

REQUEST FOR PATIENT ADMISSION FORM

Please complete and deliver to Spendelove Private Hospital (SPH) fax at your earliest convenience to facilitate your timely admission.
Please complete in BLOCK letters or tick appropriate box.

PERSONAL DETAILS

SURNAME

FIRST

TITLE MR MRS MISS DR OTHER

SEX MALE FEMALE

DATE OF BIRTH

ADDRESS

POSTCODE

POSTAL ADDRESS (IF DIFFERENT)

POSTCODE

PHONE (HOME) (WORK)

(MOBILE)

EMAIL ADDRESS

RELATIONSHIP STATUS MARRIED OR DE FACTO SINGLE
 WIDOWED DIVORCED SEPARATED

COUNTRY OF BIRTH

RELIGION

EMPLOYMENT STATUS EMPLOYED UNEMPLOYED
 NOT IN LABOUR FORCE NOT STATED/INADEQUATELY DES.

OCCUPATION

ABORIGINAL YES NO

TORRES STRAIT ISLANDER YES NO

ALLERGIES

SPECIAL NEEDS

NEXT OF KIN

NAME

ADDRESS

POSTCODE

PHONE (HOME) (WORK)

(MOBILE)

EMAIL ADDRESS

RELATIONSHIP

GENERAL PRACTITIONER'S DETAILS

NAME

CLINIC

PHONE FAX

EMAIL ADDRESS

SURGEON/CONSULTANT'S DETAILS

NAME

DIAGNOSIS/PROCEDURE

TRANSFERRING HOSPITAL

MEDICARE DETAILS

CARD NUMBER

PATIENT REFERENCE NO CARD EXPIRY DATE /

DVA | HOSPITAL INSURANCE DETAILS

NAME OF FUND

TABLE / SCALE MEMBERSHIP NO.

IS THERE AN EXCESS ON YOUR TABLE YES NO

SAFETY NET | PENSION DETAILS

DO YOU HAVE

A PENSION CARD CARD NO.

SAFETY NET ENTITLEMENT CARD NO.

SPH FEES

	Estimated Cost	Fund Rebate
Accommodation	COVERED BY HEALTH FUND	
Co-Payment after 14 days	\$50.00/per Night	
Consumables / Pharmacy / Phone	As Used	
Incidentals (TV / Wi-Fi)	\$20.00	
Doctor Consultation	MEDICARE / HEALTH FUND	
Physiotherapy	\$35.00/per visit if needed	As per individual health fund
Radiology / Pathology		As per individual health fund

CERTIFICATION | CONSENT

I understand the fees for my hospitalisation and out of pocket expenses as detailed. I understand and accept that if I do not fulfill the requirements of my health fund I am liable for all fees incurred and unforeseen costs. I allow all care needed to be carried out by SPH. I give my consent for SPH to use my personal information for the reasons disclosed in SPH's Privacy Policy.

Patient / Guardian Signature: _____ Date: _____