

**Application for Admission to  
St Vincent's Hospital Brisbane**

Telephone: 07 3240 1213  
FAX to: **07 3391 8902**

**Family Name:** \_\_\_\_\_

**Given Name:** \_\_\_\_\_

*Affix patient label if Available*

**DOB:** \_\_\_/\_\_\_/\_\_\_      **Sex:** Male / Female

Address:			
Suburb:	Post Code:	Telephone:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow/widower <input type="checkbox"/> Div/sep <input type="checkbox"/> De Facto			
Preferred Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other (specify)			
Country of Birth:		Primary language:	
Indigenous status: <input type="checkbox"/> N/A <input type="checkbox"/> Aboriginal <input type="checkbox"/> South Sea Islander <input type="checkbox"/> Torres Strait Islander			
Occupation:		Religion:	
<b>Referral to</b>			
<input type="checkbox"/> Medical <input type="checkbox"/> In Patient <input type="checkbox"/> Day Patient (DVA, W/C & Pvt Only) G.E.M <input type="checkbox"/> In Patient <input type="checkbox"/> Day Patient			
<input type="checkbox"/> Rehabilitation <input type="checkbox"/> In Patient <input type="checkbox"/> Day Patient			
<input type="checkbox"/> Pain Management Program Patient (DVA , W/C & Private Only) <input type="checkbox"/> In Patient <input type="checkbox"/> Day Patient			
<input type="checkbox"/> Tarmons Centre (Palliative Care) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> In Home care <input type="checkbox"/> Day Patient			
<input type="checkbox"/> Interim Care <input type="checkbox"/> Convalescent Care ( DVA Only) <input type="checkbox"/> Transitional Care Program ( DVA Only )			
<b>NOK / Primary Carer</b>		Relationship:	
Address:			
Tel: (H)	(W)	(M)	
2 <sup>nd</sup> Contact:			
Tel:		Relationship:	
Is there an EPOA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/> Copy sighted (If yes please give details of nominated person & attach copy)			
Advanced Health Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K			
<b>G.P</b>		Telephone	
Address		Fax	
<b>Funding Details</b>			
<input type="checkbox"/> Private Fund (inc Level)		Membership Number	
<input type="checkbox"/> DVA      DVA no		Card Colour i.e. Gold, White	
<input type="checkbox"/> Public		<input type="checkbox"/> W/C Third Party	
<input type="checkbox"/> Other specify			
<input type="checkbox"/> Centrelink		Type	Number
Medicare No	Ref:	Safety Net No	Exp:
Pharmacy Name		Contact	
If currently in hospital Date of Admission:			
<b>Referrer Name / Position</b>			
<b>Contact Tel Number &amp; Pager</b>		<b>Fax</b>	
<b>Organisation &amp; Ward/Dept</b>			
<b>Signature</b>		<b>Date</b>	

**Application for Admission  
continued**

<b>S E C T I O N  A</b>	<b>Diagnosis</b>			
	Please detail Summary of Medical / Clinical History (or attach details)			
<b>S E C T I O N  B</b>	<b>Section B to be completed for all patients EXCEPT those referred to Pain Management Program</b>			
		Provided /Attached	Not Available	
	Past Medical History			
	Recent Treatment History			
	Social/Family History			
	Recent Pathology Results (including wound swabs MSU etc)			
	Recent Medical Imaging results (includes x – ray, MRI,Ct etc)			
	Current Medication List			
	Social Situation	<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with Carer <input type="checkbox"/> other (details)		
	Previous Services			
	Cognition	<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Short term memory loss		
	Communication	<input type="checkbox"/> Normal <input type="checkbox"/> Expression impaired <input type="checkbox"/> Reception impaired		
	Swallow	Impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes please supply details of dietary needs incl. fluid consistency		
	<b>Activity</b>	<b>Assistance Required</b>		
		2 person	1 person	Supervise
		<b>Independent</b>	<b>Equipment/Aid</b>	<b>Comment</b>
	Transfers			
	Toileting			
Showering				
Dressing				
Mobility				
Eating				
Continence				
ACAT Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes please <b>Attach copy</b>		Assets Form Lodged: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Interim Care Patients Only</b>				
Facility Listings	1.	2.		
3.	4.	5.		
<b>Palliative Care Patients' Only</b> This section to be completed for <u>ALL</u> PALLIATIVE CARE patients. Please indicate below the reason for seeking admission to the Tarmon's Centre ( Palliative Care Unit) <input type="checkbox"/> Symptom management <input type="checkbox"/> End of life care <input type="checkbox"/> Carer distress <input type="checkbox"/> Other (please state) <b>Also please include details of symptoms and principal palliative issues:</b>				