| Title: | Patient Admission Registration Form | | | | ALEXANDRA DISTRICT HEALTH |
|---|---|---|---|---|---|
| Section: | Clinical Services | PRH: | Director of Clinical Services | F.NURS.055 | |

Title: _____ Surname: _____ Given Names: _____

Previous Surname (if applicable): _____ Date of Birth: _____ / _____ / _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Non-Binary ☐ Unspecified Marital Status: Select below

Country of Birth:_____State (If Australia): Select below

Do you require an interpreter? ☐ Yes ☐ No Religion: _____

Indigenous status: Aboriginal: ☐ Yes ☐ No Torres Strait Islander: ☐ Yes ☐ No

Residential Address: _____

_____ Post Code: _____

Postal Address:_____

_____ Post Code: _____

Phone: _____ Mobile: _____ Email:_____

We may use your mobile phone number or email address to send you a reminder for an appointment or follow up care, other admission related purposes or to ask for feedback about your experience with us.

**Have you previously been admitted to Alexandra District Health?** ☐ **Yes** ☐ **No**

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Position on Card: ☐ Exp Date: _____

Dept. Veterans Affairs No: _____ Healthcare / Pension No:_____

Private Health Fund: _____ Number: _____

Do you elect to use your Private Health Insurance? ☐ YES ☐ NO

Are you aware of any excess on your policy (provide details)?_____

**Do you have any of the following arrangements in place? (please tick all that apply):**

☐ Advance Care Directive
☐ Guardian
☐ Appointed Support Person
☐ Medical Treatment Decision Maker
☐ Enduring Power of Attorney (Medical Treatment)

In order for Alexandra District Health to respect your wishes, please provide a copy of the relevant documents.

**Details of Medical Treatment Decision Maker / Enduring Power of Attorney (Medical Treatment) / Next of Kin**

Title: _____ Surname: _____ Given Names: _____

Residential Address: _____

_____ Post Code: _____

Phone: _____ Mobile: _____ Relationship to patient: _____

Name of Admitting Doctor / Surgeon: _____

Name of Regular / Referring Doctor: _____ Clinic Name: _____

Clinic Email Address: _____

Do you consent to Alexandra District Health sending information about your hospitalisation to your regular doctor? (e.g. your Discharge Summary) ☐ Yes ☐ No

**I agree that the information provided on this form is true and correct to the best of my ability.**

**Signature:** _____ **Date:** _____

**If you complete this form online your signature is not required. You will be asked to sign this form on admission.*