The Digestive Health Centre

Pre-admission Assessment and Registration Form

Title

☐ **Mr**

☐ **Ms**

☐ **Mx**

☐ **Mrs**

☐ **Miss**

☐ **Master**

Surname ……

First Name ……

Middle Name ……

Preferred Name ……

Pronoun choice ☐ **he/him** ☐ **she/her** ☐ **they/them**

☐ **Other** **Has your surname changed since your last visit** ☐ **Yes** ☐ **No**

Sex ☐ **Male** ☐ **Female** ☐ **Non-binary** ☐ **Other**

Medicare Number ……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 ……..
Do you identify as being of Aboriginal or Torres Strait Islander origin? Please Circle
No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander Decline to answer
Occupation …….. Language Spoken …… Interpreter required Yes/No

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

Usual family doctor ……

Is your colonoscopy part of **the National Bowel Cancer Screening Program**? 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 ……

Have you appointed a Medical Treatment Decision Maker (MTDM)? ☐ Yes ☐ No

A MTDM is a nominated person who makes medical treatment decisions on behalf of a person who does not have decision-making capacity.

If No, Under the MTPD Act 2016 the hierarchy system is followed. Spouse, primary carer, oldest adult child, oldest parent, oldest adult sibling

If Yes, please note details below

Name …… Relationship …… Contact number ……

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……

PRE-ADMISSION ASSESSMENT Patient Name: UR:

☐ Face to Face ☐ Phone Date: Time:	ADMISSION - Date: Time:
Medical History reviewed: ☐ Yes ☐ No	☐ Gastroscopy ☐ Colonoscopy
Further action required: ☐ Yes ☐ 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			Pregnant or breast feeding		
Asthma / breathing problems eg; shortness of breath/ TB / Sleep apnoea			Is there a family history of bowel cancer / polyps?		
Cold / Flu symptoms Eg; Sore throat/Cough/runny nose/chills or a Chest infection in the past 14 days			Is there a family history of stomach cancer?		
Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B?			Migraines		
Recent loss of sense of smell or taste?			Epilepsy / fits / seizures / faints		
Kidney disease			Intellectual/physical disability requiring carer		
High blood pressure			Have you had any difficulty thinking clearly lately?		
Stroke			Have you ever been diagnosed dementia?		
Do you take any medications to assist you with your mental health?			Have you ever had an episode of delirium?		
Do you have any current mental health issues?					

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 ☐ Yes ☐ No Comments:
Do you take any tablets to thin the blood? i.e. Warfarin, Aspirin, Plavix, Iscover, Xaralto ☐ Yes ☐ No Comments:
Have you, or any blood relatives, had any problems with general anaesthesia? ☐ Yes ☐ No Comments:
Do you have a history of falls or are you at risk of falls? ☐ Yes ☐ No Comments:
Have you had or been exposed to a person with an infectious disease in the past 14 days? E.g. Chicken Pox, Measles ☐ Yes ☐ No
Have you ever been infected or colonised by MRSA, VRE, CRE/CPE, Norovirus, Clostridium Difficile? ☐ Yes ☐ No
Have you been diagnosed with COVID-19? ☐ Yes ☐ No If Yes; *Date:* Have you been symptom free for 4 *weeks* post recovery? ☐ Yes ☐ No
Are you currently required to self-isolate or quarantine, or awaiting a COVID-19 test result (except if you are part of a surveillance program)? ☐ Yes ☐ No
Are you a resident of an aged care facility? ☐ Yes ☐ No Comments:
Do you have any open wounds, ulcers, cuts, pressure areas, or other skin problems? ☐ Yes ☐ No Comments:
Do you have any problems lying on your left side? ☐ Yes ☐ No Comments:
Have you travelled overseas in the past 14 days? ☐ Yes, where? ☐ No Comments:
Have you had an overnight stay in an overseas residential aged care facility or hospital in the past 12 months? ☐ Yes ☐ No

Comments:			
Do you have any objection to receiving blood or blood products? ☐ Yes ☐ No Comments:			
Weight_____(kg) Height_____(cm)			
Alerts ☐ Yes ☐ No DOCUMENT ON ALERT FORM			
NURSING ASSESSMENT SUMMARY INDICATION:			
Prep Given:	BGLs:	BMI:	Reflux:
PPI:	FHx:		Signature:
Discharge/Carers Instructions/Responsibilities explained and given to patient:			☐ Yes ☐ No
Morning medications discussed			☐ Yes ☐ No
Comments:			