SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Concord Repatriation General Hospital
Phone: (02) 9767 6855 Fax: (02) 9767 7874
Email: CRGHAdmissions@sswahs.nsw.gov.au

M R N

To Be Completed By Patient

This registration form is used to confirm your admission.

Please complete this form and return it to:

PATIENT REGISTRATION
c/- Admissions Department
Hospital Road, CONCORD 2139
or
Fax: (02) 9767-7874
or
Email: CRGHAdmissions@sswahs.nsw.gov.au

If you have been a Patient at Concord Hospital in the last six months and your details have **not** changed, you **do not need** to return this form. Please contact Ph: (02) 9767 6855 to confirm your admission.

Thank you

If you are having problems completing questions on this form, please contact the Admission Department on telephone (02) 9767 6855

If you require an interpreter to complete this form please ring the Interpreter Service on telephone (02) 9828 6088

Personal Details:

Mr / Mrs / Miss / Ms Surname.....

Given Name: ..... Middle Name/s: .....

Gender: ☐ Female ☐ Male Date of birth ...../...../..... Age:.....

Medicare Number: ..... Expiry date: ...../...../.....

The number next to your name on the medicare card: .....

Permanent Address:

Street number or property name:..... Street Name: .....

Suburb/Town: ..... State: ..... Postcode: .....

Telephone No.: (Home) ..... (Business) ..... Mobile No.: .....

Email address:.....

Country of birth: ..... Language spoken:.....

Interpreter Required? ☐ Yes ☐ No

Aboriginal origin ☐ Yes ☐ No Torres Strait Islander origin ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Defacto ☐ Never married ☐ Widowed ☐ Separated ☐ Divorced

Religion: ..... This information enables us to provide appropriate services to you whilst you are here and is generally available to accredited chaplains at this facility. If you want your religion withheld from the chaplaincy service please tick this box ☐

Temporary Sydney Address for Visitors (Overseas or Country Patients):

Street number or property name:..... Street Name: .....

Suburb: ..... State: ..... Postcode: .....

Telephone No.: (Home) ..... (Business) ..... Mobile No.: .....

General Practitioner / Local Doctor:

Surname: ..... Given Name:.....

Address: .....

Telephone No: ..... Fax No:.....

Concord Hospital has an active Mailing Program. Would you be happy to receive this information?

☐ Yes ☐ No Signature: ..... Date: ...../...../.....

Office Use Only

P.A.C. date: ...../...../..... Ward: ..... Initial

Admission date: ...../...../..... Updated on Computer

PATIENT REGISTRATION FORM MR 9/35

FINANCIAL DETAILS

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1. Centrelink No: ..... (if applicable)

2. Private Health Fund Information:

Are you a member of a Health Fund? ☐ Yes ☐ No

Name of Fund: .....

Membership No.: ..... Table of Cover ☐ Basic ☐ Top Cover

Date joined Fund: ...../...../..... Date joined current Table of Cover: ...../...../.....

Excess Payable? ☐ No ☐ Yes Amount: $.....

Person Responsible for Account (contributor):

Relationship to Patient: .....

Mr / Mrs / Miss / Ms Surname: .....

Given Name: .....

Home phone: ..... Other phone: .....

Street No. or Property Name: ..... Street Name: .....

Suburb: ..... Postcode: .....

3. Your Preferences:

Have you elected to be treated as a Private Patient? ☐ Yes ☐ No

If yes, please specify your preferred accommodation. ☐ Single ☐ Shared

Whilst every effort will be made to provide the accommodation you request, this is subject to availability at the time of admission. Accommodation costs will be billed for the actual accommodation occupied. Thank you for supporting Concord Hospital.

4. Veterans' Affairs:

Are you a Veterans' Affairs patient? ☐ Yes ☐ No Do you need DVA transport ☐ Yes ☐ No

Veterans' Affairs Card Number: ..... Card colour: ☐ White ☐ Gold ☐ Orange

Serving Unit: ..... (eg. 2nd / 1st InF BN)

Veterans who do not wish to receive a visit by an Ex-service/Volunteer organisation representative (ESO) must advise the hospital. If you want the above information withheld from the ESO please tick this box ☐

☐ Army	☐ R.A.A.F.	☐ P.O.W.	☐ Europe
☐ Navy	☐ T.P.I. Veteran		☐ Japan
☐ Other	☐ Vietnam Veteran		☐ Korea
	☐ War Widow		☐ Vietnam

5. Workers' Compensation / Third Party Liability Claims:

Are you entitled to Third Party Liability Claim? ☐ Yes ☐ No

Are you entitled to Workers' Compensation (approval required)? ☐ Yes ☐ No

Did the accident occur in the course of your employment? ☐ Yes ☐ No

Employer Name: .....

Employer Address: ..... Postcode: .....

Contact Name: .....

Claim Number: .....

Insurer Name: .....

Date of Injury: ...../...../.....

Solicitor's Name: ..... Telephone No.: .....

Address: .....

MRN

6. Overseas Visitor:

Are you a member of a health fund / Travel Insurance? ☐ Yes ☐ No
(If yes, complete Health Fund details in paragraph 2, and bring documentation of your insurance with you)

Overseas Address:.....

Town / City: ..... Postcode ..... Country:.....

Passport number: ..... Date of entry visa ...../...../.....

Reciprocal Rights: ☐ Yes ☐ No

7. Person to Contact:

Relationship to patient: ..... (eg. neighbour, wife, sister, partner, etc.)

Surname:.....

Given Name: .....

Gender: ☐ Male ☐ Female

D.O.B.: ...../...../.....

Street Address:..... Suburb / Town: .....

State:..... Postcode: .....

Home Phone Number: .....

Work Phone Number: .....

Mobile Phone Number: .....

8. Next of Kin / Power of Attorney:

Relationship to patient: ..... (eg. husband, wife, other relative, child, etc.)

Surname:.....

Given Name: .....

Gender: ☐ Male ☐ Female

D.O.B.: ...../...../.....

Street Address:..... Suburb / Town: .....

State:..... Postcode: .....

Home Phone Number: .....

Work Phone Number: .....

COMMENTS:

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..../...../.....
Patient's Signature Date

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CANCELLATION / DEFERMENT FORM

Surname:	**Given Name/s:**
Address:	**Date of Birth:** ...../...../.....

Deferment of Admission: I request that my admission be deferred.
My reason for requesting deferral is:

- ☐ I am going away on holidays.
- ☐ Inconvenient at this time.
- ☐ Work commitments prevent me from being admitted.
- ☐ Home support not available.
- ☐ Other (please specify) .....

I will be available after ...../...../.....

Please note: If you defer your admission on **TWO** occasions for non-medical reasons your name will be removed from the waiting list.

Signature:..... Date ...../...../.....

Cancellation of Admission: I request that my admission be cancelled.
My reason for requesting cancellation is:

- ☐ I have had the procedure done elsewhere.
- ☐ My doctor advises that the procedure is not necessary.
- ☐ I do not wish to have the procedure performed.
- ☐ Other (please specify) .....
  .....

Signature:..... Date ...../...../.....

Office Use Only

Previous Admission Date	**Previous Procedure Date**	**Previous PAC Date**	
Cancellation/Deferment Acknowledged **Signature:..... Date: ...../...../.....**	**Visit ID**	**WARD**	**Fin Class**
New Admission Date	**Procedure Date**	**New PAC Date**	**Signature**
Patient advised by: **Phone / Letter / Fax / Rooms**	**Transport Arrangements**	**Signature / Date**	
SPECIALIST	**PROCEDURE**		

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