Email phox.theatre.reception@ozcare.org.au
Phone 07 3180 0015 Fax 07 3028 9660

CANOSSA
PRIVATE HOSPITAL

Operating Theatre Admission

HOSPITAL ADMINISTRATION SECTION ONLY		
Surname:	First names:	
UR:	Date of birth:	Gender:
Affix patient label here:		

DATE OF ADMISSION:	SURGEON:

Personal Details

Surname:	Title:	
First name:	Preferred name:	
Previous admissions under different name?	☐ Yes ☐ No	Date:
Details:		
Date of birth:	Gender:	Marital status:
Address:		
Home phone:	Mobile:	
Email (required):		
Occupation:	Country of birth:	
Language spoken at home:	Interpreter required: ☐ Yes ☐ No	

Health Care Nominated Contact Person/Next of Kin:

This will be the contact for Canossa Private Hospital staff to discuss any health matters including injury and emergency care while in hospital.

Name:	Relationship:
Address:	
Home phone:	Work phone:

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Mobile:

In the event my next of kin is unable to take me home following my surgery I have arranged the following nominated support person to stay with me for at least 24 hours after my procedure.

Name:	Relationship:
Home phone:	Mobile:

Ethnic Origin:

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

South Sea Islander ☐ Yes ☐ No

Advanced Health Directive:

In the event an Advanced Health Directive & /or Enduring Power of Attorney is in effect. The nominee is to please bring the original forms at time of admission.

Advanced Health Directive:	Enduring Power of Attorney in effect:

EPOA Details:

Previous Hospital Admissions:

Have you been discharged from any hospital in the last 7 days? ☐ Yes ☐ No

If yes, which hospital:

Admission date:	Discharge date:

Reason for admission:

Have you been admitted to Canossa Private Hospital before? ☐ Yes ☐ No

General Practitioner's Details

Usual General Practitioner:

Address:

Suburb:	Phone:	Postcode:

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Private Health Fund Status

Private Health Fund / DVA:		
Membership number:	Table / Card type:	
Is membership greater than 12 months old:	Approx date joined:	
Have you changed health funds:	If yes, which health fund:	
Insurer details if not an Australian Resident:		
Medicare number:	Medicare expiry date:	
Veteran's Affairs number:	☐ White Card	☐ Gold Card
Pension / Health Care Card:	Expiry date:	
Safety Net Card number:	Expiry date:	
Commonwealth Senior's Card:	Expiry date:	

Workers compensation/third party insurance patients if applicable: ☐ N/A

Employer:	Address:
Phone:	Fax:
Employer accepted liability? ☐ Yes ☐ No	
Insurance company accepted liability for admission? ☐ Yes ☐ No Approval no:	

Person responsible for account other than self:

Name:	
Street address:	
Home Phone:	Work:
Mobile:	

Please bring Medicare Card, Private Health Fund Cards and any Concessional Cards at time of admission.
I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.
I also understand that if I am unwell at the time of my admission my procedure may be cancelled.

SIGNATURE: PRINT NAME: DATE:

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