The **Royal Children's Hospital** Melbourne

FRC000100

The Royal Children's Hospital Patient Registration form

Admissions Telephone 9345 6179
Facsimile 9345 6202

Outpatient Appointments Telephone 9345 6180
Facsimile 9345 5034

Please return this form to RCH as soon as possible to avoid unnecessary delay at time of presentation.

UR No:

Office use only

Please complete and post to:
Admissions/Outpatient Appointments
The Royal Children's Hospital,
50 Flemington Rd, Parkville VIC 3052

Admission date ____ / ____ / ____

Admitting point _____

Checked by _____

Patient information

Has the patient ever attended this hospital before? ☐ Yes ☐ No

Surname _____

Given names _____

Previous names/alias/also known as: (for cross referencing purposes)

_____

Sex ☐ Male ☐ Female

Birth date ____ / ____ / ____

Address _____

_____ Postcode _____

Telephone (home) _____

Religion _____

Country of birth (if Australia specify state) _____

Aboriginal descent ☐ Yes ☐ No

If yes: ☐ Aboriginal only ☐ Torres Strait Islander only
☐ Both Aboriginal and Torres Strait Islander

Interpreter required? ☐ Yes ☐ No

Main language spoken at home by parents _____

Other language/s spoken at home _____

Is the patient a permanent resident of Australia? ☐ Yes ☐ No

Medicare number ☐☐☐☐ – ☐☐☐☐☐ – ☐ / ☐

(Number which appears on the card beside the name of the patient)

Expiry date ____ / ____ / ____

Healthcare card / Concession card / Safetynet card

Card number _____

Type of card _____ Expiry date ____ / ____ / ____

Private insurance details

Fund name _____

Membership number _____

Date joined ____ / ____ / ____

Level of cover ☐ with excess ☐ full hospital insurance ☐ insured (unknown level)

Child entering hospital as a: (tick one) ☐ Public patient ☐ Private insured

☐ Private non-insured ☐ TAC ☐ International

Local doctor's clinic details

Doctor's name _____

Address _____

_____ Postcode _____

Telephone _____ Fax _____

Referring doctor's details (if different to local doctor)

Doctor's name _____

Address _____

_____ Postcode _____

Telephone _____ Fax _____

Parent/s or carer (if address same as patient, write 'as above')

Surname _____

Given name _____

Relationship _____ Country of birth _____

Address _____

_____ Postcode _____

Telephone _____ (work) _____

Mobile _____

Surname _____

Given name _____

Relationship _____ Country of birth _____

Address _____

_____ Postcode _____

Telephone _____ (work) _____

Mobile _____

Patient's legal guardian (only complete if legal guardian is not parent/carer)

Name _____

Address _____

_____ Postcode _____

Telephone _____ (work) _____

Mobile _____

Person financially responsible for patient

(only complete if person financially responsible is not parent/carer)

Name _____

Address _____

_____ Postcode _____

Telephone _____

CONSENT TO RELEASE INFORMATION

I consent to information being sent to my health care provider and to hospital staff obtaining medical information about my child from health professionals or hospitals who have treated my child in the past (e.g. local doctor, referring doctor or other community provider).

Signed _____ Date ____ / ____ / ____

(patient, parent, guardian or person responsible for patient – please circle)

Patient Registration form MR 5/P

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