ebnc
ELMHURST BUSH NURSING CENTRE

CLIENT ADMISSION INFORMATION

Consumer Details

Family name: ______________________

Given names: ______________________

Preferred name: ______________________

Date of birth: ___/___ /___ is the DOB estimated? Y / N

Gender: ______________________

Home address: ______________________

Town: ______________Post code: ________

Postal address: ______________________

Town: ______________Post code: ________

Contact phone number/s ______________________

Home: ______________________

Work/mobile: ______________________

Email: ______________________

____

Marital Status: ______________________

Country of Birth: ______________________

Indigenous/Torres Strait Islander: ______________________

Refugee status: ______________________

Preferred Language: ______________________

Communication method: ______________________

Interpreter required: ______________________

Do you live alone: ______________________

Medical Information:

GP name: ______________________

Practice name: ______________________

Address: ______________________

Town: ______________Post code: ________

Phone: ____________ Fax:____________

Email ______________________

Specialist Doctor Y / N

Name: ______________________

Location: ______________________

Do you have any allergies or sensitivities Y / N

Have alerts been added to paper health care record Y/ N

Have alerts been added to electronic healthcare record Y / N

Name:
Date of Birth:
Gender:
Address:
UR Number:

Or affix sticker

Next of Kin / emergency Contact 1

Name:______________________

Address: ______________________

____

Contact phone number/s: ______________________

Home: ______________________

Work/mobile ______________________

Relationship: ______________________

Next of Kin / emergency Contact 2

Name: ______________________

Address: ______________________

____

Contact phone number/s

Home: ______________________

Work/mobile ______________________

Relationship: ______________________

Government Card / Benefit Status:

Health Care Card / Pension Card number:

______________________ exp. Date: __________

Medicare Card number:

______________________ exp. Date: __________

DVA Card: Type: ______________________

Number: ______________ exp. Date: __________

Private Health Insurance: Y / N

Insurer: ______________________

Number: ______________ exp. Date: __________

Ambulance subscriber: Y / N

Number: ______________ exp. Date: __________

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Medical /Surgical History

List:

Psychological History

Anxiety	Y / N	Confusion	Y / N
Depression	Y / N	Memory Loss	Y / N
Suicidal thoughts	Y / N		

Medications

ALLERGIES:

Medication	Dose	Frequency	Route	Indication

Social/Wellbeing/Emotional/Religious Beliefs

General overview:

General

Do you have a My Aged Care Number or completed an Aged Care Assessment (ACAS)? Y / N N/A
If yes, date: Home Care Package Provider: Case Manager:

Do you have an Advance Care Directive? Y / N *if yes please provide EBNC with a copy*

Do you have a substitute decision maker? Y / N *if yes please provide details:*

Do you have a refusal of treatment document Y / N can we have a copy?

Admitting nurse to complete

Has the 'SCTT Consent to share information' being completed? Y / N N/A

Consumer pack given with Consumer Rights & Responsibilities, Health Records, Your information, Elmhurst brochure, Australian Charter Health Care Rights? Y / N If no, explain:

If the client is over 65 years (or over 50 years for Aboriginal and Torres Strait Islander) have they had a Falls Risk Screen performed in the last 12 months? Y / N If no, complete a screen using the FROP-COM Screen N/A

Reason for admission

Would the client like to have a comprehensive Nursing Assessment completed? Y / N

Does client need further assessments? Y / N
Which assessments:

Have you received a copy of the Australian Charter of Health Care Rights? Y / N

Do you understand what it means? Y / N

Staff Signature: **Name:** **Designation:** **Date:**