PRE-ADMISSION FORM

SPRING HILL SPECIALIST DAY HOSPITAL	OFFICE USE ONLY: Paid QFG: Y / N MRN.
Levels 1 and 4, St Andrew's Place 33 North Street, Spring Hill Qld 4000 Phone: [07] 3307 3243 Fax: [07] 3832 3247	

PLEASE COMPLETE FORMS IN BLACK PEN AND RETURN TO US AS SOON AS POSSIBLE. IF YOUR ADMISSION IS WITHIN 48 HRS, PLEASE CALL RECEPTION ON THE ABOVE NUMBER TO PROVIDE THE NECESSARY DETAILS.

Proposed Admission Date (if known): / /	Treating Doctor:
Proposed Surgery / Procedure:	
Surname:	(Mr, Mrs, Miss, Ms, Dr)
Given Names (in full):	
Home Address:	
	Postcode:

WE WILL CONTACT YOU ON THE LAST WORKING DAY PRIOR TO YOUR SURGERY.
PLEASE PROVIDE US WITH THE MOST SUITABLE CONTACT NUMBER: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Position on Card: Valid until: /

Phone (Home): (Business): (Mobile):

Date of Birth: / / Age: Religion:

Country of Birth: _____

Main Language Spoken: _____

If required will an interpreter accompany you? ☐ Yes ☐ No

Are you of:
- ☐ Australian Aboriginal Origin
- ☐ or Torres Strait Islander Origin
- ☐ or South Sea Islander Origin
- ☐ or None of the above

Occupation:

Marital Status:
- ☐ 1. Never Married
- ☐ 2. Married / Defacto
- ☐ 3. Widowed
- ☐ 4. Divorced
- ☐ 5. Separated

Next of Kin: Relationship:

Address:

Postcode:

Contact Phone No.

If someone other than your *Next of Kin* is collecting you after surgery please provide their name and contact details:

Name: Phone:

Have you used this facility previously? ☐ Yes ☐ No Please advise if Surname changed:

Have you been a hospital inpatient in the last 28 days? ☐ Yes ☐ No

If yes, please give details: _____

DECLARATION

I accept responsibility for payment of all treatment administered at Spring Hill Specialist Day Hospital irrespective of any claim which I may have against any health fund or other party. I also accept that should admission to hospital for further care be required I will be responsible for all costs incurred.

Signature: _____ Date: / /

Relationship to Patient:

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

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INSURANCE DETAILS

PLEASE COMPLETE THE FOLLOWING

Fund Name: **Membership No.**

Type of Cover: **Annual Excess** (if applicable):

Is this procedure covered by:	YES	NO	
Workers Compensation	☐	☐	Claim Number: _____
Veterans Affairs	☐	☐	Entitlement Number: _____
Non Insured	☐		

PAYMENT OF ACCOUNTS

ACCOUNTS ARE PAYABLE IN FULL ON THE DAY OF SURGERY. PAYMENTS CAN BE MADE BY CHEQUE, CASH, EFTPOS, CREDIT CARDS OR AMERICAN EXPRESS.

PLEASE REMEMBER TO BRING YOUR HEALTH FUND DETAILS AND YOUR MEDICARE CARD WITH YOU.

To assist you in finding out any costs for your procedure, please complete the following:	Completed	Not applicable
1. If you have health insurance, ring your fund to check whether you are covered for this procedure at Spring Hill Specialist Day Hospital and if an excess is applicable.	☐	☐
2. If you do not have health insurance, please ring Spring Hill Specialist Day Hospital with your item numbers to receive a verbal / written quote for your stay.	☐	☐
3. Request written information from your surgeon about any "out of pocket costs" which may apply to the surgical fee.	☐	☐
4. Request the name and contact phone number of your anaesthetist, from your surgeon's rooms, for information on any "out of pocket costs" which may apply to the anaesthetic fee.	☐	☐
5. If pathology is required, please note that a "Gap Payment" may apply.	☐	☐

PRIVACY PRINCIPLES

1. We acknowledge our obligations to you under the Privacy Act 1988.
2. Our Personal Information Management Policy is available at Reception and our Privacy Officer, who can be contacted by telephone through our main switchboard, is happy to answer any questions you may have concerning the policy.

PLEASE READ YOUR BROCHURE TO ASSIST IN PREPARING FOR YOUR SURGERY AND YOUR DISCHARGE ARRANGEMENTS.