

PRE-ADMISSION ASSESSMENT FORM

In-patient Day Program Private Room requested Room Assigned _____

Patient's Name _____ Male Female **DOB** / /

Address _____ Postcode _____

Telephone _____ Religion _____

Next-of-Kin _____ Rel. _____ Tel. _____

Address _____

Health Fund _____	Level of Cover _____	Membership No _____
Medicare No: _____	<u>WorkCover / Third party</u>	
Expiry Date ____ / ____	Insurer _____	
Pension Number _____	Claim Number _____	
Pharm. Number _____	Case Manager _____	
SN or CN _____	Telephone No. _____	
Proposed Admission Date: / /	Date of Injury _____	
Previous Patient at Alwyn <input type="checkbox"/> YES <input type="checkbox"/> NO		

REFERRING HOSPITAL: _____ **Ward:** _____

Referring Hospital Contact: _____ **Telephone** _____

Referring Specialist: _____ **Telephone** _____

Rooms Address _____

GP Name: _____ **Telephone** _____

Address _____

DIAGNOSIS / Op _____ **Date of Operation** / /

Relevant History / Complications _____

ASSESSMENTS: Weight bearing status / Aids _____	Weight _____	Hb _____	Date / /
Wound _____	MRSA results _____		
Requires assistance with: <input type="checkbox"/> self care <input type="checkbox"/> mobilization <input type="checkbox"/> feeding <input type="checkbox"/> elimination <input type="checkbox"/> wound / pain management			
Cognitive Status: <input type="checkbox"/> alert <input type="checkbox"/> orientated <input type="checkbox"/> cooperative <input type="checkbox"/> confused <input type="checkbox"/> Dementia			
Contenance: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent – urine / faeces <input type="checkbox"/> IDC <input type="checkbox"/> SPC <input type="checkbox"/> Pressure areas _____			
Social Assessment: <input type="checkbox"/> At home- independent / carer / community supports <input type="checkbox"/> N.Home / Hostel _____			
Expected Destination on Discharge: _____			

ALWYN USE ONLY: MRN _____	Employment Status / Occupation _____
2 nd person notification _____	Rel. _____ Telephone _____
Previous Hospital/s within previous month (<i>Name, Admission, Discharge</i>) <i>Date</i> _____	
FINANCIAL: <input type="checkbox"/> YES <input type="checkbox"/> NO 12 Mths <input type="checkbox"/> YES <input type="checkbox"/> NO Private Room <input type="checkbox"/> YES <input type="checkbox"/> NO	
Fees payable at Alwyn _____ SIG: _____	
Rehabilitation Program: <input type="checkbox"/> ORTHOPEDIC <input type="checkbox"/> PHYSICAL UPGRADING <input type="checkbox"/> NEUROLOGICAL <input type="checkbox"/> MUSCULO-SKELETAL	