

The Digestive Health Centre
Pre-admission Assessment and Registration Form

Title _____ **Surname**

Mr **1st Name** **Middle Name**

Mrs **Preferred Name**

Miss **Has your surname changed since your last visit** **Yes** **No**

Master

Other

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

Address **Postcode**

Telephone: Home..... **Work** **Mobile**

Email I understand that by giving my email address, I am consenting to receive emails from Digestive Health Centre. I also understand that I can choose to “opt out” at any time.

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

Occupation **Language Spoken** **Interpreter required** Yes/No

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

Date of referral **Referring doctor.**

Usual family doctor

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

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

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 privacy 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:..... **Name:**..... **Date:**/...../20.....

The Digestive Health Centre

Pre-admission Assessment and Registration Form

PRE-ADMISSION ASSESSMENT

Patient Name: _____

UR: _____

<input type="checkbox"/> Face to Face	<input type="checkbox"/> Phone	Date: _____	Time: _____	ADMISSION - Date: _____	Time: _____
Medical History reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Gastroscopy	<input type="checkbox"/> Colonoscopy
Further action required: <input type="checkbox"/> Yes <input type="checkbox"/> No				Comments: _____	

DO ANY OF THE FOLLOWING RELATE TO YOU? (Please tick Yes or No and circle appropriate condition)

	Yes	No		Yes	No
Heart attack / angina / pacemaker / Congenital disease / valve problems/ heart surgery / palpitations			Do you drink alcohol? If yes how many glass/day?		
			Do you use social drugs eg cocaine, marijuana?		
Internal defibrillator			Smoker, if yes, how many/day		
Any other heart condition			Ex smoker		
Diabetes: Diet / Tablets / Insulin			Major Hearing Loss		
Cancer			Major Sight loss		
Blood clots in legs / lungs			Exposure to the AIDS virus		
Asthma / breathing problems / TB / Sleep apnoea			Pregnant or breast feeding		
Hepatitis / jaundice			Intellectual/physical disability requiring carer		
Kidney disease			Migraines		
High blood pressure					
Stroke			Is there a family history of bowel cancer / polyps?		
Epilepsy / fits / seizures / faints			Is there a family history of stomach cancer?		

PLEASE LIST ALL ILLNESSES, OPERATIONS & MEDICAL CONDITIONS THAT YOU HAVE HAD IN THE PAST.

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING INCLUDING COMPLEMENTARY/NATURAL MEDICINES

Do you have any allergies? i.e. drugs, tapes, latex, food <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Do you take any tablets to thin the blood? i.e. Warfarin, Aspirin, Plavix, Iscover, Xaralto <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Have you, or any blood relatives, had any problems with general anaesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Do you have a history of falls or are you at risk of falls? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Have you had an infectious disease in the last six months? E.g. MRSA, VRE, Norovirus, Clostridium Difficile <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Do you have any open wounds, ulcers, cuts, pressure areas, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Have you received growth hormone injections between 1980 and 1995, undergone brain/spinal surgery before 1992, received a corneal implant, or have any other risk of Creutzfeldt-Jakob disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Do you have any problems lying on your left side? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Have you recently travelled (within the past 4 weeks) to West Africa? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Have you had an overnight stay in an overseas residential aged care facility or hospital in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Do you have any objection to receiving blood or blood products? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Weight _____(kg) Height _____(cm)	
Alerts <input type="checkbox"/> Yes <input type="checkbox"/> No	DOCUMENT ON ALERT FORM
NURSING ASSESSMENT SUMMARY INDICATION:	
Prep Given: _____	BGLs: _____
PPI: _____	FHx: _____
Discharge/Carers Instructions/Responsibilities explained and given to patient: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments: _____	