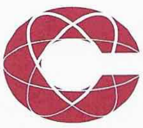

Cabrini

Registration Form

Office use only

Pre-admission Number: ________________

UR Number: ________________

Please complete & email to patientservices@cabrini.com.au or post reply paid to either:
-Cabrini Malvern, Patient Services, Reply Paid 63245, Malvern VIC 3144
-Cabrini Brighton, Patient Services, Reply Paid 85198, Brighton VIC 3183

Admitting campus Date of surgery: DD / MM / YYYY

☐ **Cabrini Malvern** ☐ **Cabrini Brighton**

FCH100900

Section 1: **Patient details - Patient to complete** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Title:________ Surname:|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Given names: |___|___|___|___|___|___|___|___|___|___|___|___| Date of birth: DD / MM / YYYY ☐ Male ☐ Female

Residential address:________________ Postcode: __________

Postal address (If different to above): ________________

________________ Postcode: __________

Tel (Home):________________ Tel (Work):________________ Mobile: ________________

Email address: ________________

What date are you being admitted? DD / MM / YYYY

Who is your admitting Doctor? ________________

Maternity patients: What is your expected delivery date? DD / MM / YYYY

Have you been a patient at Cabrini in the **last 3 months**? ☐ Yes ☐ No

If yes, only complete details that have changed and sign the declaration in section 9
If no, please complete all sections

Have you **previously** been a patient at Cabrini? ☐ Yes ☐ No

Was your name the same? ☐ Yes ☐ No

If no, what was your previous name?________________

Marital status:______________ Religious affiliation:________________ ☐ I do not wish to declare a religious affiliation

Country of birth:________________

Do you require an interpreter? ☐ Yes ☐ No Preferred language: ________________

Are you of Aboriginal or Torres Strait Islander descent? ☐ Yes ☐ No

Section 2: **Health cover details - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Name of health fund:________________ Membership number: ________________

Medicare card number: |___|___|___|___| - |___|___|___|___|___| - |___| Ref no |___| Valid to: MM / YYYY

Ambulance cover: ☐ Yes ☐ No Details: ________________

Veterans' affairs file number:________________ ☐ Gold card ☐ White card ☐ Orange card

Pension / healthcare card number: ________________ Exp: DD / MM / YYYY

Pharmaceutical safety net: Concession number (CN) ________________ Exp: DD / MM / YYYY

Safety Net (SN) number ________________ Exp: DD / MM / YYYY

Section 3: **GP details - patient to complete** (Parent or guardian to complete for persons under 18 years)

Do you consent to your GP being informed of your admission? ☐ Yes ☐ No

GP name:________________ GP address: ________________

____

GP contact number:________________ GP Fax number: ________________

Please turn over

Cabrini

OFFICE USE ONLY

Please complete & email or post in a reply paid envelope as per the instructions on the first page.

Section 4: **Emergency contact - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Title:_______Surname:_____________________________ Given names:____

Address:____Postcode: __________

Relationship to patient: ____

Tel (Home):_________________________Tel (Work):________________________Mobile: _________________________

Additional contact

Title:_______Surname: ______________________________Given names: _____________________________________

Address:____Postcode: __________

Relationship to patient: ____

Tel (Home):_________________________Tel (Work):________________________Mobile: _________________________

Section 5: **Account details - Patient to complete** (Parent or guardian to complete for persons under 18 years) Please tick ✓

Who is responsible for paying your account? ☐ Self ☐ Next of kin ☐ Workcover ☐ TAC ☐ Veterans' affairs ☐ Other

If other, is this person aware that they are responsible for paying this account? ☐ No ☐ Yes

Title:_______Surname: ______________________________Given names: _____________________________________

Address:____Postcode: __________

Relationship to patient: ____

Tel (Home):_________________________Tel (Work):________________________Mobile: _________________________

Section 6: **Insurance / claim details - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Please contact your health fund prior to admission to check your level of cover, as excess, gap or co-payment may apply which must be settled prior to admission. If you are not insured and do not have adequate cover, you must also settle all costs prior to or on admission.

☐ Overseas patient ☐ Veterans' affairs ☐ Nil insured ☐ Privately insured

Fund name: ____Membership number: ______________________________

Level of cover: ____

Section 7: **Workcover / TAC - Patient to complete** (Parent or guardian to complete for persons under 18 years)

☐ Workcover ☐ TAC Claim number: ____

Date of injury: DD / MM / YYYY Name of insurance company: ____

Employer's name: ____

Employer's address:____Postcode: ___________

Contact person:_________________________ Contact number:__________________Fax number: __________________

Has your employer accepted liability? ☐ No ☐ Yes (If Yes, please attach acceptance letter)

Section 8: **Cabrini foundation - Patient to complete** (Parent or guardian to complete for persons under 18 years)

Cabrini may contact you to support our community activities and hospital developments. We respect your privacy, so please let us know if you do not wish to be contacted for these reasons. ☐ **I do not** wish to be contacted by the Cabrini Foundation.

Section 9: **Declaration - Patient to complete** (Parent or guardian to complete for persons under 18 years)

I agree that information provided within this form is true and correct to the best of my ability.

Name:_____________________________Signature:________________________________Date: DD / MM / YYYY

Place signed form in reply paid envelope and post.