ST VINCENT'S HEALTH AUSTRALIA

PATIENT REGISTRATION FORM

FIX PATIENT IDENTIFICATION LABEL HERE

UR No: _____ ADM No: _____

SURNAME: _____

GIVEN NAMES: _____ SEX: _____

DATE OF BIRTH: _____ PHONE No: _____

ADDRESS: _____

TO BE COMPLETED BY PATIENT PRIOR TO YOUR ADMISSION

Interpreter required ☐ No ☐ Yes Language _____

Form completed by ☐ Patient ☐ Parent ☐ Relative/Carer, specify _____ ☐ Staff member

☐ I understand that the hospital is a teaching hospital & I have read the section titled "Teaching & Learning" in the Patient Information Booklet

Have you been in hospital in the last 2 months? ☐ Yes ☐ No

Reason? _____ How long? _____

Reason for this admission and history or presenting illness:

_____

_____

If reason for admission is the result of an accident, please state:

When injury occured: _____ Where injury occured (eg. Football field): _____

How injury occured: _____

_____

Medical/Surgical History: List the medical conditions/operations performed and date (attach list if insufficient space)

_____

_____

_____

_____

CURRENT MEDICATIONS

Current medications – please list ALL medications including complementary medications and bring these to hospital in their original containers (attach a list if insufficient space)

DRUG NAME	DOSE	FREQUENCY / TIME	Staff use

MEDICATIONS

Staff use

Do you take or have you recently taken blood thinning medication or natural blood thinning medication? ☐ Yes ☐ No

Is your admitting doctor aware of this ☐ Yes ☐ No

Have you been told to cease this? ☐ Yes ☐ No

Date to cease ____ / ____ / _____ Date last taken ____ / ____ / _____

Have you been told to start any other treatment eg clexane? ☐ Yes ☐ No

Have you taken any steroids or cortisone tablets/injections in the last 6 months? ☐ Yes ☐ No

If yes. specify Date last taken ____ / ____ / _____

Patient aware of management plan ☐

Notified required and completed

☐ Surgeon

☐ Anaesthetist

☐ Theatre

☐ Ward

☐ DPU

PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7