Hospital Admission & Medical Record Form

Patient Identification

Medical Record Number (MRN)

First Name

Last Name

Date of Birth
mm/dd/yyyy

Gender
○ Male ○ Female ○ Other

Primary Phone

Email

Address

Admission Details

Admission Date
mm/dd/yyyy

Admission Time
--:-- --

Admission Type
-- Select --

Referral Source
e.g., ER, Clinic, Physician

Assigned Ward / Unit
e.g., Cardiology - Ward 3

Room / Bed
Room 201 / Bed B

Emergency Contact / Next of Kin

Name

Relation

Phone

Address

Insurance / Billing Information

Insurance Provider

Policy Number

Authorisation / Pre-Auth Code

Self-Pay ☐ Patient will self-pay (no insurance)

Medical History

Allergies (list)

e.g., Penicillin, Nuts, Latex

Chronic Conditions

e.g., Diabetes, Hypertension

Current Medications

Medication name, dose, frequency

Past Surgeries (year & procedure)

Vitals on Admission

Temperature (°C)

Pulse (bpm)

Respiratory Rate (breaths/min)

Blood Pressure (systolic) / Diastolic

SpO₂ (%)

Initial Assessment / Diagnosis

Presenting Complaint

Working Diagnosis

Triage / Priority

-- Select --

Initial Orders & Medications (Admission)

Orders (e.g., Labs, Imaging, Consults)

e.g., CBC, X-ray chest, Cardiology consult

Medication Orders

Drug, dose, route, frequency

Documentation

Upload ID / Insurance Card (PDF / JPG / PNG)

Choose File No file chosen

Upload Scans / Reports (multiple allowed)

Choose Files No file chosen

Consent

Patient Consent for Treatment

I consent to necessary medical treatment. (This is

Consent Confirmed (checkbox) ☐ I confirm that consent has been obtained.

Discharge Planning (to be filled later)

Expected Length of Stay (days)

Discharge Needs (e.g., home care, equipment)

Submit Admission Reset Form