Doctor:		Usual GP:		
Proposed Stay	<input type="radio"/> Same day	<input type="radio"/> Overnight	<input type="radio"/> Maternity	<input type="radio"/> Sleep Unit
Accommodation Type	<input type="radio"/> Single	<input type="radio"/> Shared		

### PATIENT INFORMATION

<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	<input type="radio"/> Master	<input type="radio"/> Dr	<input type="radio"/> Fr	<input type="radio"/> Sr	<input type="radio"/> Male	<input type="radio"/> Female
Surname:					Given names:				
Previous name (if changed since last visit)									
Date of Birth:		Country of birth:			Marital status:				
Home address (not a PO Box)							Postcode		
Postcode		Email address:							
Mailing address (if different from home address)							Postcode		
Home Phone No.		Work Phone No.			Mobile No.				
For patients having an operation, please give us the best contact number for the day before your operation (or if on a Monday or public holiday, where you will be on the last working day).							Contact No		
Religion:		Occupation: (If retired, previous occupation)							
QLD Health Requirement:		Are you of Aboriginal or Torres Strait origin? Tick all that apply							
<input type="radio"/> No	<input type="radio"/> Yes, Aboriginal			<input type="radio"/> Yes, Torres Strait Islander			<input type="radio"/> Yes, South Sea Islander		

### HEALTH CARE CARDS

<input type="radio"/> Pension Card	Card Number:	Expiry Date:
<input type="radio"/> Healthcare Card	Card Number:	Expiry Date:
<input type="radio"/> Commonwealth Seniors Health Card	Card Number:	Expiry Date:
<input type="radio"/> Safety Net Entitlement Card	Card Number:	Expiry Date:

### MEDICARE CARD INFORMATION

Medicare Card Number:																		
Number beside patient name:											Expiry Date							

### SPECIAL NEEDS (Rockhampton, Gladstone, Yeppoon Only)

<input type="radio"/> Wheelchair access required	<input type="radio"/> Hearing impairment	<input type="radio"/> Other
<input type="radio"/> Severe speech impairment	<input type="radio"/> Intellectually disabled	
<input type="radio"/> Language difficulties/barriers	<input type="radio"/> Physically disabled	Do you have any allergies? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Special dietary requirements	<input type="radio"/> Limited sight impairment/blindness	

Details: \_\_\_\_\_

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

**NEXT OF KIN INFORMATION**

<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	Relationship:
Surname:		Given Names:		
Usual Address:			Postcode:	
Home Phone No.	Work Phone No		Mobile No.	
If they are staying locally, where can they be contacted:			Phone No.	

**EMERGENCY CONTACT INFORMATION ( Other than next of kin)**

<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	Relationship:
Surname:		Given Names:		
Address:			Postcode:	
Home Phone No.	Work Phone No.		Mobile No.	

**PAST HOSPITAL INFORMATION**

Have you ever been a patient in any of the Central Queensland Mater Hospitals?	<input type="radio"/> No	<input type="radio"/> Yes			
If Yes, which one (s)?	<input type="radio"/> Rockhampton	<input type="radio"/> Mackay	<input type="radio"/> Bundaberg	<input type="radio"/> Gladstone	<input type="radio"/> Yeppoon
Have you been a patient in ANY hospital in the last 7 days?	<input type="radio"/> No	<input type="radio"/> Yes	Name:		

**HEALTH FUND INSURANCE DETAILS**

Please indicate the payment arrangements for this hospital stay

<input type="radio"/> Private Health Insurance	<input type="radio"/> Repatriation Card (DVA)	<input type="radio"/> Workers Compensation	<input type="radio"/> Self paying	<input type="radio"/> Third Party
Name of Third Party:		Relationship:		

It is essential that you contact your health fund or insurer to obtain or verify the following information.  
If self paying, you must contact the hospital to obtain an estimation of costs and these estimation of costs must be paid on admission with the remainder being paid on discharge.

**Private Health Fund**

Health Fund Name:	Level of cover:		
Membership No:	Date joined:		
Number of years:	Name of contributor (if not the patient)		
Will an excess apply?	<input type="radio"/> No	<input type="radio"/> Yes	Amount \$
Will a co-payment apply?	<input type="radio"/> No	<input type="radio"/> Yes	Amount \$

Please note: All excesses or co-payments are payable on admission

Has your health insurance cover changed in the last 12 months?	<input type="radio"/> No	<input type="radio"/> Yes	If Yes, it is important that you contact your Health Insurer to clarify your coverage for this admission	
Workers Compensation Claim Number:	Approval letter must be attached. If not, patients will be responsible for the hospital account.			
Workers Compensation Fund and Address:				
Employers Name:				
Veterans Affairs (DVA)	Card Number	<input type="radio"/> Gold	<input type="radio"/> White	
If White, have your hospital costs been approved by DVA?	<input type="radio"/> Yes	<input type="radio"/> No	Expiry Date:	
Signature	Date:		Rev: 07/08	