THE EYE HOSPITAL

PATIENT REGISTRATION FORM

SURNAME……..…… GIVEN NAME……

ID NUMBER……..…. SEX……..

DATE OF BIRTH……

AFFIX LABEL HERE

Proposed Date of Admission …… Surgeon……

Have you had/undergone surgery at The Eye Hospital in the last 4 weeks?*(Please Circle)* Yes / No

If No, Continue to **Patient Details & Contact Details**
If Yes, What was the date of your previous surgery? Date: ……/……./……

If you have answered yes to the above question, and your information has NOT changed since your previous admission, please sign below to confirm that the previous admission details are current and may be used for THIS procedure.

Signature:…….. Date: ……/……./……

Patient Details:

Title____ **First Name**_____ **Middle Initial**_____ **Surname**_____

Date of Birth ……/……./…… **Country of Birth** _____ **Marital Status**_____

Preferred Contact Phone Number _____

Medicare Card | | | | | | | | | | **Position Number** ……. **Expiry Date**……/……/……

Pension/DVA Card | | | | | | | | | | **DVA Colour** …….. **Expiry Date**……/……/……

Safety Net Card | | | | | | | | | |

Do you identify as: *(Please tick appropriate box)*

Aboriginal? ☐ Torres Strait Islander? ☐ Aboriginal **and** Torres Strait Islander? ☐ Neither? ☐

This information is required under the National Health Information Agreement and is used in monitoring the effectiveness of health policies and programs and highlights any inequalities between various ethnic groups.

Contact Details:

Current General Practitioner (GP): Name _____

Practice Address: _____

Next of Kin:

Name:_____ Relationship: _____

Address: _____ Contact Number: _____

Person to contact in an Emergency (*must be available by phone throughout patient's procedure)*

☐ As Above

☐ Other *(Enter Details Below)*

Name:_____ Relationship: _____

Address: _____ Contact Number: _____

Please turn over and complete page 2.

PATIENT REGISTRATION FORM Pg.1

THE EYE HOSPITAL

PATIENT REGISTRATION FORM

SURNAME……..…… GIVEN NAME……

ID NUMBER……..…. SEX……..…

DATE OF BIRTH……

AFFIX LABEL HERE

PATIENT REGISTRATION FORM Pg.2

(*Please tick the boxes below wherever the answer is yes)*

Name of Escort:

☐ Next of Kin *(as detailed page 1)*

☐ Emergency Contact *(as detailed page 1)*

☐ Other: Name: _____

Planning for Discharge:

☐ I live alone and will have someone to help look after me on discharge.

Name:_____

☐ I anticipate returning home after discharge.

☐ I will not be returning home. Overnight I will be staying with _____*(Name)*

at the following Address: _____

Contact Number: _____

☐ I declare that I have read and understood the information contained in the Admission Package.

☐ I have seen and understood the Australian Charter of Healthcare Rights.

_____ Date_____/_____/_____

Signature of Patient / Parent / Guardian (if under 18)