DIGESTIVE HEALTH CENTRE REGISTRATION FORM

……………………………………………………………Mr/Mrs/Miss/Ms ……………………………………………………………………………
Surname ***Given Names*** ***Preferred Name***

If you were here previously was it under a different name? ………………………………………………………………………………………

Medicare No ……………………………………………………**Ref No** (No. next to name) ……… **Expiry Date** ……………………….

Address ……Postcode ……………

Telephone: Home……………………………………..Work …………………………. Mobile ……………………………………………

Email ………………………………………………………………………………………………..

Date of birth: …………………………………Country of birth ……………………………………….Aboriginal/Torres Strait Island descent? Yes/No

Marital Status: Married/Single/Widowed/Divorced/Defacto/Separated (Please circle) Occupation ……………………………………..

Date of referral ………………………………………..Referring doctor. ……………………………………………………………………..

Usual family doctor ………………………………………………………………

Is your colonoscopy part of the National Bowel Cancer Screening Programme? Yes/No

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INSURANCE DETAILS

Private insurance ☐ No ☐ Yes Name of Fund ……………………………………………Membership No………………………………

Work cover ☐ No ☐ Yes Insurance co.. ……………………………………Claim no……………………………………

Veteran Affairs Card No……………………………………………………. Gold/White

Pension Card No ………………………………………………… Health Care Card No ………………………………………………………

Expiry date ……………………………………………………………

HOW DID YOU HEAR ABOUT US?

☐ GP ☐ previous patient ☐ Family /friend recommendation ☐ Yellow Pages ☐ White pages
☐ DHC website ☐ Google ☐ Bowls club ☐ RSL Club ☐ Attended a talk ☐ Local paper

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Next of kin/Emergency Contact …………………………………………………Relationship……………………………………………….

Contact Home ………………………………………………………Mobile …………………………………………………………….

PERSONAL INFORMATION CONSENT

We require your consent to enable us to handle personal information about you. Please read the privacy policy carefully, and sign where indicated below. If you have any concerns or queries about this, feel free to ask us for a further explanation.
I have had the opportunity to read this centre's private policy and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I understand that my healthcare is a partnership between me and the health professionals at The Digestive Health Centre and will take reasonable steps to ensure that I provide up-to-date contact information both now and in the future to enable The Digestive Health Centre to contact me for follow-up purposes.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
I consent to the handling of my information by this centre today and in future visits for the purposes set out in the privacy policy handed to me today, subject to any limitations on access or disclosure of which I may notify this centre.

Signature:……………………………………………………………………… Date:………../……………/20….

Name:……………………………………………………………………..

PRE-ADMISSION ASSESSMENT

P.A. CLINIC:	Date: ……………………………..	ADMISSION:	Date:……………………………………………
Patient Name:			Time: …………………………………………..

B. DO ANY OF THE FOLLOWING RELATE TO YOU (please √)

	Yes	No		Yes	No
Heart attack/angina/pacemaker/ heart valve problems/ heart surgery/			Exposure to the AIDS virus		
Stroke			Epilepsy/fits/seizures		
High blood pressure			Migraines		
Diabetes			Hearing Loss		
Cancer			Sight loss		
Bleeding problems			Intellectual/Physical disability requiring carer/physical aid/physical assistance		
Asthma/breathing problems			Pregnant or breast feeding		
Hepatitis/jaundice			Smoker, if yes, how many/day		
Kidney disease			Ex smoker		
Do you drink alcohol? If yes how many glasses/day?			Is there a family history of bowel cancer/polyps?		
Do you use social drugs eg cocaine, marijuana, speed?			Is there a family history of stomach cancer?		

C. HAVE YOU: Received growth hormone injections before 1985, undergone brain/spinal surgery before 1992, received a corneal implant or have any other risk of Creutzfeldt-Jakob disease? **YES/NO**

D. IF NOT ALREADY WRITTEN ON YOUR REFERRAL, PLEASE LIST ALL ILLNESSES, OPERATIONS & MEDICAL CONDITIONS THAT YOU HAVE HAD IN THE PAST.

E. PLEASE LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING COMPLEMENTARY/NATURAL MEDICINES

F. DO YOU TAKE ANY TABLETS TO THIN THE BLOOD ie. warfarin/coumadin/plavix/iscover/aspirin
(If yes, please circle) **YES/NO**

G. DO YOU HAVE ANY ALLERGIES? ie drugs, tapes, latex, foods. YES/NO If yes, please list

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H. HAVE YOU EVER HAD ANY COMPLICATION FROM A GENERAL ANAESTHETIC? YES/NO

NURSING ASSESSMENT SUMMARY *INDICATION:*			
PREP GIVEN:			
COPIOUS FLUIDS:	*EFFERVESCENCE:*	*POLYPS:*	*BGL'S:*
REFLUX: *PPI:* *FHX:*			
OTHER:			
Referral to Doctor for Day Procedure Suitability Assessment			**YES/NO**
Height …………cm Weight ………………Kg, : BMI ……………………SIGNATURE:…………………………………………………………………			