



BETHESDA HOSPITAL PATIENT PREADMISSION FORM

IMPORTANT Complete this form and post (PO Box 45 Claremont WA 6910), fax (08) 9340 6343 or email it (admissions@bethesda.asn.au) to the Hospital *5 DAYS PRIOR* to admission date then bring original document on day of admission.

SECTION A	TO BE COMPLETED BY MEDICAL PRACTITIONER
ADMITTING DOCTOR:	PHONE NUMBER:
ADMISSION DATE:	ADMISSION TIME:
ADMISSION TYPE: <input type="checkbox"/> LA DAY CASE <input type="checkbox"/> DAY CASE <input type="checkbox"/> OVERNIGHT PATIENT	
PROVISIONAL DIAGNOSIS / PROCEDURE(S)	
PROVISIONAL CMBS CODE(S):	
PROSTHETICS AND PROSTHETIC CODE(S):	
SECTION B	TO BE COMPLETED BY PATIENT/GUARDIAN
<i>Please bring all relevant cards to hospital</i>	
PATIENT DETAILS: Mr <input type="checkbox"/> <i>Patient's Surname</i> Mrs <input type="checkbox"/> _____ Ms <input type="checkbox"/> <i>Given Name (s)</i> Miss <input type="checkbox"/> _____ Date of Birth: _____ Age: _____ Gender: _____ Postal/Residential Address: _____ _____ Postcode: _____ Phone: (h) _____ (w) _____ (mobile) _____ Email: _____ Are you of Torres Strait Islander descent? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you of Aboriginal descent? Yes <input type="checkbox"/> No <input type="checkbox"/> Marital Status: <input type="checkbox"/> Never married <input type="checkbox"/> Married / Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow / Widower Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Home Duties <input type="checkbox"/> Retired <input type="checkbox"/> Pensioner <input type="checkbox"/> Other First Language _____ Interpreter Services required Yes <input type="checkbox"/> No <input type="checkbox"/> Country/State of Birth: _____ Religion: _____	
MEDICARE NUMBER: _____ Position No: _____ Expiry Date: _____ PHARMACEUTICAL/PENSION ENTITLEMENT NO: _____ HEALTH INSURANCE DETAILS: Fund Name: _____ Membership No: _____ Table: _____ <div style="text-align: center;">UNINSURED PATIENTS ARE REQUIRED TO PAY FULL ESTIMATED FEE 24 HOURS PRIOR TO ADMISSION</div>	
DEPARTMENT OF VETERANS' AFFAIRS DETAILS: DVA File No: _____ DVA Card Colour Gold <input type="checkbox"/> White <input type="checkbox"/> DEFENCE FORCE: Service No: _____ Barracks: _____	
ADMISSION FOR: <input type="checkbox"/> Workers Compensation <input type="checkbox"/> MVIT (please tick) Date of Accident: _____ State where accident occurred (eg. WA, QLD): _____ Claim Number: _____ Employer's Name: _____ Address: _____ Phone No: _____ Insurance Co: _____ Phone No: _____ Fax No: _____	
NEXT OF KIN, FRIEND OR GUARDIAN: Relationship to patient: _____ Name: _____ Address: _____ Phone: (h) _____ (w) _____ (mobile) _____ Email: _____ OTHER CONTACT: (in Australia not living with you) Relationship to patient: _____ Name: _____ Address: _____ Phone: (h) _____ (w) _____ (mobile) _____	
ACCOMMODATION ALLOCATION: Private Room <input type="checkbox"/> Shared Room <input type="checkbox"/> <i>Whilst every effort will be made room allocation will depend on availability at time of admission. Where a shared room is requested and a private room is allocated additional payments may apply.</i>	
Have you been a patient at Bethesda Hospital previously? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, which year? _____ Surname at previous admission _____ Have you been hospitalised / been resident of, or worked in a health care facility in the last 12 months ? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where _____ If the Hospital was outside WA please contact our Admission Office immediately. <i>(It may be necessary for us to obtain microbiology test results)</i>	

BH 0004 01/10 REV2

PATIENT PRE-ADMISSION

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