North Eastern COMMUNITY HOSPITAL

580 Lower North East Road
Campbelltown SA 5074
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Email: reception@nech.com.au
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Admission Form

Admission Date: _____

Admission Time: _____

Fasting Time: _____

Please return the COMPLETED ADMISSION FORMS AT LEAST 10 DAYS PRIOR TO ADMISSION.
(If posting – at least 10 days prior)

Admission Details

Admitting Doctor _____

Admission Date _____

Admission Type _____

Admission Reason _____

Patient/Client

Title _____

First Name _____

Last Name _____

Previous Surname _____

Preferred Name _____

Address _____

Suburb _____

State _____

Postcode _____

Country _____

Phone

Mobile	Business Hours	After Hours

Email Address _____

Gender Male ❍ Female ❍

Date of Birth _____ (dd/mm/yyyy) Age _____ years

Marital Status _____

Country of Birth _____

Indigenous Status _____

Australian Resident Yes ❍ No ❍

Main Cultural Identity _____

Preferred Language _____

Language spoken at home _____

Do you need an Interpreter Yes ❍ No ❍

Occupation _____

Employment Status _____

Religion _____

Health Cover

Do you have a Medicare Card? Yes ❍ No ❍

Medicare No.	Reference ID	Medicare Expiry

Do you have a Private Health Insurance? Yes ❍ No ❍

Fund Name	Membership No.

Do you have a Veterans Affairs Card? Yes ❍ No ❍

Veteran Affairs No.	Veteran Affairs Expiry

Veteran Affairs Colour

Do you have a Pension or Concession Card? Yes ❍ No ❍

Benefits Type	Card Expiry

Card No.

Is this a Worker's Compensation or Transport Accident Claim? Yes ❍ No ❍

Claim Number	Date of Incident
Employer Name	Insurance Company
Employer Address	Insurance Contact

Do you have Ambulance cover? Yes ❍ No ❍

Membership Cover No.	Ambulance Cover Expiry

Emergency Contacts and Next of Kin

Name	Relationship	Mobile	Address

Medical Contacts (Doctor/Dentist/Specialist)

Name	Phone	Practice Address

Current Medications

Name of Medicine	Dose	Frequency	Staff Use Only

Medication History Staff Use Only

Do you administer the medication yourself? YES ❍ NO ❍

Do you usually use a dose administration aid (webster pack or dosette)? YES ❍ NO ❍

Do you take any anti-coagulant or blood thinning medications? YES ❍ NO ❍
E.g. Warfarin/Coumadin/Plavix/Iscover/Aspirin

Has this been stopped prior to surgery? YES ❍ NO ❍

When was the medication last taken? _____

Do you use recreational drugs? YES ❍ NO ❍

If Yes, what type and how much? _____

Do you drink alcohol? YES ❍ NO ❍

If Yes, how many standard drinks each day? _____

Do you have a local community pharmacy? YES ❍ NO ❍

Pharmacy Name _____ Contact number _____

Current Allergies

Allergy	Allergic Reaction	Staff Use Only

Discharge Planning Staff Use Only

Are you expecting to return to your current residential address directly from hospital? YES ❍ NO ❍

If No, please specify plans. _____

_____

_____

Do you live alone? YES ❍ NO ❍

Additional Comments _____

_____

_____

Do you have family support on discharge? YES ❍ NO ❍

Additional Comments _____

_____

_____

Do you care for others at home? YES ❍ NO ❍

If Yes, who is caring for them? _____

Have you been assessed by the Aged Care Assessment Team (ACAT)? YES ❍ NO ❍

Date of Assessment? _____

Do you live in residential aged care? E.g. Nursing Home / Hostel YES ❍ NO ❍

Residential Aged Care Name _____ Contact number _____

Has anyone been appointed as your Power of Attorney and / or Enduring Guardian? YES ❍ NO ❍

Name _____ Contact number _____

Do you have an Advanced Medical directive? YES ❍ NO ❍
If Yes, please bring it to hospital with you.

Do you use a walking stick / frame? YES ❍ NO ❍

Do you use a wheel chair? YES ❍ NO ❍

Do you use assistance to walk? YES ❍ NO ❍

Do you have steps / stairs at your home? YES ❍ NO ❍

Do you have handrails in the bathroom at your home? YES ❍ NO ❍

Do you have a shower over the bath at your home? YES ❍ NO ❍

Day Surgery Only

Are you having a Day Procedure? YES ❍ NO ❍

Have you organised an escort and transport following your discharge? YES ❍ NO ❍

Name of person taking you home? _____ Contact number _____

We would like to contact you following the procedure.
What is the best contact number? _____

Surgical History Staff Use Only

Have you had any major operations? YES ❍ NO ❍
List all operations and the year you had them.

_____

_____

_____

_____

_____

_____

Medical History Staff Use Only

What is your weight? _____ Kg

What is your height? _____ Cm

What is your BMI? (Body Mass Index)
(If Known) _____

Have you ever had anaesthetics before? YES ❍ NO ❍
Have you ever had a spinal or epidural anaesthetic before? YES ❍ NO ❍
Have you ever had any problems with anaesthetics? YES ❍ NO ❍

If Yes, describe. _____

_____

_____

Do you have any heart problems? YES ❍ NO ❍
(Irregular heart rate, murmur, etc.)

If Yes, describe. _____

_____

Have you ever had a heart attack? YES ❍ NO ❍

If Yes, when? _____

Have you ever had a bypass surgery? YES ❍ NO ❍
(bypass, valve replacement, stent)

If Yes, describe. _____

_____

Do you have a pacemaker? YES ❍ NO ❍

Do you have an implanted defibrillator? YES ❍ NO ❍

Do you suffer from angina? YES ❍ NO ❍

Do you use any of the following?
(GTN Patch, Sublingual Spray or Tablets) YES ❍ NO ❍

If Yes, how often and date last used? _____

Do you get shortness of breath, chest pain or palpitations after exercise or climbing stairs? YES ❍ NO ❍

If Yes, describe. _____

Have you ever had blood pressure problems? (Low/High) YES ❍ NO ❍

If Yes, which one? _____

Have you ever had a TIA/Stroke? YES ❍ NO ❍

If Yes, when and describe any ongoing problems. _____

Do you have any bleeding / clotting / blood disorders? YES ❍ NO ❍
If Yes, describe? _____

Have you ever had a blood transfusion? YES ❍ NO ❍

Have you ever had any reactions to a blood transfusion? YES ❍ NO ❍
If Yes, describe? _____

Do you have any previous history of blood clots in your lungs (PE), legs or arms? YES ❍ NO ❍

If Yes, which year? _____

Have you ever been diagnosed with cancer? YES ❍ NO ❍

If Yes, which type? _____

Do you have any lung or chest conditions? YES ❍ NO ❍
(Asthma, bronchitis, emphysema)

If Yes, describe? _____

Have you had a cold or flu in the past 2 weeks? YES ❍ NO ❍

Do you have diabetes? YES ❍ NO ❍

How do you manage it?
(diet controlled, insulin or tablet) _____

Do you require any special dietary needs? YES ❍ NO ❍

If Yes, please describe? _____

Do you have liver disease? YES ❍ NO ❍

If Yes, describe? _____

Do you have any gastric problems
(gastric banding, reflux) YES ❍ NO ❍
If Yes, describe? _____

Do you have any bowel problems?
(diarrhoea, constipation, incontinence, diverticulosis/stomas) YES ❍ NO ❍
If Yes, describe? _____

Do you have kidney problems? YES ❍ NO ❍

If Yes, describe? _____

Do you have any bladder problems?
(incontinence, frequency, frequent infection) YES ❍ NO ❍
If Yes, describe? _____

Do you have mobility problems?
(arthritis, back pain, leg weakness) YES ❍ NO ❍
If Yes, describe? _____

Do you suffer from depression or anxiety? If Yes, describe?	YES ❍ NO ❍	
Have you experienced fainting or dizziness in the past 12 months?	YES ❍ NO ❍	
Have you had any fits, convulsions or blackouts? (epilepsy) If Yes, describe?	YES ❍ NO ❍	
Do you have any problems with your vision? (limited, cataract, glaucoma)	YES ❍ NO ❍	
Do you wear glasses/contact lenses?	YES ❍ NO ❍	
Do you require assistance to shower, dress, get in/out of bed/chair?	YES ❍ NO ❍	
Do you have any hearing problems or hearing aids?	YES ❍ NO ❍	
Have you had any falls in the past 12 months? If Yes, describe?	YES ❍ NO ❍	
Do you have lymphoedema / existing wounds / pressure area (ulcer, broken skin or reddened skin due to friction or pressure) If Yes, describe?	YES ❍ NO ❍	
Have you ever had a multi-resistant organism infection (MRSA, Golden Staph, VRE - Please speak to the admission nurse if unsure)	YES ❍ NO ❍	
Do you have or have you had any infectious diseases? (Hepatitis A, B, C) If Yes, describe?	YES ❍ NO ❍	

Do you have any problem sleeping? YES ❍ NO ❍

Do you have sleep apnoea? YES ❍ NO ❍

Do you use a CPAP machine? (If Yes, please bring CPAP machine with you) YES ❍ NO ❍

Please describe any other sleeping problems. _____

_____

Maternity Patients Staff Use Only

Are you pregnant? YES ❍ NO ❍

Expected Date of Delivery? _____

Complications of this pregnancy? _____

_____

_____

_____

Relevant Family History: _____

_____

_____

_____

Investigations: _____

_____

_____

_____

Have you had an ultrasound? YES ❍ NO ❍

Have you had Amniocentesis? YES ❍ NO ❍

Nursing Staff Use Only:

This information has been reviewed and discussed with patient by:

Signature: _____

Designation: _____

Print Name: _____

Date: _____