MACKAY SPECIALIST DAY HOSPITAL

85 Willetts Road
North Mackay QLD 4740
Phone: [07] 4942 0777
Fax: [07] 4942 0888

PRE-ADMISSION FORM

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, Master, Dr]
Given Names [In Full]:	Male ☐ Female ☐
Home Address:	
	Postcode:
Postal Address: [write as above if same]	
	Postcode:

YOU WILL NEED TO CONTACT US ON THE LAST WORKING DAY PRIOR TO YOUR SURGERY.

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

Pension Type: Pension Number:

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: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PRE-ADMISSION FORM

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: _____
Third Party	☐	☐	Employer: _____
Non Insured	☐		

PAYMENT OF ACCOUNTS

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

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 Mackay Specialist Day Hospital and if an excess is applicable.	☐	☐
2. If you do not have health insurance, please ring Mackay 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 we are happy to answer any questions you may have concerning the policy.

DECLARATION

I certify that the information contained on this form is true and correct to the best of my knowledge.

I accept full responsibility for payment of all treatment administered at Mackay Specialist Day Hospital including any shortfall in reimbursement by my Health Fund and /or Workers Compensation gap following settlement.
I have had financial costs of my procedure clearly explained to me and understand that:

- Quotes supplied prior to admission are estimations only.
- Any excess payable under my Private Health Insurance Fund will be paid on admission.
- I may be required to pay for medical items or pharmacy not covered by my Health Fund however this will be explained to me prior to my procedure.
- I will be liable for any debt collection and/or solicitors' fees incurred if I fail to pay for any additional expenses incurred that is not covered by my health fund

I have been given a copy of my rights and responsibilities and have been given the opportunity to ask questions.

Signature: _____ Date: / /

Relationship to Patient: _____

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