

SPRING HILL SPECIALIST DAY HOSPITAL	OFFICE USE ONLY:	Paid QFG: Y / N	MRN.
Levels 1 and 4, St Andrew's Place 33 North Street, Spring Hill QLD 4000 Phone: (07) 3307 3243 Fax: (07) 3832 3247			

PLEASE COMPLETE FORMS IN BLACK PEN AND RETURN TO US AS SOON AS POSSIBLE. ALL FIELDS ARE REQUIRED TO BE COMPLETED. IF YOUR ADMISSION IS WITHIN THE NEXT 7 DAYS, PLEASE COMPLETE AND BRING WITH YOU ON THE DAY.

Proposed Admission Date (if known): / /	Treating Doctor:
Proposed Surgery / Procedure:	
Surname:	(Mr, Mrs, Miss, Ms, Dr)
Given Names (in full):	
Home Address:	
	Postcode:
Email:	

WE WILL CONTACT YOU ON THE LAST WORKING DAY PRIOR TO YOUR SURGERY.
 PLEASE PROVIDE US WITH THE MOST SUITABLE CONTACT NUMBER:

Medicare No. <input type="text"/>	Position on Card:	Valid until: /
Phone (Home):	(Work):	(Mobile):
Date of Birth: / /	Age:	Religion:
Country of Birth:	Are you of:	<input type="checkbox"/> Australian Aboriginal Origin <input type="checkbox"/> Torres Strait Islander Origin <input type="checkbox"/> South Sea Islander Origin <input type="checkbox"/> None of the above
Main Language Spoken:		
If required will an interpreter accompany you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation:		
Marital Status:	<input type="checkbox"/> Never Married <input type="checkbox"/> Married / Defacto	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Next of Kin:	Relationship:	
Address:		Postcode:
Contact Phone No:		
If someone other than your <i>Next of Kin</i> is collecting you after surgery please provide their name and contact details:		
Name:	Phone:	
Have you used this facility previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Please advise if Surname changed:		
Have you been a hospital inpatient in the last 28 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please give details: _____		

DECLARATION

I accept responsibility for payment of all treatment administered at Spring Hill Specialist Day Hospital irrespective of any claim which I may have against any health fund or other party. I also accept that should admission to hospital for further care be required I will be responsible for all costs incurred.

Signature: _____ Date: / /
 Relationship to Patient: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

INSURANCE DETAILS

PLEASE COMPLETE THE FOLLOWING

Fund Name:

Membership No:

Type of Cover:

Annual Excess (if applicable):

Is this procedure covered by:

YES NO

Workers Compensation

YES NO

Claim Number: _____

Veterans Affairs

YES NO

Entitlement Number: _____

Non Insured

PAYMENT OF ACCOUNTS

ACCOUNTS ARE PAYABLE IN FULL ON THE DAY OF SURGERY. PAYMENTS CAN BE MADE BY CHRQUE, CASH, EFTPOS, CREDIT CARDS OR AMERICAN EXPRESS.

PLEASE REMEMBER TO BRING YOUR HEALTH FUND DETAILS AND YOUR MEDICARE CARD WITH YOU.

To assist you in finding out any costs for your procedure, please complete the following:

Completed **Not applicable**

1. If you have health insurance, ring your fund to check whether you are covered for this procedure at Spring Hill Specialist Day Hospital and if an excess is applicable.
2. If you do not have health insurance, please ring Spring Hill Specialist Day Hospital with your item numbers to receive a verbal / written quote for your stay.
3. Request written information from your surgeon about any "out of pocket costs" which may apply to the surgical fee.
4. Request the name and contact phone number of your anaesthetist, from your surgeon's rooms, for information on any "out of pocket costs" which may apply to the anaesthetic fee.
5. If pathology is required, please note that a "Gap Payment" may apply.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

PRIVACY PRINCIPLES

1. We acknowledge our obligations to you under the Privacy Act 1988.
2. Our Personal Information Management Policy is available at Reception and our Privacy Officer, who can be contacted by telephone through our main switchboard, is happy to answer any questions you may have concerning the policy.

PLEASE READ YOUR BROCHURE TO ASSIST IN PREPARING FOR YOUR SURGERY AND YOUR DISCHARGE ARRANGEMENTS.