THE BAYS

The Bays Healthcare Group
Caring for the Peninsula

Hospital admission forms

Thank you for choosing The Bays Hospital for your upcoming admission.

To ensure a smooth admission process, please read the following information carefully.

Please complete your admission form online at least 14 days before your admission date - visit **www.thebays.com.au** and click on **Patient Portal**. By completing your admission online, some of your information will be retained for future admissions and will only require updating.

Alternatively, you may complete the enclosed paper admission form and return it to the hospital by:

- Post in the reply paid envelope
- Fax to 03 5975 2373
- Dropping them in to our main reception desk in Vale Street

Complete your medication chart and bring all of your current medications into hospital with you in their original packaging. If you have a medication list from your local doctor please bring this with you too.

Please contact your Private Health Fund to confirm your level of cover and whether you have an excess or co-payment on your policy. In the event that you do have an excess it is payable at the time of your admission.

Our administration staff will contact you the business day before your admission to confirm the time. This confirmation is necessary as admission times may change from the time your doctor's rooms have given you.

Please ensure you read the patient information brochure which you can download at **www.thebays.com.au/hospital/patient-info** and refer to **www.thebays.com.au** for any further information

If you have any questions regarding your admission phone us on 03 5975 2009.

The Bays Hospital
Vale Street | PO Box 483
Mornington VIC 3931
Phone 03 5975 2009
Fax 03 5975 2373
ABN 35 146 117 211 | www.thebays.com.au

THE BAYS

The Bays Healthcare Group Inc

PATIENT REGISTRATION

Vale Street, Mornington 3931
Phone 5975 2009 Fax 5975 2373
Email reception@thebays.com.au

OFFICE USE ONLY

MR NUMBER ____
SURNAME ____
GIVEN NAME(S) ____
DATE OF BIRTH ____ SEX ____

Please fill in if no Patient label available

Admission date: DD / MM / YYYY Admission time: HH : MM

EXPECTED DATE OF ADMISSION

D	D	M	M	Y	Y	Y	Y

Please use BLOCK letters when completing this form and return to the hospital immediately to confirm your admission.

REASON FOR ADMISSION | **ADMITTING DOCTOR/SURGEON**

TITLE | **SURNAME** | **PREVIOUS SURNAME**

GIVEN NAMES | **PREFERRED NAME** | **PRONOUNS**

BIRTH DATE D D M M Y Y Y Y **AGE** | **COUNTRY OF BIRTH** | **RELIGION (OPTIONAL)**

SEX AT BIRTH ☐ Male ☐ Female ☐ Another term

GENDER IDENTITY ☐ Man / Boy ☐ Woman / Girl ☐ Non binary ☐ Different term ☐ Prefer not to answer

MARITAL STATUS ☐ Never married ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

INDIGENOUS STATUS ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander ☐ Decline to answer this question

LANGUAGES SPOKEN ☐ English ☐ Other: ____ Do you require an interpreter? ☐ Yes ☐ No

RESIDENTIAL ADDRESS ____
____ State ____ Postcode ____

POSTAL ADDRESS ☐ Same as above ☐ If postal address is different, complete details below
____ State ____ Postcode ____

CONTACT Mobile No. ____ Other phone no. ____

EMAIL ____

NEXT OF KIN / FIRST CONTACT

Name. ____ Relationship. ____
Address. ____ Phone No.: ____

SECOND CONTACT

Name. ____ Relationship ____ Phone No.: ____

Medicare No. [ ][ ][ ][ ] - [ ][ ][ ][ ][ ] - [ ] **Card Ref. No** [ ] **Valid to** [ ] **Please bring in on admission**

☐ **Pension / Health care card** Number [ ] Expiry Date [ ]

Pharmacy Safety Net No. [ ]

Ambulance Victoria Subscriber? No ☐ Yes ☐ Member No. ____ (Note: Not all ambulance costs are 100% covered under health insurance)

WHO IS FUNDING THIS ADMISSION?

Private Health Fund ☐ Name of Fund: ____ Membership No.: ____

Workcover ☐ Name of Workcover insurer: ____ Claim No.: ____

Case manager name: ____ Contact No.: ____

TAC ☐ Approval No.: ____

DVA ☐ DVA No.: ____ Exp.: ____ **Gold card** ☐ **White card** ☐

Self-funded ☐ Are you a financial member of The Bays? Individual ☐ Family ☐

GP NAME | **CLINIC NAME** | **CLINIC PHONE NO.**

Have you been a patient at this hospital before? No ☐ Yes ☐ → What Year? ____

OFFICE USE ONLY

Has the Patient been discharged from another Hospital within the last seven days? No ☐ Yes ☐ Name of Hospital: ____ Adm. Date: ____

Staff Initial: Pre-booking [ ] Admission [ ] Room [ ]

DO NOT WRITE IN MARGIN

PATIENT REGISTRATION

MR/001

Allanby TB0014 February 2025

THE BAYS

The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER ______________________

SURNAME ______________________

GIVEN NAME(S) ______________________

DATE OF BIRTH ______________ SEX __________

Please fill in if no Patient label available

If you are under the care of any other Medical Specialists please provide details below

	Last review date		Last review date
Physician		Cardiologist	
Vascular Doctor		Diabetes Educator	
Kidney specialist		Respiratory Physician	

DO YOU HAVE ANAPHYLAXIS? ☐ **Yes** ☐ **No**

If yes, what causes the **ANAPHYLAXIS?** ______________________

(PLEASE ENSURE YOU BRING YOUR EPIPEN AND ANAPHYLACTIC MANAGEMENT PLAN TO HOSPITAL WITH YOU)

Do you have any ALLERGIES or ADVERSE REACTIONS to any medications, latex, tapes, skin preps, antiseptics dietary/foods or other? ☐ **Yes** ☐ **No**

If yes, please state the name and the reaction ______________________

____

____

Do you or your family have a history of MALIGNANT HYPERTHERMIA? ☐ **Yes** ☐ **No**

(If yes, please contact the Pre-admission Nurse prior to your admission on 5976 5210)

Any special dietary requirements? ☐ No ☐ Yes If so, please specify: ☐ Dairy Free ☐ Diabetic ☐ Fructose Free ☐ Gluten Free ☐ Lactose Free ☐ Vegetarian ☐ Other: ______________________

Do you have an Advanced Care Directive ☐ Advanced Care Plan ☐ Enduring Power of Attorney (medical treatment) ☐	If so, please bring a copy of these documents with you

We want to support your care as best we can. Is there anything that is important to you or anything you would like us to know about you that will make a difference to your stay? ☐ Yes ☐ No

If yes, please let us know here: ______________________

HEALTH HISTORY - please tick yes or no to the following

WEIGHT		HEIGHT		BMI	

Do you have or have had any CENTRAL NERVOUS SYSTEM problems?	☐ **No**	☐ **Yes**	**Provide details below**
Neuromuscular disease ☐ Parkinsons ☐ Epilepsy ☐ Multiple Sclerosis ☐ Motor Neurone Disease ☐ Seizures ☐			
Depression ☐ Mental illness ☐ Anxiety ☐ Panic attacks ☐			
Short term memory loss ☐ Confusion ☐ Dementia ☐ Delirium ☐			
Do you have or have had any CARDIOVASCULAR problems?	☐ **No**	☐ **Yes**	**Provide details below**
Heart attack ☐ Heart failure ☐ Angina ☐ Cardiomyopathy ☐ Heart valve regurgitation ☐			
Artificial heart valve ☐ Implantable Defibrillator ☐ Pacemaker ☐			
Cardiac stents ☐ Cardiac bypass ☐			
Blood pressure problems ☐ Low ☐ Hypertension ☐			
Irregular heart beat ☐ Murmur ☐ Palpitations ☐			
History of Deep Vein Thrombosis (DVT) ☐ Stroke ☐ TIA ☐ Pulmonary Embolus (PE) ☐			
Vascular disease ☐ Vascular aneurysm ☐			
Do you have any blood disorders / conditions? ☐			
Blood thinning medication - Aspirin (Cartia/Astrix) ☐ Plavix/Isocover ☐ Warfarin ☐ Asasantin ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Brillinta ☐ Effient ☐			Please ensure you bring your medications to hospital with you
Has your doctor advised you to stop your blood thinning medication?			If stopped - when?
Do you have or have had any RESPIRATORY problems?	☐ **No**	☐ **Yes**	**Provide details below**
Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Asbestosis ☐ Other breathing difficulties ☐			
Do you use home oxygen?			
Sleep apnoea ☐ Snoring ☐			
Do you use a CPAP machine?			*Please ensure you bring your CPAP machine to hospital with you*
Do you have or have had any GASTROINTESTINAL problems?	☐ **No**	☐ **Yes**	**Provide details below**
Speech problems ☐ Swallowing problems ☐			
Liver disease ☐ Hepatitis ☐			
Bowel disease ☐ Faecal incontinence ☐ Coeliac disease ☐			
Gastric reflux ☐ Stomach ulcer ☐ Hiatus hernia ☐			
Have you had gastric banding surgery ☐ Sleeve gastrectomy ☐ Gastric bypass ☐			*If yes, please contact your Anaesthetist*
Do you have a Stoma?			

DO NOT WRITE IN MARGIN

PATIENT HISTORY SHEET

MR/081

Allanby TB0001 December 2024

HEALTH HISTORY - please tick yes or no to the following			
Do you have or have had any ENDOCRINE problems?	☐ **No**	☐ **Yes**	**Provide details below**
Do you have diabetes? Type 1 ☐ Type 2 ☐			
Do you manage your diabetes with: Diet ☐ Tablet ☐ Insulin ☐			
Thyroid disease			
Do you have or have had any RENAL problems?	☐ **No**	☐ **Yes**	**Provide details below**
Kidney failure ☐ Dialysis ☐ Kidney disease ☐			
Bladder problems ☐ Urinary incontinence ☐			
Do you have or have had any SKIN & MUSCULO-SKELETAL problems?	☐ **No**	☐ **Yes**	**Provide details below**
Rheumatoid arthritis ☐ Osteoarthritis ☐			
Do you have a spinal cord stimulator?			If so, please bring remote into hospital
Do you have any wounds, or breaks on your skin?			
Do you have or have had any pressure injuries / ulcers / bed sores?			
Do you have or have had any ONCOLOGY problems?	☐ **No**	☐ **Yes**	**Provide details below**
Cancer: specify site(s)			
Are you currently undergoing chemotherapy?			Last given: / /
Are you currently undergoing radiation therapy?			Last given: / /
Do you have a Central Venous Access device (eg. Portacath, PICC, Hickman)?			
Do you have or have had any INVESTIGATIONS?	☐ **No**	☐ **Yes**	**Provide details below**
Blood tests taken for this admission			
Pathology company:			
ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission			Please bring with you to hospital
Do you have or have had any ALERTS?	☐ **No**	☐ **Yes**	**Provide details below**
Do you or have you ever smoked? Smoker ☐ Ex-smoker ☐			Daily amount: Date ceased: / /
What is your daily alcohol intake?			
Do you use recreational drugs?			Daily amount: Type: Ceased date: / /
Impaired vision? Glasses ☐ Contact Lenses ☐			Please bring glasses with name on frame and case
Impaired hearing? Hearing aids ☐			Please bring hearing aids in named case
Dentures ☐ Plate ☐ Crowns ☐ Caps ☐ Braces ☐			Upper ☐ Lower ☐ Both ☐
Any special needs during your stay?			
Are you pregnant? How many weeks?			
Do you use any mobility aids? Eg. Walking stick, frame, wheelchair			Please ensure you bring your mobility aid to hospital with you
Have you fallen / tripped within the last 12 months?			
Lymphoedema risk ☐ Lymphoedema condition ☐			
Any other illness / condition - please specify			

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THE BAYS

The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER ____________________

SURNAME ____________________

GIVEN NAME(S) ____________________

DATE OF BIRTH ____________ SEX ____________

Please fill in if no Patient label available

DO NOT WRITE IN MARGIN

If the response to any of the Infection Control questions BELOW is YES please contact The Bays Hospital Pre-admission Nurse: Phone 5976 5210 prior to your admission date.

	Do you have or have had any INFECTION problems?	☐ **No**	☐ **Yes**	**Provide details below**
Acute Respiratory Infection	Do you have a fever and / or respiratory symptoms? Cough, sore throat, runny nose			
	Have you had recent contact with a person diagnosed with Acute Respiratory Infection or Acute Respiratory Illness in the last 14 days - seasonal or pandemic?			
	Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or pandemic either overseas or within Australia in the last 14 days?			
Carbapenem Production Enterobacteriaceae (CPE) and Candida Auris Screening	Have you / the patient ever been informed you have had a multi-resistant organism infection (eg. MRSA, VRE, ESBL)?			
	Have you / the patient been directly transferred from any overseas healthcare facility?			
	Have you / the patient been admitted to any overseas healthcare facility in the past 12 months?			
	Have you / the patient resided in any overseas Residential Aged Care Facility in the past 12 months?			
	Have you / the patient been identified as a Candida auris and /or CPE contact during any hospitilisation?			
	Have you / the patient had a confirmed Candida auris and / or CPE infection?			
Creutzfeldt-Jakob Disease (CJD)	Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990?			
	Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prior disease, where a genetic cause has not been excluded?			
	Have you suffered from a recent (less than 12 months) progressive dementia illness (physical or mental), the cause of which has not been diagnosed / explained?			
	Have you received human pituitary hormones for infertility of human growth hormone for short stature, prior to 1986?			
	Have you been involved in a “Look Back” study for cCJD or in possession of a “Medical in Confidence Letter” regarding risk of cCJD?			

PREVIOUS PROCEDURES AND SURGERY (If yes, please list below)	Approximate year of surgery
Have you previously had a general anaesthetic? No ☐ Yes ☐	List any reactions below

MEDICATION SUMMARY

While you are a patient in our hospital we will endeavour to ensure that all medications prescribed for you are safe and appropriate. It is important to have an accurate record of all medication that you are already taking, or have recently ceased. **Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products.** Please also include all eye drops, patches, natural medicines or topical products. If you have any problems completing the list below please contact your Local Doctor (GP) or Local Pharmacy for assistance.

PLEASE BRING TO HOSPITAL A PRINTED LIST OF ALL MEDICATION PRESCRIBED TO YOU BY YOUR DOCTOR AND ALL CURRENT MEDICATIONS IN THE ORIGINAL PACKAGING IF AVAILABLE

Do you use a Dose Administration Aid eg. Webster Pack/Sachets/Pill Box? ☐ No ☐ Yes Which Pharmacy?______________

Current Medication	Strength	How many times per day	Reason for taking?	Taking for how long?
				2 years

Medication STOPPED in the past 2 weeks	Strength	How many times per day	Reason for taking?	When/why stopped?

Charges for medication provided during your stay in hospital will be billed to your pharmacy account according to the agreement between your Private Health Fund and the Hospital. Not all pharmacy items will be covered by your health fund. In this case a pharmacy account will be presented to you on discharge.

DISCHARGE PLANNING	No	Yes	Provide details below
Do you live alone?			
Do you have someone to care for you after discharge?			Please note: if going home on the same day as surgery you must have someone to care for you overnight
Name: Contact number: Relationship:			
Are you solely responsible for the care of another person at home?			
Do you currently use any community or nursing services?			
Do you require assistance with daily living?			
Do you have any concerns regarding how you will manage at home after discharge?			
Following discharge are you going home ☐ staying with friends/family ☐ rehab ☐ respite ☐			
Who is picking you up? Contact number:			

I acknowledge that I have read and understood the following:

- ☐ **My healthcare rights and responsibilities**
- ☐ **Consent to collection and use of personal and health information**
- ☐ **Patient information brochure**

The information I have provided for this admission is accurate and complete to the best of my knowledge.

Patient signature:	**Date:**
Reviewed by Pre-admission Nurse - name and signature:	**Date:** **Screen** ☐ **Phone R/V** ☐ **Clinic R/V** ☐
Admitting Nurse name and signature:	**Date:**

DO NOT WRITE IN MARGIN