

CDSC

Canossa Day Surgery Centre

Tel 07 3375 7777
 Fax 07 3375 9800
 eMail admin@cdsc.com.au

Place Patient ID LABEL here.

Surgery Booking details:

Date of admission:	Surgeon:
Referring Practitioner:	

Personal details:

Surname:		Given Names:	
Preferred name:		Previous Surname (where relevant):	
Date of birth:	Sex:	Have you ever been admitted to CDSC before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address:			
Telephone-Home:			
Postal address same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, postal address	
Marital status:			
Are you allergic to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other allergies:	
Special diet:		Occupation: «Patient_Employment_Desc»	
Country of Birth:		Language spoken at home:	
Indigenous status –			

Person to contact (usually next of kin)

Name:	Relationship to patient:
Street Address:	
Telephone-Home	
Other emergency contact name	Phone:

Private Health Fund

Name of Health Fund:	Table:	Membership Number:
Name of Contributor:	Relationship to patient:	
Street Address:	Suburb:	Postcode:
Telephone-Home:	Work:	Mobile: Fax:
Is the membership of this fund/table over 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you transferred from another fund? Please provide details.
Patients with less than 12 months membership in their fund/table may not be eligible for any benefits.		

Do not write in this space.



Medicare/Entitlements – please bring cards to hospital

Medicare card Number

Your name is position on the card. Expiry Date: ____/____

Veterans' Affairs Number _____ White Card Gold Card

Pension / Health Care Card _____ Expiry Date: _____

Safety Net Card Number _____ Expiry Date: _____

Commonwealth Senior's Card _____ Expiry Date: _____

If you are keeping a current Prescription Record Form, please bring this with you to hospital as you may be eligible for benefits under the Medicare Safety Net Scheme.

Person Responsible for Account – complete only if someone other than the patient is to receive the account

Veterans' Affairs TAC Workcover Other – Please specify

Claim/VX number: _____ Date of Accident/Injury: _____

Name: _____ Relationship to patient: _____

Street Address: _____ Suburb: _____ Postcode: _____

Telephone-Home: _____ Work: _____ Mobile: _____ Fax: _____

Financial Consent to be completed on admission

I certify the information on this form to be true to the best of my knowledge. I accept full responsibility for accounts rendered by Canossa Day Surgery Centre, including any shortfall in reimbursement by my Health Fund following settlement by Health Fund. I have had the financial cost of my surgery explained to me.

Signature: _____ Print name: _____ Date: _____

Consent to use personal information

I understand that if I have any concerns about privacy, I may raise them when I come to the hospital for admission. I have read the brochure "CDSC Personal Information and Privacy for Patients" and I understand my rights to privacy and how my personal information will be used at the hospital. I give consent to the use of my personal information as described in the brochure. I understand that I may withdraw my consent at any time.

Signature: _____ Print name: _____ Date: _____

Discharge arrangements

DVA Transport to be arranged:

I have arranged for someone to take me home following my surgery and to stay with me overnight: If not having someone stay overnight then take responsibility.

Name: _____ Relationship to patient: _____

Telephone-Home: _____ Work: _____ Mobile: _____

Signature: _____ Print name: _____ Date: _____

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature: _____ Print name: _____ Date: _____



Do not write in this space.