Please complete all fields
Once form has been completed please fax to:
x32676 – Bed Management

Form Completed By: _____ Ward: __**4S**____ Phone: __**x33458/x33446**__

PATIENT DETAILS

MRN:	Surname:	Given Name/s:
Sex: □ Male □ Female	Date of Birth:	Country of Birth:

Address:

Home Phone:	Work Phone:	Mobile:

Person to Contact:	Relationship:
Address of Person to Contact:	Contact phone number/s:

Compensable Status:

□ Medicare   □ Veteran's Affairs   □ Overseas   □ Workers Comp   □ Third Party

Medicare Care Number: __ __ __ __ __ __ __ __ __ __ /__	DVA Card No.:	DVA Card Colour: □ Gold □ White □ Orange
Health Fund Name:	Health Fund No.:	Type of cover: □ Single □ Shared □ Basic
GP Name:	GP Address:	

ADMISSION DETAILS

Admission Date:	Admission Time:	Admit Ward: **4S**	Admit Bed: **4SM_OVPD01**
Admitting Medical Officer:		AMO Specialty: **Renal**	
Referring Doctor:		Referring Hospital: **St George Hospital**	
Intended LOS: ☑ Day Only □ Overnight		Financial Classification:	

Presenting Problem: **Peritoneal Dialysis patient with contaminated PD Catheter**

OFFICE USE ONLY

Date / Time received:	Date / Time entered:	Entered by:
Date / Time PLO notified:	PLO Name:	

DIRECT ADMISSION FORM