ST JOHN OF GOD
Frankston Rehabilitation Hospital

PATIENT REGISTRATION

U.R. Number _____

Surname _____

Given Names _____

Date of Birth ___ / ___ / ___ Sex ___

Use Label If Available or BLOCK LETTERS

To assist St John of God Healthcare to provide you with the best possible care please go to www.sjog.org.au/frankston for further information about your admission to hospital.

Admission Date ___ / ___ / ___ Admitting Doctor _____

Reason for Admission: _____

Have you ever been a patient at this hospital before? ☐ Yes ☐ No **Are you staying for** ☐ The day only ☐ One night or more

Patient Details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other (please specify) _____

Surname _____ **Previous Surname** _____

Given Name/s _____ **Preferred Name** _____

Sex ☐ Male ☐ Female ☐ Indeterminate **Date of Birth** ___ / ___ / ___ **Age** ___

Home Address _____ Suburb _____

Postcode ___ Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Postal Address (if different from home) _____

Marital Status ☐ Defacto ☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Widowed

Religion _____ Tick If No Religion: ☐

Do you consent to a visit from a hospital accredited representative of your faith community while you are in hospital? ☐ Yes ☐ No

Country of Birth _____ If Australia, which state? _____ **Are you an Australian resident?** ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Do you need an Interpreter? ☐ Yes ☐ No Main language spoken at home _____

Employment

☐ Child, not at school ☐ Student ☐ Unemployed ☐ Employed

☐ Home Duties ☐ Retired ☐ Pensioner ☐ Other

Cards

Medicare Card Number _____ Number beside your name _____ Valid to ___ / ___

Pharmacy Safety Net ☐ Yes ☐ No Card Number: SN _____ CN _____

Concession ☐ Pension ☐ Health Care Card ☐ Other, please specify _____

Card Number _____ Expiry date ___ / ___ / ___

Financial Information

Are you responsible for your account? ☐ Yes ☐ No If not, name of the person responsible: _____

☐ **Public Patient** ☐ **Overseas Resident** ☐ **Uninsured / Self Funded** Payment is required prior to admission.

☐ **Veteran's Affairs** ☐ Gold Card ☐ White Card Card Number _____ Card Expiry ___ / ___

☐ **Private Patient** Fund _____ Membership Number _____

Level of cover _____ Have you confirmed with your fund that you are covered for this admission? ☐ Yes ☐ No

☐ **Workcover**

Injury Date ___ / ___ / ___ Claim Number _____ Insurer _____

Employer Name _____ Employer Phone _____

Employers Address _____

☐ **MVIT / TAC**

Claim Number _____ / _____ Date of Accident ___ / ___ / ___

Type Of Room

Type of Accommodation Preferred ☐ Private Room ☐ Shared Room ☐ No Preference

Whilst every reasonable effort will be made to accommodate your preferred room type request, Hospital circumstances may result in this not being possible.

Please note that not all health funds/insurance/compensation schemes include cover for private rooms, therefore you may incur a gap if you occupy this room type.

Your GP

Name of your G.P./Clinic/Dr _____ Clinic Phone _____

Clinic Address _____ Suburb _____

We routinely send information about your admission to your G.P. Do you agree to this? ☐ Yes ☐ No

ST JOHN OF GOD
Frankston Rehabilitation Hospital

PATIENT REGISTRATION

U.R. Number
Surname
Given Names
Date of Birth / / Sex
Use Label If Available or BLOCK LETTERS

Referring GP

If a G.P. other than your local G.P. listed on the previous page, referred you to this hospital please complete their details.

Name of your referring Doctor Clinic Phone

Clinic Address Suburb

Diet

Do you have any special dietary requirements (not food preferences)? ☐ Yes ☐ No If yes, please complete the next line.

☐ Kosher ☐ Halal ☐ Vegetarian ☐ Vegan ☐ Antenatal ☐ Diabetic ☐ Gluten Free

☐ Other (please specify)

Do you have any food allergies? ☐ Yes ☐ No If yes, please complete the next line.

☐ Nut ☐ Dairy ☐ Egg ☐ Soy ☐ Shellfish ☐ Fish ☐ Sesame ☐ Wheat

☐ Other (please specify)

Research

I consent to being contacted by St John of God Health Care in relation to future research projects / studies as outlined in St John of God Health Care's Privacy Policy. ☐ Yes ☐ No

I consent to allow my health information to be used for research, teaching and quality assurance projects aimed at improving health care, on the understanding that my information will be kept confidential at all times in accordance with St John of God Health Care's Privacy Policy. ☐ Yes ☐ No

Foundation

St John of God Health Care is a not-for-profit group which relies on the generosity of its community to assist it to continue to deliver excellence in treatment and care. From time to time St John of God Foundation contacts patients seeking their support.

Please let us know if you do not wish to be contacted by ticking the box. ☐ I do not wish to be contacted

Marketing

I consent to being contacted by St John of God Health Care marketing in relation to other services it offers. ☐ Yes ☐ No

Next of Kin / Emergency Contacts

Next of Kin / Contact 1 Preferred Emergency Contact ☐ Yes ☐ No

If we are unable to contact you about your admission, we may need to contact your next of kin to provide information relating to your admission.

Surname Given Name

Relationship To Patient Private Phone

Address Work Phone

Suburb Mobile Phone

Postcode Email

Contact 2 Preferred Emergency Contact ☐ Yes ☐ No

Surname Given Name

Relationship To Patient Private Phone

Address Work Phone

Suburb Mobile Phone

Postcode Email

Declaration

I agree the information provided on this form is true and correct, to the best of my knowledge.

St John of God Health Care is committed to protecting the privacy of its patients. St John of God Health Care collects personal information for the primary purpose of providing health care services.

By signing this form I acknowledge and agree that St John of God Health Care can collect, store, use and disclose my personal information in accordance with the St John of God Health Care Privacy Policy which can be provided to me on request or can be found at www.sjog.org.au/privacy.

Print your name

Relationship to Patient: ☐ Patient ☐ Parent / Guardian ☐ Next of Kin ☐ Carer ☐ Other

Signature Date / /

PLEASE CHECK THAT YOU HAVE COMPLETED ALL SECTIONS OF THE FORM AND RETURN IT TO THE HOSPITAL AS SOON AS POSSIBLE BEFORE YOUR ADMISSION DATE.

NO WRITING IN MARGINS