Your Hospital's Logo Here

Street Address City, State Zip

INPATIENT ADMISSION

MED REC #:	ENCOUNTER #:

INSURANCE

PATIENT NAME:	SSN:	FC:	TYPE:	PHONE-HOME:	PHONE-WORK:			
ADDRESS:				DATE OF BIRTH:	AGE:	SEX:	RACE:	MS:
				MAIDEN NAME:				

GUARANTEE NAME EMP

	MAIDEN NAME:	
	PHONE-HOME:	PHONE-WORK:

NOTIFY

EMERGENCY NOTIFICATION:	RELATION:	PHONE-HOME:	PHONE-WORK:

INSURANCE

INSURANCE COMPANY:	POLICY #:	GROUP #:	CONTRACT HOLDER:	REL:

ADMISSION

ICD9 CODE:	ADMITTING DIAGNOSIS:						
ACCOM. ROOM / BED	SERVICE:	VIA	SRC	INFORMANT:	ADMIT BY:	ADMIT DATE:	ADMIT TIME:
ADMITTING PHYSICIAN:	ATTENDING PHYSICIAN / AHP:			PRINCIPAL PHYSICIAN:		DISCHARGE DATE:	

NARRATIVE

PRINCIPAL DIAGNOSIS: THE CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION OF THE PATIENT TO THE HOSPITAL.

OTHER DIAGNOSIS: SEQUENCE IN ORDER OF SIGNIFICANCE TO THE CASE; INCLUDE ALL RELEVANT COMPLICATIONS AND COMORBIDITIES.

SEQ #:

TNM STAGING CLASSIFICATION: (APPLIES ONLY TO NEWLY DIAGNOSED CANCER CASES WITH SOLID TUMORS)

T ___________

N ___________

M ___________

PRINCIPAL PROCEDURE: PERFORMED FOR DEFINITIVE TREATMENT, RATHER THAN FOR DIAGNOSTIC OR EXPLORATORY PURPOSES; USUALLY MOST RELATED TO PRINICIPAL DIAGNOSIS. — DATE

OTHER DIAGNOSIS: SEQUENCE IN ORDER OF SIGNIFICANCE TO THE CASE; INCLUDE ALL RELEVANT COMPLICATIONS AND COMORBIDITIES. — DATE

SEQ #:

CONSULTANTS:

DISPOSITION: ☐ Home ☐ SNF ☐ ICF ☐ HOME CARE ☐ OTHER HOSPITAL ☐ AMA ☐ OTHER INSTITUTION

☐ UNDER 48 HRS ☐ OVER 48 HRS AUTOPSY: ☐ YES ☐ NO

RESIDENT / AHP	ATTENDING PHYSICIAN	
SIGNATURE	SIGNATURE	
PRINTED NAME	PRINTED NAME	DATE

I certify that the narrative description of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

CHART COPY

PART OF THE MEDICAL RECORD

PERMISSION FOR AUTOPSY

Permission is hereby given to perform an autopsy upon ______________________________

and to remove and retain whole or parts of organs for study as necessary.

Witness ______________________ Signed ______________________ Relationship ______________________

______________________ ______________________

Date __________ ______________________

CONSENT FOR TREATMENT OF CONDITION OF ABORTION

I, the undersigned, a patient applying for admission to YOUR HOSPITAL, believe that I am in a condition of Abortion. I hereby declare that neither the attending Physician nor the Hospital, nor any person employed by or connected with said Hospital, has knowingly performed any act which may have contributed to the induction of the Abortion.

Witness ______________________ Signed ______________________

____

Date __________

DEPARTURE AGAINST MEDICAL ADVICE

This is to certify that I ______________________, a Resident in LONG TERM CARE, am leaving against the advice of the attending Physician and faculty authorities. I also acknowledge that I have been informed of the risk involved and hereby release the attending Physician and hospital from all responsibility for any of its effects which may result.

Witness ______________________ Signed ______________________

____

Date __________

APPLICATION FOR ADMISSION & RELEASE OF HOSPITAL RECORDS

1. I, ______________________, hereby apply for admission to YOUR HOSPITAL as a patient and request that I be furnished appropriate hospital care and services for the condition(s) for which I am being admitted. My Physician, Dr. ______________________, is authorized to utilize the facilities of YOUR HOSPITAL on my behalf, and I hereby authorize YOUR HOSPITAL to furnish and administer to me such diagnostic procedures, treatments, medications, and other services as my said physician may direct.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of the examination or treatment in the hospital.

3. If a health care worker is exposed significantly to my blood or body fluids, I consent to a test of my blood for hepatitis and antibodies to the virus that causes AIDS.

4. The Hospital records concerning the patient are the property of YOUR HOSPITAL and are maintained for the benefit of the patient, the medical staff and the Hospital. I hereby authorize YOUR HOSPITAL to release these records to the patient's personal physician and to any other individual and private or governmental agency responsible for payment of the patient's care and treatment.

Witness ______________________ Signed ______________________

In behalf of ______________________, who is a minor and/or unable to greant permission or sign the document and/or in need of emergency treatment, I ______________________, hereby make the aforementioned requests and give the aforementioned authority to YOUR HOSPITAL on his/her behalf.

Signature ______________________ Age __________
PERSON ACTING FOR THE PATIENT

Relationship ______________________

Address ______________________

Witness ______________________ Date __________

Was Hospital policy on placing patient's name on their door explained to patient? ☐ Yes ☐ No

FOR CHAPLAIN'S USE

Sacraments received? ☐ Yes ☐ No Date __________ Signature ______________________

PART OF THE MEDICAL RECORD