PERTH EYE HOSPITAL
Our vision is improved vision

42 Ord St, West Perth WA 6005
T: (08) 9216 7900 E: pehtheatres@pertheyehospital.com.au

Office use only – Affix patient label here

URN: .....

Patient Admission Form

Please complete this form and return by email or in person at least ONE week prior to the date of your procedure, DO NOT POST

Patient admission details

Admission date: ..... / ..... / .....
Admitting doctor:

Procedure:

Have you been a patient at this hospital before? ☐ Yes ☐ No

Have you been admitted to hospital in the last 28 days? ☐ Yes ☐ No
If Yes – Name of hospital: .....
Reason for admission: .....
Admission date: ..... / ..... / ..... Discharge date: ..... / ..... / .....

Patient details

Title: | Surname: | Given name(s):

Previous name(s):

Preferred name: | Sex: | Date of birth: ..... / ..... / .....

Residential address:

Postal address (if different to above):

Home phone: | Work phone: | Mobile phone:

Best form of phone contact: ☐ Home ☐ Work ☐ Mobile

May we leave a voicemail message? ☐ Yes ☐ No ☐ Opt out SMS

Email address:

Marital status: ☐ Married (including de facto) ☐ Never married/single ☐ Divorced ☐ Separated ☐ Widowed

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown/no answer

(QLD hospitals only) Are you of Australian South Sea Islander Ancestry? ☐ Yes ☐ No ☐ Unknown/no answer

Country of birth: | State (if born in Australia):

Preferred language: | Interpreter required: ☐ Yes ☐ No

Religion (optional):

Employment status:
☐ Child not at school ☐ Student ☐ Employed ☐ Unemployed ☐ Home duties ☐ Retired ☐ Pensioner ☐ Other

Referring doctor/general practitioner (GP)

Referring doctor surname: | Referring doctor first name:

Practice address: | Practice phone number:

Is your referring doctor your GP? ☐ Yes ☐ No If No, please complete below.

GP surname: | GP first name:

Practice address: | Practice phone number:

Informing GP/my health record

Do you consent to uploading your admission details to My Health Record? ☐ Yes ☐ No
Would you like us to inform your GP of your admission? ☐ Yes ☐ No

Next of kin

Title: | Surname: | Given name(s):

Relationship to patient: | Best contact number:

Emergency contact

Title: | Surname: | Given name(s):

Relationship to patient: | Best contact number:

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Entitlements (complete for all that apply)

Medicare number: ..... Reference number: ..... Expiry date: ..../....

☐ Australian Resident ☐ Eligible (reciprocal rights) ☐ Overseas visitor ☐ Ineligible ☐ Not known

Do you have any types of pension/concessional benefits card?

☐ Pension card Number: ..... Expiry date: ..../..../....

☐ Concession card Number: ..... Expiry date: ..../..../....

☐ Safety Net card Number: ..... Expiry date: ..../..../....

☐ Other (specify): ..... Number: ..... Expiry date: ..../..../....

Veteran's Affairs number: ..... Card Colour: ☐ Gold ☐ White Expiry date: ..../..../....

Australian Defence Force – Service Number/EP ID: ..... DAN (if known): .....

How will you claim for this admission (please tick one box only)

☐ Private Health Insurance – complete Section A and C
☐ Department of Veteran's Affairs/Australian Defence Force – complete entitlements above and Section C
☐ Worker's Compensation, Third Party, Motor Vehicle – complete Section B and C
☐ Self-funded – complete Section C only
☐ Overseas Insurance – complete Section B and C
☐ Public – continue to Patient health history

Section A: Private health insurance

Insured patients: It is recommended you contact your health fund prior to admission to confirm whether the reason for admission is covered under your selected level of cover. Informing the health fund of the item numbers provided by your doctor's rooms will assist your fund with confirming eligibility. You may wish to ask them if there are any additional costs you should expect, such as an excess or co-payment which will be payable on admission.

Health fund name:	Membership number:

Do you have an excess or co-payment to pay? ☐ Yes ☐ No If Yes, how much? .....

Have you changed your level of insurance in the last 12 months? ☐ Yes ☐ No

Section B: Worker's compensation, motor vehicle or other third party

Claim number:	Date of accident: ..../..../....
Insurance company name:	Contact number:
Address:	

Worker's compensation only – Approval letter for admission (from your insurance company) must accompany this form.

Employer name:	Contact number:
Address:	

Section C: Person responsible for account

Is the patient responsible for this account? ☐ Yes (go to next section) ☐ No (complete this section)

Title:	Surname:	Given name(s):
Previous name(s):		
Residential address:		
Postal address (if different to above):		
Home phone:	Work phone:	Mobile phone:

Best form of phone contact: ☐ Home ☐ Work ☐ Mobile

Email address:

Relationship to patient:

Confirmation details

Patient/guardian name:	Signature:	Date: ..../..../....

DO NOT WRITE IN THIS BINDING MARGIN

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