MATER HOSPITAL
A FACILITY OF
ST VINCENT'S
HEALTH AUSTRALIA

REGISTRATION & PRE-ADMISSION DETAILS

The Mater Hospital Sydney would like to ensure that your admission process is efficient and that all your registration details are ready for your arrival at the hospital on the day of your admission. Please complete this form as soon as possible and following completion:

post to: PO Box 958 North Sydney NSW 2059 Australia
together with your Privacy Collection statement and Patient Health Summary

If you are able to complete your registration online please go ahead and do so by following the instructions provided with your admission paperwork.

This form is to be completed only if you are unable to complete your registration online, (or do not have family members or friends who are able to assist with the online process).

This admission	Date of admission: _ _ _ _ 2 0 _ _	Admitting Doctor
	Date of procedure: _ _ _ _ 2 0 _ _	Procedure

Type of admission:
☐ The Mater Hospital ☐ Endoscopy Unit
☐ Mater Orthopaedic Day Surgery ☐ Day Surgery Unit

Accommodation preference:
(preference cannot always be guaranteed)
☐ Single ☐ Shared ☐ No preference

Have you ever been a patient at the Mater Hospital / Day surgery or were you born at the hospital? ☐ Yes ☐ No
If *yes*, year of last admission
Previous surname *(if applicable)*

Patient details	Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	Marital status: ☐ Single ☐ Married (including defacto) ☐ Divorced ☐ Widowed ☐ Separated	Sex: ☐ Male ☐ Female

Surname:		Given name:	Phone(H):
Second given name:		Date of birth	Phone(W):
Unit No.	Street No.	Street name:	Mobile:
Suburb		P/code	email:

Postal address (if different to above)	☐ Yes ☐ No	If No. postal address	Sydney contact No.(s) if not from Sydney

Country of birth
Year of arrival in Australia [ ] ☐ N/A
Australian resident: ☐ Yes ☐ No

Do you require an interpreter? ☐ Yes ☐ No
If yes, main language spoken at home:

Indigenous status ***(please tick at least one box)***
☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Religion

Next of kin	Name	Relationship	Home Phone
	Street address (*if different from above*)		Work Phone
Suburb		P/code	Mobile No.

Name of other Emergency contact	Name	Contact Phone No.(s)
	Relationship	

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REGISTRATION & PRE-ADMISSION DETAILS
(continued)

Details also to be completed by patient

Surname	Date of birth
Given name	

GP details	Name	Address			
	Suburb		P/code	Phone:	
	Is this GP the person that referred you to this specialist?			☐ ***Yes***	☐ ***No***
	If **No**, Name of the doctor that referred you to this specialist				
	Name	Address			
Health Fund	***Funding details - if WC complete details in Workers' Compensation section below***				
	☐ Private Health Fund ☐ Self funded ☐ WC	Fund name		Client / membership No.	
	Name of policy	Have you been in this fund / table for over 12 months?		☐ Yes ☐ No	
Medicare Card	Card No			Medicare ID No. Left of name	Expiry ___ ___/___ ___
Other Card Type	☐ Pensioner Card ☐ Health Care Card ☐ C'wealth Senior Card			Expiry ___ ___/___ ___/____ ____	
Safety Net Card	☐ Safety Net Entitlement ☐ Safety Net Concession				
Veterans' Affairs	☐ Gold ☐ Orange* DVA No ☐ White			* (Pharmaceutical benefits only) Expiry ___ ___/___ ___	
Workers' Compensation *(A copy of approval is required)*	Date of accident	Name of Insurer at time of accident		Insurer's claim no.	
	Insurer's address		P/code	Insurer's fax.no.	
	Name of insurer	Contact name		Insurer's phone no.	
Person responsible for account *(if other than patient)*		Name	Relationship to patient		
Post address for account (if different to above)				Home phone	
Suburb		P/code	Work phone	Mobile	
Power of attorney / Enduring guardian / Advance Care Directive		Do you have an Advance Care Directive?		☐ Yes ☐ No	
(A copy of these is required if applicable)	Name of Enduring Guardian *(if one appointed)*			Phone no.	
	Name of Power of Attorney *(if one appointed)*			Phone no.	
Re-admission details	Hospital admission in the last 28 days (including Mater Hospital Sydney)	☐ Yes ☐ No	If Yes, which hospital? From: ..../........./........... to: ..../........./...........	Reason If Mater Hospital Sydney was this a planned admission	☐ Yes ☐ No
Completeness of form	I certify the information on this form to be true & complete to the best of my knowledge.				
	.... *Print name*	.... *Signature*		........./.........../.......... *Date*	