Do not write in this space.

Pre Admission Form

HONEYSUCKLE Day Hospital
Premium care, Optimum results

Surgery Booking (to be completed by Surgeon's Rooms):

Date of admission:	Surgeon:
Referring Practitioner:	

Personal details:

Title:	Surname:	Given Names:
Preferred name:	Previous Surname (where relevant):	
Date of birth:	Sex:	Have you ever been admitted to the day hospital before? ☐Yes ☐ No
Street Address:		
Telephone-Home:		
Postal address same as above? ☐Yes ☐ No	If no, postal address	
Marital status:		
Special diet:	Occupation:	
Country of Birth:	Language spoken at home:	
Indigenous status –		

Person to contact (usually next of kin)

Name:	Relationship to patient:
Street Address:	
Telephone-Home:	
Other emergency contact name	Phone:

Private Health Fund

Name of Health Fund:	Table:	Membership Number:
Name of Contributor:	Relationship to patient:	
Street Address:	Suburb:	Postcode:
Telephone-Home:	Work:	Mobile: Fax:
Is the membership of this fund/table over 12 months? ☐Yes ☐ No	If no, have you transferred from another fund? Please provide details.	
Patients with less than 12 months membership in their fund/table may not be eligible for any benefits.		

MR 1.1

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Pre Admission Form

Medicare/Entitlements – please bring cards to hospital

Medicare card Number: ☐☐☐☐ ☐☐☐☐☐ ☐

Your name is position ☐ on the card. Expiry Date: ____/ ____

Veterans' Affairs Number: _____ ☐ White Card ☐ Gold Card

Person Responsible for Account – complete only if someone other than the patient is to receive the account

☐ Veterans' Affairs ☐ TAC ☐ Workcover ☐ Other – Please specify

Claim/VX number:	Date of Accident/Injury:
Name:	Relationship to patient:
Street Address:	Suburb: Postcode:
Telephone-Home: Work:	Mobile: Fax:

Financial Consent to be completed on admission

I certify the information on this form to be true to the best of my knowledge. I accept full responsibility for accounts rendered by the Hospital, including any shortfall in reimbursement by my Health Fund following settlement by Health Fund. I have had the financial cost of my surgery explained to me.

Signature: Print name: Date:

Consent to use personal information

I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the brochure "Personal Information and Privacy for Patients" and I understand my rights to privacy and how my personal information will be used at the hospital. I give consent to the use of my personal information as described in the brochure. I understand that I may withdraw my consent at any time.

Signature: Print name: Date:

Discharge arrangements

DVA Transport to be arranged:

I have arranged for someone to take me home following my surgery and to stay with me overnight: If not having someone stay overnight then take responsibility.

Name:	Relationship to patient:
Telephone-Home: Work:	Mobile:
Signature: Print name:	Date:

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature: Print name: Date:

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