SPENDELOVE
PRIVATE HOSPITAL

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 AG

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 — SPH FEES

☐ A PENSION CARD CARD NO.

☐ SAFETY NET ENTITLEMENT CARD NO.

	Estimated Cost	Fund Rebate	Patient Cost
Accommodation	COVERED BY HEALTH FUND		Excess if applicable
Co-Payment after 14 days	$50.00/per night		
Consumables / Pharmacy /etc.	As Used		
Incidental Fee (TV/WiFi / Amenities/Ward-Stock etc.)	$25.00		
Doctor Consultation	MEDICARE / HEALTH FUND		
Physiotherapy		As per individual health fund	
Radiology / Pathology		As per individual health fund	Accounted separately if required

CERTIFICATION | CONSENT

I understand the fees for my hospitalization 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 staff. I give my consent for SPH to use my personal information for the reasons disclosed in SPH's Privacy Policy.

_____ _____

Patient / Guardian Signature *Date*