



## ADMISSION SUMMARY

URN: \_\_\_\_\_ VOL: \_\_\_\_\_ ROOM: \_\_\_\_\_  
SURNAME: \_\_\_\_\_  
GIVEN NAMES: \_\_\_\_\_  
GENDER: M ☐ F ☐ X ☐ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PCODE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
MOBILE: \_\_\_\_\_ HOME: \_\_\_\_\_

ADMISSION DATE:		ADMISSION NO:	
DISCHARGE DATE:		BED DAY COUNT:	

The following questions are asked in order to plan and provide appropriate patient care

COUNTRY OF BIRTH: \_\_\_\_\_ RELIGION: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ BOTH ☐ NEITHER ☐ NOT DISCLOSED ☐

REFERRING DR: \_\_\_\_\_ CLINIC: \_\_\_\_\_  
USUAL GP: \_\_\_\_\_ CLINIC: \_\_\_\_\_  
ADMITTING PSYCH: \_\_\_\_\_ ADMISSION APPT TIME: \_\_\_\_\_

PRIVATE HEALTH ☐ DVA ☐ WORKCOVER/ THIRD PARTY ☐ SELF INSURED ☐  
INSURER: \_\_\_\_\_ LEVEL: \_\_\_\_\_ M'SHIP/ CLAIM NO.: \_\_\_\_\_  
MEDICARE NO.: \_\_\_\_\_ REF: \_\_\_\_\_ EXPIRY: \_\_\_\_\_  
PENSION/ HEALTH CARE CARD NO.: \_\_\_\_\_ EXPIRY: \_\_\_\_\_  
AGED ☐ DISABILITY ☐ UNEMPLOYED ☐ SICKNESS BENEFIT ☐  
REGULAR PHARMACY: \_\_\_\_\_  
PBS SAFETY NET REACHED: NO ☐ YES ☐ SN \_\_\_\_\_  
HOSPITALISATION IN LAST 7 DAYS? (or 28 days for BUPA/ HCF): NO ☐ YES ☐  
NAME OF HOSPITAL: \_\_\_\_\_ DISCHARGE DATE: \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PCODE: \_\_\_\_\_  
PHONE (M): \_\_\_\_\_ (W): \_\_\_\_\_ (H): \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
PHONE (M): \_\_\_\_\_ (W): \_\_\_\_\_ (H): \_\_\_\_\_



## ADMISSION CHECKLIST

URN: \_\_\_\_\_ VOL: \_\_\_\_\_ ROOM: \_\_\_\_\_  
 SURNAME: \_\_\_\_\_  
 GIVEN NAMES: \_\_\_\_\_  
 GENDER: M ☐ F ☐ X ☐ DATE OF BIRTH: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_ PCODE: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_  
 MOBILE: \_\_\_\_\_ HOME: \_\_\_\_\_

## ADMISSION OFFICER TO COMPLETE

	Health Fund eligibility checked
	Informed Financial Consent explained, signed, copy given to patient (and Addendums if required)
	'Consent to the Use of Personal Info' Form (MR1B) signed (Inpatients only) (THC Privacy Policy offered, if applicable)
	'Patient Agreement' Form (MR1D) signed (Day Program patients only)
	Admission Summary faxed to Pharmacist @ South Arm Pharmacy (Ensure Medicare, Pension/ Health care cards, Safety Net listed, if applicable)
	GP letter faxed or emailed
	Patient labels printed and affixed
	Prefilled Psych Care certificate provided to Psychiatrist for completion (All funds except BUPA, DVA, W/Comp, SLM)
	Patient pharmacy dispensing history and/ or webster pack history requested
	Redbook updated for new patients
	Tracer placed in medical file room
	HosCare entry (incl Bed Day Count, applied for readmissions)
	ZedMed entry (incl referral details, patient alerts and NOK)
	MPI spreadsheet - new details entered; existing details verified
	Programs Discharge Planner updated (Inpatients only)
	Copy of Admission Summary front page (New patients and updates) provided to hospital accounts for MYOB (EXO) entry (All funds except BUPA, DVA, W/Comp, SLM)

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_