ADMISSION FORM

Rockhampton
Ward St
PO Box 924
Rockhampton, 4700
Tel: 07 4931 3313
Fax: 07 4931 3477

Mackay
76 Willetts Rd
PO Box 214
Mackay, 4740
Tel: 07 4965 5666
Fax: 07 4965 5600

Bundaberg
313 Bourbong St
PO Box 715
Bundaberg, 4670
Tel: 07 4153 9539
Fax: 07 4153 9496

Gladstone
Rossella St
Gladstone, 4680
Tel: 07 4971 3713
Fax: 07 4971 3703

Yeppoon
Cliff St,
Yeppoon, 4703
Tel: 07 4939 4611
Fax: 07 4939 4787

MERCY HEALTH AND AGED CARE CENTRAL QUEENSLAND LIMITED **MATER MISERICORDIAE HOSPITALS**

Item Number:	AHS/ MIMS Admitting Doctor: (Mackay only)

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO THE HOSPITAL WHERE YOU WILL BE ADMITTED AT LEAST 7 DAYS BEFORE ADMISSION OR AS SOON AS POSSIBLE.

ADMISSION INFORMATION

Proposed Admission Date:	Proposed Time:
Admitting Doctor:	Usual GP:

Proposed Stay	◯ Same day	◯ Overnight	◯ Maternity	◯ Sleep Unit
Accommodation Type	◯ Single	◯ Shared		

PATIENT INFORMATION

◯ Mr	◯ Mrs	◯ Miss	◯ Ms	◯ Master	◯ Dr	◯ Fr	◯ Sr	◯ Male	◯ Female

Surname:	Given names:
Previous name (if changed since last visit)	

Date of Birth:	Country of birth:	Marital status:
Home address (not a PO Box)		Postcode
Postcode	Email address:	
Mailing address (if different from home address)		Postcode
Home Phone No.	Work Phone No.	Mobile No.
For patients having an operation, please give us the best contact number for the day before your operation (or if on a Monday or public holiday, where you will be on the last working day).		Contact No
Religion:	Occupation: (If retired, previous occupation)	
QLD Health Requirement:	Are you of Aboriginal or Torres Strait origin? Tick all that apply	

◯ No	◯ Yes, Aboriginal	◯ Yes, Torres Strait Islander	◯ Yes, South Sea Islander

HEALTH CARE CARDS

Card	Card Number	Expiry Date
◯ Pension Card	Card Number:	Expiry Date:
◯ Healthcare Card	Card Number:	Expiry Date:
◯ Commonwealth Seniors Health Card	Card Number:	Expiry Date:
◯ Safety Net Entitlement Card	Card Number:	Expiry Date:

MEDICARE CARD INFORMATION

Medicare Card Number:	
Number beside patient name:	Expiry Date

SPECIAL NEEDS (Rockhampton, Gladstone, Yeppoon Only)

◯ Wheelchair access required	◯ Hearing impairment	◯ Other
◯ Severe speech impairment	◯ Intellectually disabled	
◯ Language difficulties/barriers	◯ Physically disabled	Do you have any allergies? ◯ Yes ◯ No
◯ Special dietary requirements	◯ Limited sight impairment/blindness	

Details:

Patient Name: | MRN:

NEXT OF KIN INFORMATION

○ Mr ○ Mrs ○ Miss ○ Ms | Relationship:

Surname: | Given Names:

Usual Address: | Postcode:

Home Phone No. | Work Phone No | Mobile No.

If they are staying locally, where can they be contacted: | Phone No.

EMERGENCY CONTACT INFORMATION (Other than next of kin)

○ Mr ○ Mrs ○ Miss ○ Ms | Relationship:

Surname: | Given Names:

Address: | Postcode:

Home Phone No. | Work Phone No. | Mobile No.

PAST HOSPITAL INFORMATION

Have you ever been a patient in any of the Central Queensland Mater Hospitals? ○ No ○ Yes

If Yes, which one (s)? ○ Rockhampton ○ Mackay ○ Bundaberg ○ Gladstone ○ Yeppoon

Have you been a patient in ANY hospital in the last 7 days? ○ No ○ Yes | Name:

HEALTH FUND INSURANCE DETAILS

Please indicate the payment arrangements for this hospital stay

○ Private Health Insurance ○ Repatriation Card (DVA) ○ Workers Compensation ○ Self paying ○ Third Party

Name of Third Party: | Relationship:

**It is essential that you contact your health fund or insurer to obtain or verify the following information.
If self paying, you must contact the hospital to obtain an estimation of costs and theses estimation of costs must be paid on admission with the remainder being paid on discharge.**

Private Health Fund

Level of cover: | Membership No

Date joined: | Number of years:

Name of contributor (if not the patient)

Will an excess apply? ○ No ○ Yes | Amount $

Will a co-payment apply? ○ No ○ Yes | Amount $

Please note: All excesses or co-payments are payable on admission

Has your health insurance cover changed in the last 12 months? ○ No ○ Yes | If Yes, it is important that you contact your Health Insurer to clarify your coverage for this admission

Workers Compensation Claim Number:

Workers Compensation Fund and Address:

Employers Name:

Approval letter must be attached.
If not, patients will be responsible for the hospital account.

Veterans Affairs (DVA) | Card Number | ○ Gold ○ White

If White, have your hospital costs been approved by DVA? ○ Yes ○ No | Expiry Date:

Signature | Date: | Rev: 07/08

PLEASE NOTE: For patients completing this form online, a signature will be required on admission.