PRE ADMISSION MEDICAL REPORT

MOTHER BABY UNIT

<u>Please return via fax to</u>: 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____

Observation/treatment ____

Provisional Diagnosis – Baby____

Observation/treatment ____

Duration of Problem____

____

Relevant History, i.e. illness/operations in past____

____

Current medications____

Previous hospitalisation for this problem? Yes ☐ No ☐

When______________________ Where______________________

Any psychiatric problems or treatment? Please provide details.

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Referring Doctor's Name______________________ Provider No.______________________

(Please print)

Medical Practice Name____

Address ____

____ P/Code______________

Telephone No.______________________ Fax No.______________________

Signature______________________ Date______________________