St .Kilda Day Hospital
26 Dickens Street
Elwood 3182

Patient Information Form

Please complete in full and return to the Hospital at least 5 days before surgery.

Surname: _____ Given Names _____ Title: _____

Address: _____ Suburb _____ Post Code_____

Telephone : _____ Email: _____ Gender: _____

Date of Birth: _____ Marital Status:_____ Country of Birth:_____

Main Language: _____Medicare No/Reference: _____ Expiry: ____

Are you (is the person) of Aboriginal or Torres Strait Islander origin: ☐ No ☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to Answer

Have you been admitted to this hospital before? Yes ☐ No☐ Occupation: _____

Did you receive a 'Guide of Privacy' & 'Patients Rights & Responsibilities' brochure? Yes ☐ No ☐

Did you receive a pre-operative phone call from the Anaesthetist? Yes☐ No☐

Next of Kin: _____ Tel: _____ Relationship: _____

Do you have a legal decision maker? Yes ☐ No ☐ Same as above ☐ Other: _____

Health Fund Details (if applicable)

Name of Health Fund: _____ Membership No: _____ Table: _____

Length of Membership in this fund/table: less than 12 months over 12 months

Doctor Information

Admitting Doctor: _____ Admission Date: _____

Proposed Operation: _____

DISCHARGE

You must have a responsible adult take you home. You cannot drive for 24 hours. We recommend that someone stays with you for at least 24 hours after your procedure. Please list contact details of person taking you home:

Name:_____ **Tel:** _____ **Relationship:** _____

Signature: _____Witness Signature: _____ Date: _____

OFFICE USE: Admission No: _____ Date of Admission: _____