
Coburg
ENDOSCOPY
Centre


DR.SCOPE

PATIENT ADMISSION FORM

PLEASE COMPLETE ALL SECTIONS AND BRING WITH YOU ON THE DAY OF ADMISSION – PLEASE DO NOT POST OR EMAIL

Contact Details:	Procedure Date:
493 Ballarat Road Sunshine 15 Munro Street Coburg Ph: 03 9044 4200	

Title	Given Name	Surname	
Date of Birth	Gender (circle) Male / Female / Non-binary / Other / Prefer not to answer	Marital Status (circle) Single / Married / Divorced / De Facto/ Separated / Widowed/ Prefer not to answer	
Address:			Weight: Height:
Home Number	Work Number	Mobile Number	
Email Address: (please print clearly)		Preferred method of contact: Mobile - Email - home phone	

Are you an Australian Resident?	Permanent Y/N		Temporary Y/N	Visitor Y/N
Are you of Aboriginal / Torres Strait islander decent?	Yes	No	Both	Decline to answer
Do you live Alone?	Yes		No	
Country of Birth				
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:

General Practitioner Details:

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

All patients are required to have a responsible adult to take them home and stay overnight following procedure. Failure to arrange this will 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:

ALLERGIES / ALERTS (PLEASE LIST)	**Infection Control Screen: (Please Tick)** Affix Patient Label Here

Question	**YES**	**NO**	**Question**	**YES**	**NO**	**Question**	**YES**	**NO**
Have you been in hospital last twelve months?			Have you travelled overseas in last twelve months?			Are you generally in good health?		
In the last 7 days have you been unwell?			Are you currently taking antibiotics?					
Have you been diagnosed with CJD?			Have you had a Dura Mater Graft?			Have you been treated with Pituitary Hormone?		
Have you been diagnosed with MRSA/VRE/KPC/CRE?			Have you had Measles, Mumps, Chicken Pox in last 14 days?			Have you had any other infectious disease eg tuberculosis?		
General Health Questions. Please answer Yes or No if you have or have had any of the following.								
	YES	**NO**		**YES**	**NO**		**YES**	**NO**
Asthma/Bronchitis			Pneumonia			Stroke		
Diabetes			Sleep Apnoea			Kidney Disease		
High Blood Pressure			Thyroid Disease			Liver disease/Hepatitis		
Chest Pain			Heart Disorder/Heart Surgery			Cardiac Implants/Stents/ Pacemaker		
Blood Clots			Blood Transfusions			Bleeding disorders/Anaemia		
Epilepsy			Other neurological condition			Pressure Area /Wounds		
Heart Burn/Reflux			Depression/Mental Health issues			Falls in the past 6 months		
Sleeve Gastrectomy, Gastric Bypass or Lap banding			Bowel disorders (IBD, Crohns, Ulcerative Colitis, CDiff)			Females – Are you Pregnant?		
Delirium			Advance Care			Renal/Hepatic or Neurological condition		

Write any details of any Yes Answers in this space:

Have you or your family ever had problems with Anaesthetic? 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:

ALLERGIES / ALERTS (PLEASE LIST)	**Life style Questionnaire:** Affix Patient Label Here

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? ie: Aspirin/Plavix/Warfarin/Pradaxa? Yes / No **Last Taken: Date: Time:**	**Please list medication/ dose and frequency and last taken time:**
Other relevant clinical details:	

Clinical Assessment – Clinical staff to complete circle answer		
Date/Time of last Fluid? _____ Food?_____ Preparation Completed Y/N Result: Clear Yellow Brown Liquid Solid (circle)	Patient ID/Procedure verified? Yes Lift Home Confirmed? Yes Overnight Carer Confirmed? Yes Own Teeth Yes/No Loose Teeth Yes/No If yes notify anaesthetist	Clinical Alerts Identified
Enema required Yes/No	Denture/ Caps/Crowns/Plates? (circle)	
Weight:	Hearing Aid/Glasses/Walking aid(circle)	
Height:		
BMI:	Handover to Anaesthetist? Yes	
Admitting Nurse name, signature, and designation:		Time of Admission:

Ask the patient what are their expectations of today? _____

On discharge – Did we meet their expectations? _____

Discharge Home Arranged ☐ ADLs back to normal ☐ Foods/Fluids Tolerated ☐

Cannula removed ☐ Discharge Instructions given. ☐ Reviewed by Proceduralist. ☐

Discharge Payment Required ☐ Follow up appointment ☐ Gastro ☐ GP ☐

Nurse signature on discharge _____ Time of discharge: _____

Carer Name and signature on discharge _____

CONSENT PAGE PLEASE READ CAREFULLY BEFORE SIGNING.	**Procedure Consent:** Affix Patient label here

I, _____ of (address) _____

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 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/ Dr Scope 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 anaesthetic involved including associated risks and potential complications. In my opinion he/she has understood the explanation.

Signature of Doctor: _____ Date: _____

PRIVACY STATEMENT AND CONSENT- to be completed by patient.

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.

Signature of Doctor: _____ Date: _____