SPORTSMED•SA

HOSPITAL & ORTHOPAEDICS REGISTRATION FORM

Affix patient identification label in this box

U.R. No. ....

Temp U.R. ....

PERSONAL INFORMATION

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Male ☐ Female

Surname: .... Date of birth ☐☐ / ☐☐ / ☐☐

Given names: .... Preferred name: ....

Marital status: ☐ Single ☐ Married/Defacto ☐ Widowed ☐ Separated ☐ Divorced

Previous name: (If changed since last visit) ....

Home address: (not a PO Box) ....

.... Postcode: ....

Mailing address: (If different from home address) ....

.... Postcode: ....

Phone No: Home .... Mobile ....

Work .... Adelaide Contact ....

Country of birth: .... Occupation: ....

Are you of Aboriginal or Torres Strait Origin? (Tick all that apply) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Email: ....

If you do not wish to be on our newsletter distribution list please tick here ☐

MEDICARE CARD INFORMATION

Medicare card number: ☐☐☐☐☐☐☐☐☐☐ Ref number: ☐ Expiry date: ☐☐ / ☐☐☐☐

Safety net number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Veterans Affairs (DVA) Card number: .... ☐ Gold ☐ White

If white card, have your hospital costs been approved by DVA?: ☐ Yes ☐ No Expiry date: ☐☐ / ☐☐☐☐

PRIVATE HEALTH FUND (NOT EXTRAS)

Health fund name: .... Level of cover: ....

Membership No: .... Date joined: ....

Name of contributor: (If not the patient) ....

Will a hospital excess apply? ☐ No ☐ Yes Amount: ....

Will a co-payment apply? ☐ No ☐ Yes Amount: ....

Has your health insurance cover changed in the last 12 months ☐ No ☐ Yes

If Yes, it is important that you contact your health insurer to clarify your coverage for admission.

HEALTH CARE CARDS (PLEASE CIRCLE)

Pension card / Healthcare card / Commonwealth Seniors health card (please circle)

Card number: ☐☐☐☐☐☐☐☐☐☐ Expiry date: ☐☐ / ☐☐ / ☐☐

Office Use Only: Restrictions ☐ No ☐ Yes Waits ☐ No ☐ Yes Financial ☐ No ☐ Yes

Please Note: All excesses or co-payments are payable on admission

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WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY

Type of Claim: Worker's Compensation ☐ Third Party Patients ☐ Public Liability ☐

Name of Insurer: .... Claim No: ....

Cause of injury / body part: .... Date of injury: __ __ / __ __ / __ __

Insurer's address: ....

.... Postcode: ....

Phone: .... Fax: ....

Name of employer .... WCA Contact person / Case Manager ....

AUSTRALIAN DEFENCE FORCE PATIENTS ONLY

EP: ....

DAN:	Body Part:	Surgeon: ....
DAN:	Body Part:	Surgeon: ....

NEXT OF KIN/EMERGENCY CONTACT

1. Name: .... Relationship: ....
   Address: (If different to above) ....
   Suburb: .... Postcode: ....
   Phone No: Home .... Mobile .... Work ....

2. Name: .... Relationship: ....
   Address: (If different to above) ....
   Suburb: .... Postcode: ....
   Phone No: Home .... Mobile .... Work ....

GP / REFERING DOCTOR - MUST BE COMPLETE TO ENSURE CORRESPONDENCE IS SENT BACK TO YOUR USUAL DOCTOR.

Full name of usual GP: ....

Practice/Clinic Name: ....

GP phone no: ....

GP address: ....

....

Full name of referring Doctor (if different from above): ....

Practice/Clinic Name: ....

Referrer phone No: ....

Referrer address: ....

....

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Revised April 2016

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PATIENT HEALTH HISTORY FORM
(PRE-CONSULTATION)

OFFICE USE ONLY **Height:**	**Weight:**			**BMI:**	**Date:**	Notify Surg >150kg
Please tick box and attach separate sheet for any lists below if required.	**Yes**	**No**	**Details / Specify**			**Staff Use / Initial Actions**
Have you previously been admitted to SPORTSMED·SA Hospital or Day Surgery?						
Do you have any allergies or sensitivities to medicines, tapes, foods, latex, other?			Specify allergy and reaction:			Notify Anaes Chef / HCO
Have you ever had a blood clot in your legs (DVT) or lungs (PE)?			Please specify:			
Do you have any family history of blood clots?			Please specify:			
Are you currently taking any medications to prevent blood clots or "blood thinners"?			Please specify:			Notify as approp
Do you have any heart problems? e.g. heart attack, heart surgery, angina, pacemaker, stents			Details:			
Are you currently taking any medications relating to a cardiac condition?			Please specify:			Notify as approp
Do you have diabetes?			Diet: Insulin:	Tablets: Type:		Notify Chef
Could you be pregnant?						Notify as approp
Do you have a history of falls?			Please specify:			
Do you or have you ever smoked?			Number per day:	Date stopped:		
Do you drink alcohol?			Amount per day:			
Do you use recreational or alternative drugs?			Type:	List below.		
Have you ever had an infection following surgery? (include MRSA, VRE, C-Diff)			Details (year etc.):			Notify IC / Surg if approp
What are your sport, leisure, physical activities?						

PAST MEDICAL AND SURGICAL HISTORY.
Please list all previous serious illnesses, operations and the years you had them including any implants or prosthesis in your body. Please include any previous surgery to limb being operated on first.

MEDICATION HISTORY
Please list all medicines that you are currently taking including those to be stopped prior to surgery. For example: Aspirin, Warfarin, anti-inflammatory, steroids, contraceptive pill, and alternative medicines(e.g. fish oil). (Please attach a list if not enough room or you have one from your GP)

Medication	Dose & Directions	Medication	Dose & Directions	Notify Surg / Anaes If approp

FINANCIAL / PRIVACY CONSENT

PLEASE BRING ALL MEDICINES, INSULIN, PUFFERS YOU ARE CURRENTLY TAKING TO HOSPITAL IN THEIR ORIGINAL LABELLED PACKAGE. NO DOSETTES PLEASE.

I: (Insert name) ....

The patient or nominee named herein undertakes to pay the patient payment of the total amount or any outstanding balance if your insurer or other payer does not cover the full costs of the consultation/treatment.

PRIVACY: At SPORTSMED·SA we acknowledge our obligations under the Privacy Act 1988. By completing this form you are acknowledging and giving consent to the collection and use of your personal information as described our Privacy Statement (available in the Patient Information Booklet) and Policy. If you wish to view our full Privacy Policy please speak to one of our staff.

Patient/Nominee Signature: .... Date: __ / __ / __

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