

# Admission Form – Sleep Study



Innovation Parkway  
Birtinya, 4575  
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AFFIX LABEL HERE

**SECTION A: TO BE COMPLETED BY YOU THE PATIENT/GUARDIAN - PATIENT DETAILS**

Title:	Surname:		
Given Names:		DOB:	
Postal Address:			
Residential Address:			
Home Telephone:		Work Telephone:	
Occupation:		Country Of Birth:	

**Health Insurance Details**

Medicare No:	Valid To: ___/___/___
<input type="checkbox"/> <b>Health Fund Details</b> Fund Name: _____ Excess \$ _____ Contributor's Name: _____ Membership No: _____ Plan: _____	
<input type="checkbox"/> Veterans Affairs Patient DVA Card Type: Gold / White DVA Card No: _____	
<input type="checkbox"/> Self Funded	

**Workers Compensation, Third Party or Public Liability Details (Complete Information If Applicable)**

<input type="checkbox"/> <b>Workers Comp</b>  <input type="checkbox"/> <b>Third Party</b>  <input type="checkbox"/> <b>Public Liability</b>	Date of Accident: _____ Claim No: _____ Name Of Employer: _____ Contact Phone No: _____ Employer Address: _____ Name of Insurance Company: _____ Insurance Company Phone No: _____ Insurance Company Address: _____
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**Additional Details** Any Special Dietary Requirements:

Is an interpreter required?	Yes	No
Marital Status:(Please Circle)	Married	Single
	Widowed	Divorced
	Separated	Defacto
Next Of Kin (Name):		
Next Of Kin Phone No:	Relationship:	
Are You Of Aboriginal Or Torres Strait Islander Descent?	Yes	No
Have You Been In Hospital Within The Last 28 Days?	Yes	No
Have You Previously Been Admitted As A Patient To This Hospital?	Yes	No

ADMISSION FORM MR-01b



**SECTION B:**

**PATIENT/GUARDIAN TO COMPLETE – HOSPITAL CONSENT**

I (Patient or Parent/Guardian), ..... consent for myself /  
Other (specify) .....to be admitted to this facility for care and treatment.

My doctor and I have discussed and have agreed to have the following treatment/procedures :

.....  
performed on myself/other (specify) .....

I acknowledge that this facility has not given me any advice as to the medical treatments/procedures to be undertaken and I understand this to be the responsibility of my Doctor.

I acknowledge that the facility uses nursing and other staff to assist my Doctor in the provision of care and treatment. I understand that during this admission other unexpected treatments/procedures are sometimes necessary and I agree to these if required.

I consent to the facility transferring me to another hospital where this is considered necessary for my well-being.

I acknowledge full responsibility for payment of accounts rendered by the facility including any shortfall in reimbursement by my health fund.

Please note that the hospital acknowledges its obligations under the Privacy Act 1988 (as amended). Personal information will be used strictly according to the Privacy Principles Policy which is displayed at reception and conforms to the Privacy Act. The Administration Officer is happy to answer any questions concerning the policy prior to signing this document.

**By signing this consent I acknowledge that I have read and understood the above information.**

.....  
Signature Of Patient/Parent/Guardian

...../...../.....  
Date

.....  
Witness Signature