MANLY WATERS/DELMAR PRIVATE HOSPITAL

PALLIATIVE / REHAB / MEDICAL PRE-ADMISSION INFORMATION

DATE & TIME OF EXPECTED ADMISSION NAME: DOB: AGE: ADDRESS: TELEPHONE: NEXT OF KIN: RELATIONSHIP: PHONE: HEALTH FUND.: MEMBERSHIP NO: PENSION NO.: REHAB SPEC. PROGRAMME VETERAN AFFAIRS No.: COLOUR OF DVA CARD; MEDICARE CARD NO: MEDICARE EXPIRY DATE: HAVE YOU BEEN A PATIENT IN MANLY WATERS PRIVATE HOSPITAL BEFORE: Yes No Year: Phone: USUAL GP Phone: ATTENDING DOCTOR TO MWPH Phone: YEANSFERRING FROM OTHER HOSPITAL: Yes No MOSPITAL NAME: PHONE NO: ADMISSION DATE FROM HOSPITAL TRANSFERRING: JIAGNOSIS: PAST MEDICAL HISTORY: Yeast MEDICAL HISTORY:	DATE O TIME OF EVELOPED INTO		No	Room No.:
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MRSA STATUS: Swabs YES NO DATE TAKEN RESULTS: NOSE AXILLAE WOUND	MRSA STATUS: Swabs YES NO	DATE TAKEN	RES	SULTS: ONSE AXILLAE GROIN WOUND
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