

# JESSIE MCPHERSON PRIVATE HOSPITAL



246 Clayton Road, Clayton Vic 3168 Tel 9594 2776

Unit Record Number .....

Surname .....

Given Name .....

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

Affix Patient Identification Label

## PATIENT TO COMPLETE REGISTRATION FORM B

Referring Specialist ..... Admission/Due Date ..... Time .....

Procedure / Treatment ..... Operation Date .....

Have you been a patient in Jessie McPherson Private Hospital or Monash Health before? ☐ YES ☐ NO

Does this admission relate to an accident at work or involving a motor vehicle? ☐ YES ☐ NO

Have you been hospitalised within 7 days prior to this admission? ☐ YES ☐ NO

If yes what was the reason for this admission? .....

Surname ..... Given Names .....

Title ..... Previous Names Registered .....

Date of Birth ..... ☐ Male ☐ Female

Address ..... Postcode .....

Contact Number (M) ..... (H) ..... (W) .....

Email Address ..... Marital Status .....

Religion ..... Country of Birth .....

Aboriginal or Torres Strait Islander? ☐ YES ☐ NO

Preferred language..... Interpreter Required? ☐ YES ☐ NO

### 1ST CONTACT PERSON/NEXT OF KIN

Surname ..... Given Names .....

Address ..... Post Code .....

Relationship ..... (H) ..... (W) ..... (M) .....

### 2ND CONTACT PERSON/NEXT OF KIN/POWER OF ATTORNEY (please circle)

Surname ..... Given Names .....

Address ..... Post Code .....

Relationship ..... (H) ..... (W) ..... (M) .....

Local Doctor / GP ..... Contact Number .....

Address ..... Fax .....

..... Post Code .....

Medicare No ☐ ☐ ☐ ☐ - ☐ ☐ ☐ ☐ ☐ - ☐ ☐ Reference number (left of patient name)

Medicare expiry date ..... Safety Net Card No .....

Health Insurance Fund ..... Membership Number .....

Do you have a pension card? ☐ YES ☐ NO Type of card .....

Pension card No. .... Expiry date .....

Do you have Ambulance cover? ☐ YES ☐ NO Membership Number .....

Do you have a DVA card? ☐ YES ☐ NO ☐ White ☐ Gold Card No: .....

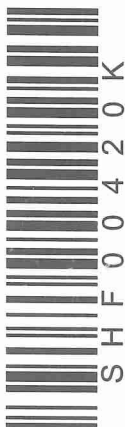
WORKCOVER ☐ TAC ☐ Approved ☐ YES ☐ NO

Insurance Provider ..... Date contacted .....

Claim Number ..... Case Manager .....

Employers Name ..... Address .....

.....



**ELECTION FOR ADMISSION TO JESSIE McPHERSON PRIVATE HOSPITAL  
(FORM B CONTINUED)**

**ACCOMMODATION REQUEST**    ☐ Day Patient    ☐ Shared Room    ☐ Single Room (Subject to availability)

**HOSPITAL VALUABLES POLICY:**

- ☐ I understand that Jessie McPherson Private Hospital does not accept any responsibility for damage to or loss of any personal items, valuables or money brought to the hospital.

**PRIVACY CONSENT:**

- ☐ I have received and read "Rights and Responsibilities" and "The Privacy of your Personal Information" and consent to the collection, follow-up, use and disclosure of my information.

**ELECTION FOR ADMISSION:**

- ☐ I elect to be treated as a private patient at Jessie McPherson Private Hospital. I authorise the hospital to release information about my admission to my insurer for the purpose of claims processing. Should my insurer (Health Fund, Transport Accident Commission, Department of Veterans' Affairs, Workcover, etc) reject my claim or reduce benefits paid, I understand that I am personally responsible for paying in full the balance on the account.

Please refer to page 3 of this booklet outlining accounts information.

**ELECTION FOR ADMISSION AS A SELF FUNDED PATIENT:**

- ☐ I understand that as a self funded patient I am personally responsible for all costs and charges associated with my admission to Jessie McPherson Private Hospital.

**I have read and understand the above information and agree to settle my account at the time of discharge or upon request.**

Signed ..... Date ...../...../.....

Print Name .....

**Person Responsible for Account (if other than patient)**

Name .....

Relationship to Patient .....

Address .....

Suburb ..... State ..... Postcode .....

Phone (H) ..... (W) ..... (M) .....

Witness (signature) ..... Date ...../...../.....

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## PATIENT HISTORY FORM D

Patient's name .....

Reason for admission .....

Operation date .....

Name of Operation .....

### ALLERGIES

Do you have any allergies ☐ YES ☐ NO.

If YES please specify allergy and reaction below:

ALLERGY	REACTION

Height: ..... Weight: .....

### PREVIOUS SURGERY

OPERATION / PROCEDURES	YEAR	OPERATION / PROCEDURES	YEAR

### ANAESTHETIC AND MEDICATION HISTORY

ANAESTHETIC HISTORY	YES	NO	MEDICATION	YES	NO
Have you ever had an anaesthetic?			Have you recently taken blood thinning medication (aspirin /warfarin)?		
Has anyone in your family had a problem with anaesthetic?			Have you taken any steroids or cortisone in the last 6 months?		
Have you ever had problems with anaesthetic?			If yes, please explain:		

### MEDICATIONS

*Please bring your current medications in original packaging with you*

Please list the medications you currently take / or attach list:

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

Do you take recreational drugs? ☐ YES ☐ NO Details: .....

Have you been instructed to withhold any medication prior to your admission? ☐ YES ☐ NO

Details:

Have blood tests been taken for this admission? ☐ YES ☐ NO

☐ Dorevitch

☐ Melbourne Pathology

☐ Gribbles

☐ Other

Have x-rays been taken for this admission? ☐ YES ☐ NO

Who has the x-rays/scan? ☐ With patient ☐ With doctor

*Please bring any x-rays/scans related to this admission with you.*

ADMISSIONS PACK - PATIENT HISTORY

MRD04(II)A



**PATIENT HISTORY FORM D**

**Have you ever had any of the following:**

Please tick either yes or no

**YES NO HEAD & SPINE**

**SPECIFY**

- |                          |                          |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's Disease              |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / seizures              |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines / headaches            |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping problems                |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression / mental illness      |
| <input type="checkbox"/> | <input type="checkbox"/> | Swallowing / speech difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)                  |

_____
_____
_____
_____
_____
_____
_____

**YES NO HEART & CIRCULATION**

**SPECIFY**

- |                          |                          |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Family history of heart problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina / chest pain                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack                        |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                 |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart rate / palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker / AICD insitu             |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)                     |

_____
_____
_____
_____
_____
_____
_____
_____
Date inserted _____ Type _____
_____

**YES NO LUNGS & BREATHING**

**SPECIFY**

- |                          |                          |                               |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia / bronchitis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Airways disease eg. emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnoea                  |

_____
_____
_____

CPAP ☐ YES ☐ NO Bring CPAP machine in

- |                          |                          |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have oxygen at home   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent cold / cough / sputum |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)              |

_____
_____
_____

**YES NO METABOLIC / HORMONAL**

**SPECIFY**

- |                          |                          |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes/Insulin/Injections/Tablets |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease / hepatitis           |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)                     |

_____
_____
_____
_____

**YES NO KIDNEY / REPRODUCTIVE**

**SPECIFY**

- |                          |                          |                               |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder problems / infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems               |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems             |
| <input type="checkbox"/> | <input type="checkbox"/> | Gynaecological problems       |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)               |

If incontinent, specify aids used: _____
_____
_____
If female, currently pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO
_____



**PATIENT HISTORY FORM D**

<b>YES</b>	<b>NO</b>	<b>GASTROINTESTINAL</b>	<b>SPECIFY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Bowel problems	_____
			If incontinent, specify aids used: _____
			_____
<input type="checkbox"/>	<input type="checkbox"/>	Stoma - ileostomy / colostomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	Regular aperients _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hiatus hernia / reflux	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other conditions (specify)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Usual diet (specify)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other dietary requirements: (specify)	_____
<b>YES</b>	<b>NO</b>	<b>BLOOD</b>	<b>SPECIFY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Problems with bleeding or clotting	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous blood transfusion	Date _____ If yes, any reaction?
<input type="checkbox"/>	<input type="checkbox"/>	Other problems (specify)	_____
<b>YES</b>	<b>NO</b>	<b>MUSCLE &amp; BONES</b>	<b>SPECIFY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fractures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous Joint Replacement	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other problems (specify)	_____
<b>YES</b>	<b>NO</b>	<b>INFECTIOUS</b>	<b>SPECIFY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Any infectious diseases eg. HIV, AIDS, VRE, MRSA	_____
<b>YES</b>	<b>NO</b>	<b>OTHER</b>	<b>SPECIFY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any health problems not already mentioned	eg. Cancer, Mental health, Chronic Pain _____
<b>YES</b>	<b>NO</b>	<b>PROSTHESIS / AIDS/OTHERS</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Glasses / Contact Lenses	Comments/Details _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid or other hearing appliance	Comments/Details _____
<input type="checkbox"/>	<input type="checkbox"/>	Dentures / caps / crowns / loose teeth	Comments/Details _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use mobility aids eg. Walking stick, frame etc	_____
<b>YES</b>	<b>NO</b>	<b>LIFESTYLE</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever smoked	Daily amount _____ Date ceased _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol	Average Daily amount _____ Date ceased _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have an enduring power of health attorney – health and medical guardian	
		Name of person _____	Contact Number _____

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*Affix Patient Identification Label*

## QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

	YES	NO
Have you had a Dura mater graft between 1972 - 1989?		
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorders?		
Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?		
Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?		

## DISCHARGE PLANNING

YES NO

- ☐ ☐ 1 Do you live alone? .....
- ☐ ☐ 2 Do you live in a rooming house or in a long term care facility?  
If Yes please circle: nursing home / hostel / special accommodation
- ☐ ☐ 3 Do you have responsibility for the care of others at home?  
If Yes please circle: sole parent / care of disabled
- ☐ ☐ 4 Do you currently require assistance with: (please circle)  
toileting / showering / bathing / dressing / cooking / housework / shopping
- ☐ ☐ 5 If needed will assistance be available to you when you return home?
- ☐ ☐ 6 Do you currently receive any support services? (please circle)  
e.g. district nursing / meals on wheels / home-help / personal care / respite care /  
Linkages / Community Aged Care Packages
- ☐ ☐ 7 Are you currently employed?
- ☐ ☐ 8 What is your occupation? .....
- ☐ ☐ 9 Do you need a medical certificate?
- ☐ ☐ 10 How long do you expect to be in hospital? .....

Signature of Person Completing Form: ..... Date signed: .....

Relationship to patient (if not completed by the patient) .....

Please deliver/post this form as soon as possible to:

**Jessie McPherson Private Hospital**  
246 Clayton Road  
Clayton VICTORIA 3168

**Jessie McPherson Private Hospital Staff use only**

Screened by: ..... Date: .....

Further comments

Signature of admitting nurse: ..... Date: .....