

# Admission Request Form

New Request OR  Changes Made (Please Tick)

**Important:** this form is the standard admission form for all elective medical, surgical and procedural patients. All patient requiring immediate admission must be discussed with the Bed Manager 07 3232 7906

**Please return by emailing to: [twh.bookings@uchealth.com.au](mailto:twh.bookings@uchealth.com.au)**

If you require assistance please telephone the Bookings Office on 07 3232 7200

## 1. Admitting Doctor Contact Details

Admitting Doctor:	Contact Number:
Details provided by:	Date:

## 2. Patient's Details

Title:	Surname:	Given name:	D.O.B.
Address:		Suburb:	Postcode:
Home Phone:	Mobile:	Business phone:	

## 3. Patient's Insurance

<b>Private Insurer</b>	<input type="checkbox"/> Medibank	<input type="checkbox"/> BUPA	<input type="checkbox"/> Other _____	Membership no.:
<input type="checkbox"/> MEDICARE	Membership no.:	Ref. no.:	Expiry	
<input type="checkbox"/> VETERAN	DVA card no.:	White Card approval no.:		
<input type="checkbox"/> WORKCOVER	Claim no.:	<input type="checkbox"/> <b>Uninsured</b>		

## 4. Admission Details

Admission date:	Admission time:	<input type="checkbox"/> am <input type="checkbox"/> pm	Procedure date:
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### IF ADMITTING DAY BEFORE PROC/OT please provide reason:

<input type="checkbox"/> Day patient	<input type="checkbox"/> Overnight patient	Estimated length of stay:
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Admission Diagnosis / Indication for procedure :

Procedure 2:

Other significant medical issues:

Is the patient? (please tick)  Obese  BMI \_\_\_\_ &/or Weight in kgs \_\_\_\_  Confused  Limited Mobility

### Allergies:

Diabetic  Type 1  insulin infusion required\*  pre-op endocrinology review arranged  
 insulin pump  insulin pump to remain insitu during procedure  
 Type 2  insulin  pre-op insulin plan discussed with patient

**\*patients requiring an insulin infusion must be admitted to the ward the night before a procedure (if on a.m. list) or the morning of the procedure (if on p.m. list) to allow for endocrine review and infusion set-up**

Prov. MBS Item nos. (If not outlined in standing orders):

Procedure time:  am  pm Procedure length: Hours Minutes

Anaesthetist:  Local  General  IVS  Epidural  Reg Block

ICU required  CCU required

## 5. Infection Control

Has the patient been an inpatient in another facility within the last seven days?  Yes  No

Is there a history of multi resistant infections?  Yes  No

Doctor's Signature:	Date:
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**If you are unable to email this form please fax it to 07 3232 7503**