NSW GOVERNMENT Health
South Eastern Sydney Local Health District
Illawarra Shoalhaven Local Health District
Sydney Children's Network

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility:

RECOMMENDATION FOR ADMISSION

SEI030005

Information on this page To Be Completed By Doctor.

Name: .....

D.O.B.: ..... Sex: ☐ Male ☐ Female Telephone: ( ) .....

Interpreter Required: ☐ Yes ☐ No Prefered language: .....

☐ Medicare ☐ Privately insured ☐ Self funded ☐ Other .....

(Please note: Patient must complete page 7-12 before submitting)

Please indicate the preferred hospital for the patient to be admitted:

Presenting Problem

Planned Procedure *(if applicable)*

Estimated OT time _____

Significant Medical History / Co-morbidities

Anticoagulant therapy. If yes, please state:

Known Infectious Risk ☐ YES ☐ NO **Known Allergies** If yes, please state:
☐ Airborne Pathogen ☐ Blood Borne Pathogen ☐ History of Multi Resistant Organism
☐ Other, please state: _____

Clinical Priority admission within: ☐ 30 days ☐ 90 days ☐ 12 months ☐ *Can attend at short notice*
☐ - Staged Procedure - Not ready for care at this time **PLANNED ADMISSION DATE:** / /
If not recommended priority provide clinical reason. **Estimated LOS:** _____

Admission Plan ☐ Admit day stay ☐ Admit for no more than 23hrs ☐ Admit day of Procedure ☐ Other
Instruction on admission: _____

Special Requirements. ☐ Nil ☐ ICU Bed ☐ HDU Bed ☐ Autologous Blood
☐ Other e.g. equipment / Prosthesis, please specify: _____

Pre-Admission Review Recommended ☐ Pre-Anaesthetic Review Recommended ☐
Diagnostic Tests Required ☐ If yes, please state:

Admitting AMO: _____ **Signature:** _____
Name If not admitting AMO: _____ Date: _____

RECOMMENDATION FOR ADMISSION SEI030.005

BINDING MARGIN - NO WRITING

020913

NO WRITING