Friendly Society Private Hospital

MEDICAL ADMISSION REQUEST

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

PATIENT DETAILS

Date:	Surname:	Given Name:
D.O.B:	Contact Nº:	

ADMITTING DOCTORS CONTACT DETAILS

Admitting date:		Time of request:	
Transferring Doctor:		Transferring Facility:	
Person requesting admission:		Contact Nº:	
Admitting Doctor:		☐ Medical	☐ Cardiac ☐ Surgical

PATIENT HEALTH FUND/ INSURANCE

Private Insurer ☐ Medibank ☐ BUPA ☐ Other:	**Veteran:** ☐ DVA Gold ☐ DVA White
Membership No: Financial: ☐ N / ☐ Y PEA: ☐ N / ☐ Y Excess $:	
Has the patient health fund been accessed? ☐ Not sure ☐ No ☐ Yes *(complete admission assessment)*	
Workcover: Approved QLD private hospitalisation? ☐ No ☐ Yes	Claim Nº:
Uninsured: Patient quote generated? ☐ No ☐ Yes	Payment received: ☐ No ☐ Yes

ADMISSION SCREENING

Admitting Medical Diagnosis: ☐ Medical ☐ Cardiac ☐ Surgical	
Is the patient currently an inpatient in another hospital? ☐ No ☐ Yes *(complete admission assessment)*	
Hospital:	Date admitted:
Has the patient been an inpatient in hospital, in the last 7 days: ☐ No ☐ Yes *(complete admission assessment)*	
Hospital:	How long:

ADMISSION ASSESSMENT

What is the acute medical/ disease reason for admission? **(e.g. why does the patient need to be in hospital)**

What is the reason for transfer: **(e.g. Is the current facility unable to offer the treatment required)**

What is the treatment plan for the patient:

Does the patient have a plan for discharge:

Check funding implications with Patient Accounts (if applicable)

Patient admission reviewed by: **(please indicate staff involved)**

☐ Hospital Co-Ordinator/ Bed Manager: ……

☐ Clinical Business Manager: ……..

☐ Senior Manager: ……

AUTHORISATION

Patient to be admitted? ☐ No ☐ Yes	Unit:	Bed:
Name of person authorising admission:	E.T.A:	

DO NOT WRITE IN THIS BINDING MARGIN

MEDICAL ADMISSION REQUEST

MR 10

Patient Name:	D.O.B:	URN:

CLINICAL CONDITION

Are there concerns that the patient has an infectious condition? ☐ No ☐ Yes

Has the patient been infectious in the last 48 hours? ☐ No ☐ Yes

☐ Diarrhoea/Vomiting ☐ MRSA/ VRE / C/Diff ☐ Increased Temperature ☐ Other:

Does the patient have any infection precaution in place? ☐ Contact ☐ Droplet ☐ Airborne

Has the patient travelled overseas in the last 21 days? ☐ No ☐ Yes

Does the patient have cognitive impairment? ☐ No ☐ Yes

Due to ☐ Acute ☐ Delirium ☐ Infection ☐ Other:

☐ Chronic ☐ Dementia ☐ Alzheimers ☐ Neuro deficit ☐ Other:

Behaviour: ☐ Compliant ☐ Non-Compliant/Uncooperative ☐ Intrusive/disruptive ☐ Aggressive/violent

Does the patient have: ☐ Advance Health Directive ☐ EPOA ☐ ARP ☐ N/A

Is the admission a result of an accident? ☐ No ☐ Yes

Type of accident:

Location of accident:

NOTES

ADMISSION TYPE

☐ Not Re-Admission (**NA**) ☐ Planned (**PL**) ☐ Unplanned-Expected (**PM**) ☐ Unplanned-Related (**UO**)

If admission delayed/ cancelled specify reason:

☐ No show ☐ Physician Cancelled ☐ Transfer Cancelled

☐ Not Insured ☐ Surgeon Cancelled ☐ Patient Cancelled

☐ Waiting Period ☐ Operator Error ☐ Patient Deceased

☐ Other: