Cabrini

Office use only

Pre-admission Number: _____

UR Number: _____

Registration Form

Please complete & email to patientservices@cabrini.com.au or post reply paid to either:
-Cabrini Malvern, Patient Services, Reply Paid 63245, Malvern VIC 3144
-Cabrini Brighton, Patient Services, Reply Paid 85198, Brighton VIC 3183

Admitting campus Date of surgery: DD / MM / YYYY

☐ **Cabrini Malvern** ☐ **Cabrini Brighton**

FCH100900

Section 1: **Patient details** - Patient to complete (Parent or guardian to complete for persons under 18 years) Please tick ✓

Title:_____Surname:|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Given names: |___|___|___|___|___|___|___|___|___|___|___| Date of birth: DD / MM / YYYY ☐ Male ☐ Female

Residential address:_____Postcode: _____

Postal address (If different to above): _____

_____Postcode: _____

Tel (Home):_____Tel (Work):_____Mobile: _____

Email address: _____

What date are you being admitted? DD / MM / YYYY

Who is your admitting Doctor? _____

Maternity patients: What is your expected delivery date? DD / MM / YYYY

Have you been a patient at Cabrini in the **last 3 months**? ☐ Yes ☐ No

If yes, only complete details that have changed and sign the declaration in section 9
If no, please complete all sections

Have you **previously** been a patient at Cabrini? ☐ Yes ☐ No

↓

Was your name the same? ☐ Yes ☐ No

If no, what was your previous name?_____

Marital status:_____ Religious affiliation:_____ ☐ I do not wish to declare a religious affiliation

Country of birth:_____

Do you require an interpreter? ☐ Yes ☐ No Preferred language: _____

Are you of Aboriginal or Torres Strait Islander descent? ☐ Yes ☐ No

Section 2: **Health cover details** - Patient to complete (Parent or guardian to complete for persons under 18 years)

Name of health fund:_____Membership number: _____

Medicare card number: |___|___|___|___| - |___|___|___|___|___| - |___| Ref no |___| Valid to: MM / YYYY

Ambulance cover: ☐ Yes ☐ No Details: _____

Veterans' affairs file number:_____ ☐ Gold card ☐ White card ☐ Orange card

Pension / healthcare card number: _____Exp: DD / MM / YYYY

Pharmaceutical safety net: Concession number (CN) _____Exp: DD / MM / YYYY

Safety Net (SN) number _____Exp: DD / MM / YYYY

Section 3: **GP details** - patient to complete (Parent or guardian to complete for persons under 18 years)

Do you consent to your GP being informed of your admission? ☐ Yes ☐ No

GP name:_____GP address: _____

_____

GP contact number:_____GP Fax number: _____

Please turn over

REGISTRATION FORM MR002B

Cabrini

OFFICE USE ONLY

Please complete & email or post in a reply paid envelope as per the instructions on the first page.

Section 4: **Emergency contact** - **Patient to complete** (Parent or guardian to complete for persons under 18 years)

Title:_____Surname:_____ Given names:_____

Address:_____Postcode: _____

Relationship to patient: _____

Tel (Home):_____Tel (Work):_____Mobile: _____

Additional contact

Title:_____Surname: _____Given names: _____

Address:_____Postcode: _____

Relationship to patient: _____

Tel (Home):_____Tel (Work):_____Mobile: _____

Section 5: **Account details** - **Patient to complete** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Who is responsible for paying your account? ☐ Self ☐ Next of kin ☐ Workcover ☐ TAC ☐ Veterans' affairs ☐ Other

If other, is this person aware that they are responsible for paying this account? ☐ No ☐ Yes

Title:_____Surname: _____Given names: _____

Address:_____Postcode: _____

Relationship to patient: _____

Tel (Home):_____Tel (Work):_____Mobile: _____

Section 6: **Insurance / claim details** - **Patient to complete** (Parent or guardian to complete for persons under 18 years)

Please contact your health fund prior to admission to check your level of cover, as excess, gap or co-payment may apply which must be settled prior to admission. If you are not insured and do not have adequate cover, you must also settle all costs prior to or on admission.

☐ Overseas patient ☐ Veterans' affairs ☐ Nil insured ☐ Privately insured

Fund name: _____Membership number: _____

Level of cover:_____

Section 7: **Workcover / TAC** - **Patient to complete** (Parent or guardian to complete for persons under 18 years)

☐ Workcover ☐ TAC Claim number: _____

Date of injury: DD / MM / YYYY Name of insurance company: _____

Employer's name: _____

Employer's address:_____Postcode: _____

Contact person:_____ Contact number:_____Fax number: _____

Has your employer accepted liability? ☐ No ☐ Yes (If Yes, please attach acceptance letter)

Section 8: **Cabrini foundation** - **Patient to complete** (Parent or guardian to complete for persons under 18 years)

Cabrini may contact you to support our community activities and hospital developments. We respect your privacy, so please let us know if you do not wish to be contacted for these reasons. ☐ **I do not** wish to be contacted by the Cabrini Foundation.

Section 9: **Declaration** - **Patient to complete** (Parent or guardian to complete for persons under 18 years)

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

Name:_____Signature:_____Date: DD / MM / YYYY

Place signed form in reply paid envelope and post.

Cabrini

Unit Record Number _____

Surname * _____

Given Names * _____

Affix patient label here or complete details

DOB * _____ Sex * _____

Acknowledgement of Consent to Treatment

FCH101200

Patient to complete and bring to hospital (Parent or guardian to complete for persons under 18 years) Please tick ✓

*Do you require an interpreter to assist you in completing this form ☐ No ☐ Yes

*If yes, has an interpreter been involved in completing this form ☐ No (Please provide reason _____) ☐ Yes

*Has **anyone been appointed** to make a decision about your care?[1] ☐ No ☐ Yes

If yes, please specify: _____

_____

_____

*Have you prepared any **written requests / requirements / instructions** relating to your care?[2] ☐ No ☐ Yes

If yes, please provide a copy

Acknowledgement of consent to treatment

I _____*_____, on behalf of myself * ☐ or _____

Print name Relationship to patient

acknowledge that Mr Raymond Yap

Name of Medical Practitioner or Medical Imaging Technologist*

has explained to me the procedure(s) or treatment(s) detailed below to my satisfaction, and I consent to these. I understand the explanation the Doctor / Medical Imaging Technologist* gave me as to the need, benefits, risk and complications related to this procedure or treatment.

I also consent to the testing of my blood for infections, including HIV (AIDS) or Hepatitis, if a Medical Practitioner determines that any person is or may be at risk of infection through contact with me.

I further consent to the confidential use by staff at Cabrini of information contained in my Medical Record for the purposes of quality improvement.

*for IV contrast only

Description of procedures or treatments on * DD / MM / YYYY (Date of planned procedure)

*_____

_____

_____

_____

Signature: *_____ Date of signature: * DD / MM / YYYY

Signature of patient / relative / guardian

Ackowledgement of consent to Anaesthesia or Sedation (To be completed after seen by Anaesthetist)

I consent to having an Anaesthetic or Sedation. I understand the explanation given to me by

Doctor: _____ as to the needs, benefits, risk and complications related to this.

Print name of Doctor

Signature: _____ Date of signature: DD / MM / YYYY

Signature of patient / relative / guardian

Note 1. An **agent** appointed under the Medical Treatment Act (Enduring Power of Attorney)
A **guardian** or an **enduring guardian** appointed under the Guardianship & Administration Act.

Note 2. Refusal of Treatment Certificate under the Medical Treatment Act or an Advance Care Plan or similar document.

ACKNOWLEDGEMENT OF CONSENT TO TREATMENT MR002D

Cabrini

Unit Record Number _____

Surname _____

Given Names _____

DOB _____ Sex _____

Affix patient label here or complete details

Please bring this form to hospital on day of admission

Acknowledgement of informed consent for transfusion of blood or blood products

Patient to complete (Parent or guardian to complete for persons under 18 years) Please tick ✓

Has the Doctor discussed the possibility that you may have a transfusion of blood products? ☐ No ☐ Yes

- The Doctor has explained why I may need / will need a blood transfusion
- The risk or benefits of receiving / not receiving blood or blood products have been discussed
- I have received an information brochure about blood transfusion
- The availability and appropriateness of any other blood management strategies have been discussed
- My questions have been answered

☐ Yes = I confirm all of the about have occurred

☐ No = Discuss with a member of staff prior to commencing / consenting to a transfusion.

I consent to having a transfusion of blood or blood products if required.

Signature: _____ Date of signature: DD / MM / YYYY
Signature of patient / relative / guardian

Or

I refuse to have a transfusion of blood or blood products at this time.

Signature: _____ Date of signature: DD / MM / YYYY
Signature of patient / relative / guardian

Doctor to complete - if patient is unable to complete any part of the consent, and there is no nominated enduring Power of Attorney (Medical) or relative / guardian immediately available.

(For use in an emergency situation or when a patient is physically unable to sign).

I _____ have discussed the proposed procedure / treatment
Print name of Doctor

with _____, _____,
Print name of person Relationship to patient

who has agreed that the procedure / treatment be undertaken.

Doctor's signature: _____ Date of signature: DD / MM / YYYY
Signature of Doctor

FCH101300

Cabrini

Unit Record Number_____

Surname_____

Affix patient label here or complete details

Given Names_____

DOB_____ Sex_____

Pre-operative Medical Orders

Allergies and drug reactions

☐ Yes ☐ None known Name:_____ Signature:_____

Drug substance	Reaction	Date	Drug substance	Reaction	Date
		/ /			/ /
		/ /			/ /
		/ /			/ /

Doctor to complete

Patient to bring this form to hospital on day of admission

Treatment order on admission (E.g. pre-warming, sequential compression device)	**Doctor's name**	**Doctor's signature**

Test on admission (E.g. ECG, Pathology)	**Doctor's name**	**Doctor's signature**

Preoperative medications only - to be given on admission (Eye drops, enema and topical preparations only)

Date prescribed	**Medication order**			**Prescribing Doctor**		**Record of administration**				
	Drug Name			Prescriber number	Doctor's name	Date	Time	Time	Time	Time
	Dose	Frequency	Route		Doctor's signature		Given by	Given by	Given by	Given by
/ /						/ /	___:___	___:___	___:___	___:___
/ /						/ /	___:___	___:___	___:___	___:___
/ /						/ /	___:___	___:___	___:___	___:___
/ /						/ /	___:___	___:___	___:___	___:___

Cabrini

List ALL medicines currently used, including:
prescription medicines, over-the-counter medicines, herbal and natural medicines.

Medicines come in many forms including:
tablets, liquids, inhalers, drops, patches, creams, suppositories and injections.
List any medication allergies.

Allergies and drug reaction ☐ Yes ☐ None known

Drug substance	Reaction	Date	Drug substance	Reaction	Date
		DD/MM/YYYY			DD/MM/YYYY
		DD/MM/YYYY			DD/MM/YYYY
		DD/MM/YYYY			DD/MM/YYYY

Medication list

Patient to complete this form and bring to hospital on day of admission

Surname:_____ Given names:_____ Date of birth: DD / MM / YYYY

Your address:_____ Postcode:_____ Name of your Pharmacy:_____

Name of medicine, active ingredient or brand name	Strength	What is this medicine for?	How much do I use and when?	Special instructions or comments	Date started	When to stop or review
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	
					DD/MM/YYYY	