MANLY WATERS/DELMAR PRIVATE HOSPITAL

PALLIATIVE / REHAB / MEDICAL PRE-ADMISSION INFORMATION

Date of request for Admission _____

Private Room Request Yes ☐ No ☐ Room No.: _____

DATE & TIME OF EXPECTED ADMISSION			
NAME:		DOB:	AGE:
ADDRESS:		TELEPHONE:	
NEXT OF KIN:	RELATIONSHIP:	PHONE:	
NEXT OF KIN:	RELATIONSHIP:	PHONE:	
HEALTH FUND.:		MEMBERSHIP NO:	
PENSION NO.:	REHAB SPEC.	PROGRAMME	
VETERAN AFFAIRS No.:		COLOUR OF DVA CARD:	
MEDICARE CARD NO:		MEDICARE EXPIRY DATE:	
HAVE YOU BEEN A PATIENT IN MANLY WATERS PRIVATE HOSPITAL BEFORE: Yes ☐ No ☐ Year:			
REFERRING DOCTOR TO MWPH		Phone:	
USUAL GP		Phone:	
ATTENDING DOCTOR AT MWPH		Phone:	
TRANSFERRING FROM OTHER HOSPITAL: Yes ☐ No ☐ Ward Name			
HOSPITAL NAME:		PHONE NO:	
ADMISSION DATE FROM HOSPITAL TRANSFERRING:			
DIAGNOSIS:			
PAST MEDICAL HISTORY:			
GASTRO IN WARD PAST 96 HOURS YES ☐ NO ☐ KNOWN INFECTIONS: ☐ HEP ABCDE ☐ ESBL VRE ☐ MRPA ☐ OTHER			
MRSA STATUS: Swabs YES ☐ NO ☐ DATE TAKEN		RESULTS: ☐ NOSE ☐ GROIN AXILLAE WOUND	
ESTIMATED LENGTH OF STAY:	DISCHARGE PLAN :		
HOME SITUATION:			
MOBILISATION STATUS:		WEIGHT :	
WOUND/DRAIN:	MINI MENTALS OR COGNITIVE STATE		
IS THIS ADMISSION A RESULT OF: A FALL IN THE COMMUNITY YES ☐ NO ☐ MVA/WORKPLACE ACCIDENT YES ☐ NO ☐			

BINDING MARGIN - DO NOT WRIT

REHABILITATION / MEDICAL PRE-ADMISSION

MR1