RAMSAY HEALTH CARE
People caring for people

MITCHAM PRIVATE HOSPITAL

PRE ADMISSION MEDICAL REPORT
MOTHER BABY UNIT

Please return via fax to: 03 9210 3183

Dear Doctor,

After you have completed assessment of this patient, would you please fill in the details below to streamline admission and Health Fund approval.

Mother's Name: _____

Baby's Name: _____

Address: _____

Tel No: _____ Mobile Tel: _____

Provisional Diagnosis – Mother: _____

Observations / Treatment: _____

Provisional Diagnosis – Baby: _____

Observation / Treatment: _____

Duration of Problem: _____

_____

Relevant History, i.e. illness / operations in the past: _____

_____

Current Medications: _____

Previous hospitalisation for this problem? ☐ Yes ☐ No

When: _____ Where: _____

Any psychiatric problems or treatment? Please provide details:

_____

_____

_____

Referring Doctor's Name: _____ Provider No: _____

(Please print)

Medical Practice Name: _____

Address: _____

_____ Postcode: _____

Telephone No: _____ Fax No: _____

Signature: _____ Date: ____ / ____ / _____