Sunshine Private Hospital
part of unitas healthcare

PATIENT REGISTRATION FORM

Patient Surname	
Patient First Name	
Unique Record Number	
Date of Birth	
Gender	

Write details or affix label here

FORM TO BE COMPLETED BY THE PERSON OR SUPPORT PERSON AT LEAST 7 DAYS PRIOR TO ADMISSION
Email the completed form to surgicalandmedicalbookings@unitas.com.au

Consent to be contacted prior to your admission

SPH admission staff will need to contact you **3 days prior** to your admission to discuss **1)** any out of pocket expenses and **2)** to confirm the date and time of your admission. Do you consent to being contacted? ☐ No ☐ Yes → If Yes, via ☐ Email ☐ SMS/Text ☐ Phone

Admission details

Your Specialist: ..... **Diagnosis:** .....
[PRINT NAME] [CONDITION BEING TREATED]

Admission DAY: ...../...../..... **TIME:** ..... AM/PM **Procedure:** .....
[IF SURGICAL ADMISSION – OPERATION TO BE PERFORMED]

Admission Type: ■ Surgical ☐ Endoscopy ☐ Sleep Study ☐ General Medicine ☐ Inpatient Mental Health ☐ ECT or TMS

STAFF USE ONLY: Is this admission Public in Private initiative? ☐ No ☐ Yes → If Yes, admin officer to register patient as PUBLIC & confirm eligibility under Reciprocal Rights Agreement.

Have you been admitted to Sunshine Private Hospital previously? ☐ No ☐ Yes →If yes, Please provide further details;

Date of Admission: ...../...../..... **Details:** .....
Date of Admission: ...../...../..... **Details:** .....

Have you been hospitalised 7 days prior to this admission? ☐ No ☐ Yes →If yes, Please provide further details;

Hospital: ..... **Reason:** .....

Patient details

☐ **Mr.** ☐ **Mrs.** ☐ **Dr** ☐ **Miss** ☐ **Master:** ....
[Surname] [First Name]

....
[Second Name/s] [Preferred name]

Date of Birth: ...../...../..... **Sex/Gender:** ☐ Male ☐ Female ☐ Intersex ☐ Other: .....

Address: ....
[Number & Street name] [Suburb] [State] [Postcode]

Telephone: ....
[Home] [Work] [Mobile]

Email Address: .....

Resident of Australia: ☐ Yes ☐ No **Country of Birth:** .....

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Are you of Aboriginal or Torres Strait Islander Origin: ☐ No ☐ Yes →If yes, ☐ Aboriginal ☐ TSI ☐ Both

Language spoken at home: ..... **Preferred language:** .....
Interpreter required? ☐ Yes, I require an interpreter ☐ No

Religion: ☐ None ☐ Christian ☐ Orthodox ☐ Islamic ☐ Other: .....
Do you consent to a clergy visit? ☐ No ☐ Yes

Binding Margin – Do Not Write

PATIENT REGISTRATION FORM ADM003

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Next of Kin [NOK] details

NOK #1: ....
[Name] [Relationship ie. Wife, mother etc] [Phone]

NOK #2: ....
[Name] [Relationship ie. Wife, mother etc] [Phone]

General Practitioner [GP] details

Practice Name: ..... **GP Name:** .....

Address: ....
[Number & Street name] [Suburb] [State] [Postcode]

Contact Details: ....
[Phone] [Email] [Fax]

Your GP may be notified of your admission. Do you consent to you GP being notified? ☐ No ☐ Yes

Referring Doctor/ Specialist & Referral letter

Specialists Name: .....

Address: ....
[Number & Street name] [Suburb] [State] [Postcode]

Contact Details: ....
[Phone] [Email] [Fax]

Pharmacy Details

Pharmacy Name: .....

Address: ....
[Number & Street name] [Suburb] [State] [Postcode]

Contact Details: ....
[Phone] [Email] [Fax]

MyHealth Record https://www.digitalhealth.gov.au/initiatives-and-programs/my-health-record

Are you enrolled in MyHealth Record? ☐ No ☐ Yes

Do you consent for your discharge summary to be sent to MyHealth Record? ☐ No ☐ Yes

Health Information & Medical records [including electronic health record]

Unitas Healthcare Sunshine Private Hospital (SPH) will create and retain records of your condition and the treatment provided, this information will be held in an electronic patient administration system and electronic health record.

These records are confidential. SPH store and manage your health information in accordance with Privacy Act 1988(Cth) which governs the collection, storage, use and disclosure of health information. SPH comply with all relevant legislation including the Health Records Act 2001 (Vic), My Health Records Act 2012 (Cth) and Privacy and Data Protection Act 2014 (Vic).

The contents may only be released or divulged with your consent, where justified law or where the request for release of information meets the Freedom of Information (FOI) Act (1982). Requests for access to your SPH health record can be made by submitting a FOI request form to healthdata@unitas.com.au via our website https://sunshineprivate.com.au

It may be necessary for parts of your medical record to be disclosed to other medical professionals to plan and provide your treatment. This includes activities required to operate our hospital, including providing information to your health fund, DVA, the Supplier/manufacturer of your prosthesis, to our insurer, your specialist and your general practitioner. A full version of the Sunshine Private Hospital Privacy and Confidentiality Policy on our website https://sunshineprivate.com.au

PATIENT REGISTRATION FORM

ADM003

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FINANCIAL INFORMATION

Person responsible for the account ☐ Same As Patient details [if not please provide details below]

☐ Mr. ☐ Mrs. ☐ Dr ☐ Miss ☐ Master: ....
[Surname] [Given Names]

Address: ....
[Number & Street name] [Suburb] [State] [Postcode]

Telephone: ....
[Home] [Work] [Mobile]

Entitlements

Medicare No. ☐☐☐☐☐☐☐☐☐☐	**Pension No.**	**Expiry Date** ...../...../.....
Number next to patient name ☐	**Health Care Card No.**	**Expiry Date** ...../...../.....
Valid From / To ☐☐ / ☐☐	**Ambulance No.**	**Expiry Date** ...../...../.....

Safety Net Card ☐ No ☐ Yes → If Yes, please provide your card no. here:

Veterans Affairs Vx No. **DVA Card Colour** ☐ Gold ☐ White* ☐ Orange*
*If White or orange please provide approval letter from DVA

How will this Admission be Claimed? [Please check appropriate box]

☐ Private Health Insurance – Please complete ***section A***	☐ Repat/Veterans Affairs – Please complete ***Entitlement*** section above
☐ Work Cover – Please complete ***section B***	☐ Uninsured or Travel/Overseas – Please contact **1300 600 978** for an estimate of your hospital costs. These costs are payable preadmission
☐ TAC or Third Party – Please complete ***section c***	☐ Public in Private – Please contact us on **1300 600 978** for more Information.

Section A – Insurance Details

Health Insurance Fund Name: **Level of Cover:**

Member Number: **Date joined:** ...../...../.... **Date Paid to:** ...../...../....

Excess $..... **Excess paid this year?** ☐ No ☐ Yes **Copayments?** ☐ No ☐ Yes

Sunshine Private hospital recommend that you confirm your level of cover with your health fund prior to your admission

- ensure that you are covered for this admission and any procedure performed
- understanding your excess and any out of pocket expenses, including Anaesthetist fees
- confirm items numbers with your referring specialist

Certain levels of cover have out of pocket expenses that patients are required to pay. Out of pocket fees are payable on admission. Any additional fees such as pharmacy, pathology, radiology are payable on discharge.

Section B – Work Cover Details

Employers Name: **Contact Name:** **Ph:**

Address:

Date of Injury ...../...../.... **Is this date 6 months from the procedure date?** ☐ No ☐ Yes →If yes, please provide an approval letter from the workplace Insurer

Claim accepted by WCA ☐ No ☐ Yes **Name of WCA Insurer:**

Claim Number: **WCA Contact Name:** **Ph:**

Section C – TAC or Third Party Details

Date of Injury ...../...../.... **Is this date 6 months from the procedure date?** ☐ No ☐ Yes →If yes, please provide an approval letter from the TAC Insurer

Claim accepted by TAC? ☐ No ☐ Yes **Accident Location:**

TAC claim Number: **TAC Contact Name:** **Ph:**

....
[Name of person filing out this form] [Signature]

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