Seymour Health
Locked Bag 1,
Seymour, Vic, 3660
Phone (03) 5793 6100
Fax (03) 5792 4193

PATIENT REGISTRATION

To be completed for all admissions to Seymour Hospital and forwarded as soon as possible for processing to;
Admissions
Seymour Hospital
Locked Bag 1
Seymour VIC 3660

ADMISSION DATE	**TIME**	**24 hr**
SURGEON	**LOCAL GP**	

Surname	Previous Surname
Given Names	Title
Address Postcode	Sex ☐ Male ☐ Female Date of Birth
Home Phone	*Medicare Number* Expiry date ___ ___ / ___ ___
Mobile Phone	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___
Work Phone	*Pension Number* Expiry date ___ ___ / ___ ___
Marital Status ☐Single ☐Married ☐Widowed ☐ De Facto ☐ Separated ☐ Divorced	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___ ☐ Health ☐ Disability ☐ Aged
Country of Birth If Australia, what State?	Language Spoken | Interpreter Required ☐ Yes ☐ No Religion | Aboriginal /Torres Strait Islander ☐ Yes ☐ No

NEXT OF KIN (Contact Person 1)	**NEXT OF KIN (Contact Person 2)**
Name ____________________	Name ____________________
Relationship ____________________	Relationship ____________________
Home Phone ( ) ______________	Home Phone ( ) ______________
Bus Mob ____________________	Bus Mob ____________________

RE-ADMISSION

Have you been hospitalised in the past twenty eight (28) days? ☐ Yes ☐ No If so, where ______________

Have you been hospitalised in the past seven (7) days? ☐ Yes ☐ No If so, where ______________

Have you ever been a patient of Seymour Hospital? ☐ Yes ☐ No When (year)______________

ADMISSION TYPE

If your Doctor has requested you to be a private patient for this episode at Seymour Health please ensure you provide the following;

☐ **Private →** **Health Fund** ______________ **Member Number** ______________

Also complete ☐ National Private Patient Hospital Claim Form (left front side only)
☐ Patient Election Form and specify Doctor and single/non single room
☐ Medicare Simplified Billing Form if you are eligible (see back of election form)

☐ Public

☐ DVA → DVA Number ______________ Card Colour ______________

☐ TAC → Reference No ______________ Date of Accident ____/____/____

☐ WorkCover → Employer's Business Name ______________

Insurance Company ______________ Claim No ______________

PATIENT REGISTRATION

MR003

Seymour Health
Bretonneux Street, Locked Bag 1,
Seymour, Vic, 3660
☎ (03) 5793 6100 Fax (03) 5792 4193

PRE-OPERATIVE ASSESSMENT

(Please place identification label here)

UR No: ____________________

Name: ____________________

Address: ____________________

Date of Birth: ______/______/______

All patients please complete this pre-operative assessment questionnaire and return to Seymour Hospital at least 10 working days prior to operation/procedure. Failure to do so may result in rescheduling or cancelling of your appointment.

Surgeon: **Proposed procedure:** **Date:**

List previous operations including approximate dates and places:

How tall are you? _________cm How much do you weigh? ___________kg BMI_______

PLEASE ANSWER ALL QUESTIONS

Do you have any ALLERGIES / SENSITIVITIES to: ☐ No ☐ **Yes, please add details**

Medications	☐ Latex ☐ Rubber	☐ Tapes ☐ Lotions ☐ Food
	Other	

Current Medications	Dose	Freq	Current Medications	Dose	Freq

A medication summary report from your Doctor can be attached

Have you recently taken the following medications? ☐ No ☐ Yes **(please circle)**

Blood thinning / Aspirin based	Cortisone / Steroids	Have you ceased this medication for the procedure? ☐ No ☐ Yes
Anti Inflammatory, Arthritis	Warfarin	

Past Anaesthetic Details	No	Yes	Details
Have you or a relative ever had a reaction to an anaesthetic?			
Have you ever had a blood transfusion?			

Lifestyle	No	Yes	Details
Do you smoke tobacco/cigarettes?			No.per day ______Ex-Smoker (Date ceased) ______
Do you consume alcohol?			☐ Daily ☐Weekly Quantity ____________
Do you require a special diet?			

Do you wear: ☐ Contact lenses ☐ Glasses ☐ Hearing Aids ☐ Dentures ☐ Other ____________

Creutzfeldt Jacob Disease (CJD)	No	Yes
Have you had a dura mater graft prior to 1989?		
Do you have a family history of CJD?		
Have you received human pituitary (growth) hormone prior to 1985?		
Have you suffered from a recent progressive dementia the cause undiagnosed?		

Infectious Disease (H1N1)	No	Yes
Have you travelled overseas lately and where to?		
Have you been back in Australia less than 14 days?		
Do you have signs and symptoms of a respiratory infection or fever?		

SH Pre-Op Assessment (Jul 2012)
ruralhealthforms@ymail.com

Do you currently have, or ever had, any of the following complaints (please circle condition)	No	Yes
Diabetes (please circle) NIDDM Type 2 OR IDDM Type 1 (please also circle) Insulin dependant, Tablet, Diet controlled		
Angina / Coronary Disease / Heart Attack / any heart problems		
Cardiac Surgery / Pacemaker / Heart valve replacement (please bring pacemaker details)		
Rheumatic fever / Heart Murmur / Atrial Fibrillation		
Palpitations / Irregular heart beat		
High Blood Pressure (Hypertension)		
Asthma / Chronic Bronchitis / Emphysema / Sleep Apnoea / Hay fever		
Pneumonia / TB		
Blood clot in Legs or Lungs (thrombosis or embolism)		
Blood Disease / Bleeding or Bruising problems / Haemophilia / Anaemia		
Stroke / TIA's / Blackouts / Fits / Epilepsy / Conditions of the nervous system		
Kidney / Bladder Problems (specify)		
Heartburn / Gastric Reflux / Hiatus Hernia / Peptic or Duodenal Ulcer		
Bowel problems eg. Diverticulitis, Crohns		
Jaundice / Liver Disease / Hepatitis A / B / C		
Mental Health Condition eg. Depression, Schizophrenia, Panic Attacks, Anxiety		
Could you be pregnant or are you pregnant? If yes, how may weeks?		
Cancer diagnosis (specify)		
Have you had chemotherapy / radiotherapy?		
Recent Cold / Flu / Other infections		
Do you believe you may be at increased risk of HIV / Hepatitis?		
Do you have any health problems not covered by these questions?		
Details		

Do you require assistance with any of the following daily activities?	No	Yes
Walking / Moving Dressing Toileting Shower / Bathing Shopping Other ________________ Cooking / Eating Stairs in home		

Do you care for another person?	No	Yes
Frail Aged Person Disabled Person Baby / Child Other__________ Arrangements made are		

Do you receive community support, for example	No	Yes
Meals on wheels Nursing care Social Worker Home help Home oxygen Other Lifeline Respite Care		

Do you require information regarding	No	Yes
Medical certificate Sickness benefits Workers compensation Carers certificate Social security Other		

Do you live

Alone With family With spouse/partner Nursing home Other _______________

Who will be caring for you after discharge? Name:

How will you get home when you are discharged?

Self/family Public transport Taxi Ambulance Other ______________________

Person completing this form: ___________________________________(print name)

Relative (specify relationship) Date:

Nurse - Print name Designation Date