

The Digestive Health Centre
Pre-admission Assessment and Registration Form

Title Surname
Mr First Name
Ms Middle Name
Mx Preferred Name
Mrs Pronoun choice he/him she/her they/them
Miss
Master 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

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
Consent to access and upload to My Health Record? Yes No
Have you appointed a Medical Treatment Decision Maker (MTDM)? p 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

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PRE-ADMISSION ASSESSMENT

Patient Name:

UR:

DOB:

<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?		
Internal defibrillator			Do you use social drugs eg cocaine, marijuana?		
Any other heart condition			Smoker, if yes, how many/day		
Diabetes: Diet / Tablets / Insulin			Ex smoker		
Cancer			Major Hearing loss		
Blood clots in legs / lungs			Major sight loss		
Asthma / breathing problems eg; shortness of breath/ TB / Sleep apnoea			Pregnant or breast feeding		
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 bowel cancer / polyps?		
Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B?			Is there a family history of stomach cancer?		
Recent loss of sense of smell or taste?			Migraines		
Kidney disease			Epilepsy / fits / seizures / faints		
High blood pressure			Intellectual/physical disability requiring carer		
Stroke			Have you had any difficulty thinking clearly lately? (With cognitive impairment)		
Do you take any medications to assist you with your mental health?			Have you ever been diagnosed dementia?		
Do you have any current mental health issues?			Have you ever had an episode of delirium?		
			Weight loss surgery/procedure		

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

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING INCLUDING WEIGHT LOSS MEDICATION AND ANY 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 or been exposed to a person with an infectious disease in the past 14 days? E.g. Chicken Pox, Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been infected or colonised by MRSA, VRE, CRE/CPE, Norovirus, Clostridium Difficile? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes; <u>Date:</u>
Have you been symptom free for 4 <u>weeks</u> post recovery? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a resident of an aged care facility? <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:
Do you have any problems lying on your left side? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:

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Patient Name:	UR:	DOB:
Have you travelled overseas in the past 14 days? <input type="checkbox"/> Yes, where? <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:	BMI:
PPI:	FHx:	Signature:
Discharge/Carers Instructions/Responsibilities explained and given to patient:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Morning medications discussed		<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		