PATIENT REGISTRATION FORM

Admission date: ……………… Time :……… Release date :…………………… Time: ………

ETIQUETTE

PLEASE COMPLETE, AND TICK WHEN APPROPRIATE

Male ☐ Female☐ Under 18 yrs old☐

Surname: ……………………………………………………………

Maiden name: ……………………………………………………

First Name: …………………………………………………………

Date of birth: ………… /……… / …………

Place of birth: ……………………………………………………

Current nationality: ……………………………………………

Country of residence: …………………………………………

Marital status:

Single ☐ Married ☐ Divorced ☐ Widow ☐

Do you have a health insurance?: Yes ☐ / No ☐

Name of insurer: …………………………………………………

You are the: Main Policyholder ☐ Beneficiary ☐

Policyholder's name :……………………………

Membership number: ……………………………

☐ Other: ……………………………………………

Your employer: **Retired:**☐

Company :……………………………………………

Tel :…………………………

Work -related accident: Yes ☐ No ☐

Accident date: ……………………………………………

Your residential (home) address:

……

……

City: …………………………………………………… Postcode …………………………

P.O. box: ………………………………… Postcode: ……………………………………………

Your email address:

……

Your mobile phone number: ……………………………………………………………………………

PERSON TO CONTACT IN CASE OF EMERGENCY

Full name: …………………………………………………………………………………………

Link with the patient: ……………………………………………………………………………

Home phone: …………………………………… Mobile phone: ………………………………

IF APPLICABLE, YOUR ADDRESS WHILE STAYING IN NEW CALEDONIA:

PERSON TO CONTACT (IN NEW CALEDONIA):

(Surname, first name – specify the link)

- ……………………………………………………………… Tel: ………………………………
- ……………………………………………………………… Tel: ………………………………

Over the last 12 months, have you been admitted in a hospital abroad or at NC public hospital (CHT)? Yes ☐ No ☐

PATIENT REGISTRATION FORM – ADDITIONAL INFORMATION

CARE FOLLOW-UP - CONTACTS

Family doctor: .... Email : ....

Heart specialist: .... Email : ....

Eye specialist: .... Email : ....

Lung specialist: .... Email : ....

Nurse: .... Phone : ....

✓ PARENTAL CONSENT - GUARDSHIP - CURATORSHIP

I / We, the undersigned..

acting as (state your link to patient) ....

of the child (child's name) ....

of the adult (adult's name) ....

I / We allow Clinique Kuindo Magnin medical staff and doctors to carry out all the required medical exams and investigations, including surgery under general anaesthesia.

Please date, sign and write 'Read & approved":

Father's signature: Mother's signature: Guardian's signature:

✓ PAYMENT OF HOSPITAL'S COSTS & FEES - PERSONAL GUARANTEE

I, the undersigned...

undertake to pay the full amount of the hospitalisation costs & fees, or the full amount of hospital costs & fees that would not be covered by my insurance policy, including all examination costs, emergency consultation and all laboratory and imagery fees.

Please date, sign and hand write 'Read & approved":

✓ PROTECTION OF PERSONAL DATA

I, the undersigned..

Accept that my personal data can be shared with other care partners within Clinique Kuindo Magnin as part of my medical care.

Please date, sign and hand write 'Read & approved":

TO BE COMPLETED BY CARE SERVICES ONLY

✓ ADMISSION / PARCOURS

Mouvement : cocher si passage en chambre seule ☐

No de chambre (Room number):

- N° Chambre ....Le : .... Heure ....
- N° Chambre ....Le : .... Heure ....
- N° Chambre ....Le : .... Heure ....

☐ Isolement (Confinement) du................ au ....

☐ Soins palliatifs (Palliative care) du................au ....

☐ USC (Continuous care) du......................... au ....

MODE DE SORTIE – HOSPITAL RELEASE :

☐ Domicile (Home)

☐ Sortie sans authorisation (Unauthorized – patient signed disclaimer)

☐ Transfert dans un autre établissement CHT / CSSR (patient transferred to another care structure CHT or CSSR)

☐ Mutation au SSR de la clinique Kuindo Magnin (transferred to rehabilitation ward at Kuindo Magnin hospital)

☐ Autres (si décès) Heure - Other (date & hour of death):

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