

PATIENT ADMISSION FORMCoburg
ENDOSCOPY
Centre

DR.SCOPE

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15 Munro Street Coburg
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Email Coburg:
admin@coburgendo.com.au
Email Sunshine:
reception@drscope.com.au

PLEASE COMPLETE ALL SECTIONS AND RETURN IT BY FAX OR EMAIL 3 DAYS PRIOR TO YOUR BOOKING. 03 9044 4222 (Sunshine) 03 9386 4433 (Coburg)

Contact Details:**Surgery Date:** _____

Title	Given Name	Surname
Date of Birth	Gender Male / Female	Marital Status Single – Married - Div - De Fact - Sep - Wid
Address:		Height:
		Weight:
Home Number	Work Number	Mobile Number
Email Address: (please print clearly)		Preferred method of contact: Mobile - Email - home phone

Residential Status: (circle one)

Are you an Australian Resident?	Permanent	/	Temporary	/	Visitor
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Do you live alone? Yes / No	Country / State of Birth	Are you of Aboriginal / Torres Strait islander decent? Yes / No
Language Spoken:	Do you need an Interpreter?	Specify Language:

Next of Kin / Emergency Contact Details: (this will be the person we contact if you are unavailable)

Carer/Emergency Contact person:	Relationship to Patient:	Best Contact Phone number:
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General Practitioner Details:

Name of Usual GP:	GP Address Details:	Referral Date (GP -> Specialist)
GP Phone Details:	GP Fax Details:	Provider Number:

Specialist (Gastroenterologist/Hepatologist/ Surgeon Detail:

Specialist Doctor Name:	Specialist Address:	Date Procedure Booked:
Specialist Phone Details:	Specialist Fax Detail:	Provider Number:

Patient Booking Form Continued

Do you have advanced care directives in place? Yes / No

Detail: _____

Provide Copy of any directives or Power of Attorney:

Details Attached? Yes / No

Affix Patient Label Here

Doctor's Name _____

Procedure Date: _____

Health Fund Details:

Medicare Number		Exp:	Position on Card:
Health Fund:		Membership Number:	
Veterans Affairs Number		Exp:	
Health Care Card Number		Exp:	
Do you have Ambulance Cover	Yes / No	Member Number:	

TAC / WorkCover:

Is this admission due to a TAC / work injury	Yes / No
Is the claim accepted?	Yes / No
Please attach letter of Approval. Is the letter attached?	Yes / No
Employers Contact Details :	Phone:
Insurers Contact Detail:	Phone:

IMPORTANT INFORMATION REGARDING YOUR DAY SURGERY PROCEDURE

Please indicate which procedure you are having done

Day Surgery Patients will be required to have a responsible adult to take them home and stay overnight following anaesthetic. Failure to arrange this may result in cancellation of your procedure.

Who will be taking you home on day of your procedure?	Name:
Relationship:	Contact Details:
Who will be staying with you overnight?	Name:
Relationship:	Contact Details

Have you been issued with Patient Health care rights? Yes / No

ALLERGIES / ALERTS (PLEASE LIST)
ie: Tapes/Latex/Medication/Foods /falls

Affix Patient Label Here

Infection Control Screen: (Please Tick)

Date of Admission: _____

Question	YES	NO	Question	YES	NO	Question	YES	NO
Have you been in hospital in last 7 days?			Have you been in hospital last 12 months?			Have you travelled overseas in last 12 months?		
Is your general health well?			Have you been unwell in last 7 days?			Are you on Antibiotics?		
CJD Questionnaire Relating to you and family members - please answer if you have had or if yes or no								
	YES	NO		YES	NO		YES	NO
Been diagnosed with CJD?			Dura Matter Graft			Pituitary Hormone ?		
MRSA/VRE/KPC/CRE			Measles/Mumps in last 14 days			Chicken Pox in last 14 days		
General Health Questions. Please answer Yes or No if you have had any of the following.								
	YES	NO		YES	NO		YES	NO
Asthma/Bronchitis			Pneumonia			Stroke		
Diabetes			Sleep Apnoea			Kidney Disease		
Heart Disorder/Surgery			Implants/Stents/Pacemaker			Hepatitis		
Chest Pain			Blood Clots			Thyroid Disease		
High Blood Pressure			Blood Transfusions			Pressure Area /Wounds		
Epilepsy			Bleeding disorders/Anaemia			Falls in the past 6 months		
Heart Burn/Reflux			Depression/Mental Health issues			Females – Are you pregnant		

Write any details of any Yes Answers in this space:

Other relevant clinical details:

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Affix Patient Label Here

Have you had previous Anaesthetics? Yes / No

Details:

Have you or your family ever had problems with Anaesthetic?
Yes / No

Details?

Have you or your family ever been diagnosed with malignant
Hyperthermia? Yes / No

Details?

Life style Questionnaire: (please circle answer and list answers)

Do you smoke? Yes / No

Do you use recreational Drugs Yes / No

How many per day?

List drug used and frequency.

Medications:

Do you take any blood thinning medication?

i.e. Aspirin/Warfarin/Plavix/Pradaxa Yes / No

Last taken Date:

Time:

Please list all your current medications: (please ensure that this section is filled in before your arrival at the hospital)

Pre-procedure observations:

Pulse

BP

SO2

Resp

Temperature

Height / Weight/ BMI

CM

KG

BGL

Mmol/l

Preparation Completed Y / N
Enema Required

Result: Clear/ Yellow / Brown
Solid / Liquid

Denture/Crown/Caps/Plate

Hearing aid/Glasses/ Walking Aid
Brought in Y/ N

Lift home confirmed Y / N

Overnight carer confirmed Y/N

Anaesthetist Handover Y/N

Any instruction.

Admitting Nurse:

Name.....

Designation.....

Patient last ate at:

Time:

PRIVACY: I understand that my personal and health information may be collected, used and disclosed by Dr Scope/Coburg Endoscopy and my medical practitioner for the following purposes: To provide medical treatment, Quality assurance, accreditation, liaising with the Health Insurance Commission regarding Medicare entitlements and claims, liaising with my private health insurer (if relevant) regarding health insurance entitlements and claims, liaising with other health service providers associated with my care, liaising with Government, legislative departments and at all times external consultants, administration, billing and liaising with Dr Scope/Coburg Endoscopy and the medical practitioner's lawyers and insurers.

I understand, consent to and authorise Dr Scope/Coburg Endoscopy and my medical practitioner to disclose information relating to myself and my medical condition in respect of the above mentioned conditions. I have read and understood and consent to the above Privacy Statement and have had a chance to read the Australian Charter of Health Care Rights.

Pt Name: _____ Signed: _____ Date: _____

CONSENT PAGE**PLEASE READ CAREFULLY BEFORE SIGNING.****PAC REQUIRED YES / NO (CIRCLE)**

Affix Patient label here

Procedure Consent:

I, _____ of _____

Hereby confirm that I have given consent to Dr _____

To perform the procedure of _____

On myself or _____ (the Patient)

I confirm that I have consented to such further or alternative measures as the person performing the procedure may find necessary during the course of the procedure and the administration of anaesthetic for the forgoing purpose. The answers I have given are, to the best of my knowledge true, and I have not withheld any information. I have read and understood all information provided to me by my Specialist / Coburg Endoscopy including my rights and responsibilities. I have arranged for a responsible adult to accompany me home following my procedure and to stay with me overnight. I understand that following my procedure my judgement may be impaired for several hours due to the anaesthetic administered. I have been advised not to drive, operate machinery, or sign legal documents after my procedure.

Signature (patient or guardian): _____ Date: _____

DOCTOR'S CONFIRMATION – to be completed on admission day by the specialist performing the procedure

_____ (Drs Name) has explained to the patient or person legally responsible for the nature of the above procedure and anaesthetics involved including associated risks and potential complications. In my opinion he/she has understood the explanation.

Signature of Doctor: _____ Date: _____

FINANCIAL CONSENT – to be completed on admission day with reception

I agree that I am personally responsible for payment of all hospital treatment (including pathology services where necessary) irrespective of any claim I may have against any health funds or other third party. I agree that I am personally responsible for payment of any additional doctors or anaesthetist fees. I agree that I am personally responsible for the costs of transfer to another hospital, including ambulance costs, if necessary. I understand that Coburg Endoscopy Centre will not be liable for any valuables I bring to the centre.

ESTIMATE out of Pocket costs for attendance at the centre \$ _____ (to be advised by reception)

Additional Fee (Please cross out if not applicable to visiting surgeons)

Snare: \$50.00	Polyp Trap \$10.00	Haem Banding \$70.00	Oesoph. Dilation \$75.00	Endo Clip \$150.00
Endo Marker \$120.00	Sclero. Needle/Inj. \$50.00	Argon Assist proc. \$290	Pill Cam Intro. \$150.00	Booking Fee: \$70.00 Non Refundable

Signature of patient or guardian _____ Date: _____

ALLERGIES / ALERTS (PLEASE LIST)
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Affix Patient label here

[illegible][illegible]