MR1

JOLIMONT ENDOSCOPY

Please return paperwork to:

Email: efbookings@epworth.org.au
Fax: (03) 9418 8186
Mail: Level 3, 124 Grey St
East Melbourne VIC 3002

Unit Record Number:..... Adm. Number:.....

Surname .....

Given Name.....

D.O.B. ..... Age..... Sex.....

Medical Specialist.....

Affix Patient Identification Label

ADMISSION DETAILS (MUST BE COMPLETED)

Admission Date: _____ Admission Time: _____

Admitting Dr: _____ Dr Phone: _____

Procedure: _____

Provisional Item Number(s): _____

Estimated Length of Stay: _____ days Day Case ☐ Overnight Case ☐

PATIENT DETAILS

Have you been a patient at Epworth? ☐ **Yes** ☐ **No** **Most recent date**

Have you stayed in any hospital within the last month? ☐ **Yes** ☐ **No** **If Yes, Hospital name:**

Title: (Mr/Mrs/Miss/Ms/Master)

Surname: Previous Surname:

Given Names: Preferred Name:

Sex: ☐ Male ☐ Female Date of Birth:

Country of Birth: Marital Status: Preferred Language:

Residential Address:

Suburb / Town: State: Postcode:

Postal Address: Tick if as per above ☐

Contact No: Home: Work: 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 puposes or to ask for feedback about your experience with us.

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No Religion: Tick if No Religion ☐

Medicare Number: Number beside name on card

Pension / Concession No: Exp Date:

PBS Entitlement Card No: HealthCare Card No:

CONTACT PERSON

Title:

Surname:

Given name:

Relationship to patient:

Address:

Suburb/Town: Postcode

Contact No: (home)

Contact No: (work)

Contact No: (mobile)

MEDICAL ATTORNEY / GUARDIAN / MEDICAL TREATMENT DECISION MAKER

Do you have - please tick:

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

So we can respect your wishes, please bring the relevant documents so we can make a copy for your records.

ADMISSION DETAILS

MR1

GP DETAILS

OFFICE USE ONLY
Is this the Admitting Medical Officer? ☐ Yes ☐ No

Name of regular Dr:

Dr Address: State: Postcode:

Dr Phone: Fax: Email:

We routinely send information about your hospitalisation to your local Dr. Do you consent to this information being sent? ☐ Yes ☐ No

Referring Specialist: ..... Phone: ..... Fax: .....

Referring Specialist Address: .....

Do you have a regular community pharmacist? ☐ Yes ☐ No If Yes, please provide their name and contact number:

.....

PERSON RESPONSIBLE FOR ACCOUNT (if not patient)

Surname: Given Name:

Home Address: State: Postcode:

Contact No: Home: Work: Mobile:

Email address:

By providing this information you consent to us disclosing information regarding your admission to the person responsible for the account, and you acknowledge that the person responsible for the account is entitled to provide us with informed financial consent before accepting responsibility for the account.

INSURANCE / CLAIM DETAILS – please tick relevant box

We recommend you contact your Private Health Insurer to check if your reason for admission, including any surgery is covered under your level of insurance. You may wish to ask if there are any additional costs you should expect, such as an excess or co-payments. All out-of-pocket expenses are required to be paid prior to your admission.

Privately Insured Name of Fund:

Membership No: Level of Cover:

Self Insured ☐ Overseas Patient ☐ DVA – Card No: Gold Card ☐ White Card ☐ Orange Card ☐

I understand that the hospital may contact my Health Fund and/or Medicare for verification of my eligibility for treatment. ☐ Yes ☐ No

WORKCOVER / TAC – please attach claim acceptance letter

OFFICE USE ONLY
EMU ☐ Yes ☐ No

Approval of your application is necessary prior to your admission. Workcover / TAC will not be liable for the cost of providing treatment to you unless they have confirmed that you are a client and accepted liability for your hospitalisation, treatments and other associated costs.

☐ Workcover ☐ TAC Claim No:

Date of Injury: Name of Insurance Company:

Employer's Name:

Employer's Address: State: Postcode:

Contact Person: Contact No: Fax No:

Please be advised that Workcover, Veteran Affairs and Transport Accident Commission patients are accommodated in shared rooms only - single room charges apply.

FUNDRAISING SUPPORT

Epworth is a not-for-profit hospital group which relies on the generosity of its community to assist it to continue to deliver excellence in treatment and care. We have a fundraising body called the Epworth Medical Foundation, which hosts and undertakes fundraising activities. From time to time the Epworth Medical Foundation contacts patients seeking their support. Please let us know if you **do not** wish to be contacted.

☐ I **do not** wish to be contacted by the Epworth Medical Foundation to seek my support.

DECLARATION

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

Signature: Name: Date:

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PATIENT HEALTH HISTORY

Affix Patient Identification Label

Unit Record Number .....
Surname .....
Given name .....
D.O.B. ..... Age ..... Sex.....
Medical Practitioner .....

MR9z

HEALTH INFORMATION

Full name:
Date of birth:
Today's date:
Reason for admission:
Surgical history:

Height:
Waist circumference: Weight:
Primary language spoken:
Do you require an interpreter? ☐ Yes ☐ No
Do you have diabetes ☐ Type 1 ☐ Type 2 ☐ Yes ☐ No
Is your diabetes managed by: ☐ diet ☐ tablets ☐ N/A ☐ insulin
Do you have high/low blood pressure? ☐ Yes ☐ No
If 'yes', controlled by medication? ☐ N/A ☐ Yes ☐ No
Are you a registered organ donor? ☐ Yes ☐ No
Blood tests taken for this admission? ☐ Yes ☐ No
Company & date taken:
X-rays taken for this admission? ☐ Yes ☐ No

Nutrition information

Do you require a special diet? ☐ Yes ☐ No
Please specify:
Do you have speech or swallowing difficulties? ☐ Yes ☐ No
Any appetite problem causing weight loss? ☐ Yes ☐ No
Have you lost over 5kg without trying? ☐ Yes ☐ No

LIFESTYLE

Please tick and specify frequency if you:

Drink alcohol? ☐ Yes ☐ No
Smoke? ☐ Yes ☐ No
Have ever smoked? ☐ Yes ☐ No
Use recreational drugs? ☐ Yes ☐ No

ALLERGIES

Any allergies to:	If 'yes', please specify:
☐ No known allergies	
☐ Anaesthetics (self/ family)	
☐ Blood products	
☐ Chemotherapy	
☐ Food	
☐ Medication	
☐ Rubber/ latex	
☐ Tapes/ lotions	
☐ Other	

HEALTH HISTORY

Answer all questions and circle as needed:

Dentures		☐ Yes ■ No
Limited jaw movement		☐ Yes ☐ No
Cough, cold or sore throat (last 2 weeks)		☐ Yes ☐ No
Migraines / motion sickness		☐ Yes ☐ No
Epilepsy / fits / seizures (date last seizure)		☐ Yes ☐ No
Multiple sclerosis / motor neurone disease		☐ Yes ☐ No
Dementia		☐ Yes ☐ No
Short term memory loss		☐ Yes ☐ No
Psychiatric problems (anxiety / depression)		☐ Yes ☐ No
Strokes / ministrokes / TIA		☐ Yes ☐ No
Any residual weakness?		☐ Yes ☐ No
Heart problems (chest pain, heart attack)		☐ Yes ☐ No
Blood / clotting problems		☐ Yes ☐ No
Breathing problems (shortness of breath, sleep apnoea)		☐ Yes ☐ No
Asthma		☐ Yes ☐ No
Home oxygen / CPAP machine use		☐ Yes ☐ No
Indigestion or reflux		☐ Yes ☐ No
Bowel bleeding / constipation / diarrhoea		☐ Yes ☐ No
Interested in bowel cancer screening program?		☐ Yes ☐ No
Bladder problems / incontinence		☐ Yes ☐ No
Kidney disease		☐ Yes ☐ No
Prostate problems	☐ N/A	☐ Yes ☐ No
Physical disability / mobility issues		☐ Yes ☐ No
Arthritis (location & type)		☐ Yes ☐ No
Neck or back problems		☐ Yes ☐ No
Fallen in the last 6 months		☐ Yes ☐ No
Impairment: ☐ vision ☐ hearing		☐ Yes ☐ No
Aids used?		☐ Yes ☐ No
Prosthesis (pacemaker, port, joint)		☐ Yes ☐ No
Current wounds or breaks to skin		☐ Yes ☐ No
Hospitalisation overseas within last 12 months		☐ Yes ☐ No
History of chicken pox or vaccination		☐ Yes ☐ No
History of measles or vaccination		☐ Yes ☐ No
History of multi resistant bacterial infection (e.g.: MRSA/VRE/CRE/ESBL)		☐ Yes ☐ No
Pregnant / breast feeding	☐ N/A	☐ Yes ☐ No
Cancer (record type and location below)		☐ Yes ☐ No
Chemotherapy / radiotherapy		☐ Yes ☐ No

Provide extra information or list any other health issues you have:

PATIENT HEALTH HISTORY MR9

08/18

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PATIENT HEALTH HISTORY

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Unit Record Number .....
Surname .....
Given name .....
D.O.B. ..... Age ..... Sex.....
Medical Practitioner .....

MEDICATIONS

Please list ALL medications you are currently taking: prescribed, over the counter & complementary medicine (including vitamins & supplements):

			Hospital use only					Hospital use only	
Medication	**Dose**	**Frequency**	**Brought in?**	**Last taken?**	**Medication**	**Dose**	**Frequency**	**Brought in?**	**Last taken?**

Please bring all your listed medications with you in the original packaging, as well as any repeat / authority prescriptions, safety net and concession cards.

Have you been instructed to stop any medications prior to your admission? ☐ Yes ☐ No

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

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

If you are taking oral contraception medication, please speak with you surgeon or anaesthetist

CREUTZFELDT JAKOB DISEASE

Did you receive pituitary hormone for infertility or Human Growth Hormone prior to 1986? ☐ Yes ☐ No

Have you had brain or spinal surgery before 1990 that involved dura mater grafting? ☐ Yes ☐ No

Is this admission related to rapid onset dementia? ☐ Yes ☐ No

Do you have CJD or do you have **two or more** first degree relatives with CJD? (i.e. mother, father, sibling) ☐ Yes ☐ No

Have you been assessed for CJD or do you have a "medical in confidence letter" regarding your risk of CJD? ☐ Yes ☐ No

DISCHARGE PLAN

Day patients

If you are having an anaesthetic, you cannot drive yourself home and will need someone to accompany you home.

Do you have a responsible adult to take you home and stay with you for the day and night? ☐ Yes ☐ No

Please provide their name and contact number:

Overnight patients

As a result of this admission are you likely to have problems managing at home? ☐ Yes ☐ No

Are you a carer for others at home? ☐ Yes ☐ No

Are you receiving home nursing services? ☐ Yes ☐ No

Please specify: _____

How long do you expect to be in hospital? _____ days

Do you live: ☐ Alone ☐ With others ☐ Residential care

Please specify: _____

Do you need assistance with: ☐ Walking ☐ Meals ☐ Hygiene

Where do you plan to go after discharge?

VALUABLES

PLEASE DO NOT BRING ANY VALUABLES INTO HOSPITAL

I am aware that any valuables (including jewellery, cash, credit cards, computer equipment, mobile phones or other items of personal property with a high monetary value) I bring to hospital or decide to keep with me during my admission are my responsibility and I understand that the hospital is not liable for any losses of my personal property.

Name: Signature: Date:

HOSPITAL USE ONLY: REFERRALS

Initial and date	Referral	Review		Referral	Review		Referral	Review
Anaesthetist			Discharge coord/ CCL			Speech therapy		
Breast care nurse			Occupational therapy			Stomal therapy		
Cardiac nurse			Pastoral care			Urology nurse		
Diabetes Educator			Physiotherapy			Other:		
Dietitian			Social work					

Note: All staff actioning a referral must document the assessment in the appropriate location in the medical history

Preadmission nurse name:		Signature:		Designation:		Date:	
Admitting nurse name:		Signature:		Designation:		Date & time admitted:	

ADDITIONAL COMMENTS

- Check the MR1 Admission Details for Advance Care Directive (ACD) information.
- Update A1 Alert Card & iPM (eg: ACD, Medical Treatment Decision Maker, Allergies)

PATIENT HEALTH HISTORY

MR9