VICTORIAN GUT CENTRE

ADMISSION FORM

Please complete and return this form at least one week before your procedure.

☐PREADMISSION COMPLETE
☐ALERT PRESENT

Address: 119 Plenty Rd, Bundoora, VIC 3083
Ph: (03) 9466 8466 Fax: (03) 9466 8455
Email: reception@vicgut.com.au

Date of Admission: DD/MM/YYYY

GENERAL INFORMATION

How did you hear about us? ☐GP ☐Specialist/Surgeon ☐Internet ☐Friend/Relative ☐Previous Patient

Have you had a consult with a gastroenterologist or surgeon in the last 30 days? ☐Yes ☐No

Planned procedure/s: ☐Gastroscopy ☐Colonoscopy ☐Flexible Sigmoidoscopy ☐Iron Infusion

LAST NAME:	**TITLE**	**GIVEN NAME/S:**	**PREFERRED NAME:**

Home address:	**Suburb:**	**Postcode:**

Date of birth: dd/mm/yyyy	**Email:**	**Height**
Age:	**Mobile:**	**Weight**
Country of birth:	**Home Ph:**	**BMI**

Pronouns	☐She/her	☐He/him	☐They/them	☐Different term, specify:	☐By name
Gender	☐Female	☐Male	☐Non-binary	☐Different term, specify:	☐Prefer not to say
Sex at birth	☐Female	☐Male	☐Another term, specify		

Are you of Aboriginal or Torres Strait Islander Origin?
☐No ☐Yes, Aboriginal ☐Yes, Torres Strait Islander ☐Yes, Both Aboriginal and Torres Strait Islander ☐Decline to Answer

Do you have any religious/cultural needs? ☐Yes ☐No If yes, specify

Do you need an interpreter? ☐Yes ☐No If yes, ☐family to interpret ☐professional interpreter
Preferred language: (*Costs apply if no Medicare*)

Referring doctor's name: Address: Phone:

MEDICARE, HEALTH FUND AND OTHERS

Medicare Number:	**No. In Front of Name:**	**Expiry:** ☐ Do not have Medicare

Individual Health Identifier for My Health Record (MHR): ☐ Do not upload to MHR

Private Health Insurance: Yes / No	Fund Name:	Membership no:
Are you currently an in-patient in any hospital? Yes / No	Any excess paid in the last 12 months? Yes / No	Excess Or Co-Payment: $
Department Of Veterans Affair (DVA) Yes / No	DVA Card Number:	Card Colour: ☐ Gold ☐ White
Is this a Workcover or TAC:	Yes / No	Workcover or TAC approval number:

ALL PATIENTS RECEIVING SEDATION MUST HAVE A RESPONSIBLE ADULT TO ACCOMPANY THEM HOME AND STAY WITH THEM AT HOME OVERNIGHT

CERTIFICATE/S	☐Medical certificate ☐Carer certificate ☐Not Applicable		
REQUIRED: Pick-up person	Name:	Relationship	Contact no.
REQUIRED: Staying with you at home after discharge	Name:	Relationship	Contact no.
REQUIRED: Next of kin or emergency contact	Name:	Relationship	Contact no.

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

HEALTH QUESTIONNAIRE DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE PROVIDE FURTHER INFORMATION		
1. Blood pressure ☐ High ☐ Low	☐ Yes ☐ No	Is it controlled with medication?
2. Heart attack	☐ Yes ☐ No	When?
3. Arrhythmia or irregular heartbeat	☐ Yes ☐ No	Resolved? Is it controlled with medication?
4. Angina or chest pain	☐ Yes ☐ No	How frequently?
5. ☐Heart surgery ☐Pacemaker ☐Defibrillator ☐Stents	☐ Yes ☐ No	Last date of check up with cardiologist?
6. Other heart problems	☐ Yes ☐ No	If yes, specify
7. Asthma	☐ Yes ☐ No	Is it controlled with medication? When was the last asthma attack? **PLEASE BRING YOUR PUFFER**
8. Other lung issues or shortness of breath	☐ Yes ☐ No	Specify
9. Difficulty walking up more than two flights of stairs	☐ Yes ☐ No	What stops you from walking further?
10. Sleep apnoea	☐ Yes ☐ No	Do you use a CPAP machine?
11. Diabetes ☐Type 1 ☐Type 2	☐ Yes ☐ No	☐Diet controlled ☐Tablets ☐Insulin
12. Thyroid problems	☐ Yes ☐ No	Specify
13. Stomach problems	☐ Yes ☐ No	☐Hiatus hernia ☐Reflux ☐Ulcer ☐Heartburn ☐Other:
14. Bowel problems	☐ Yes ☐ No	☐Crohn's ☐Colitis ☐Stoma ☐Other, specify
15. Liver disease	☐ Yes ☐ No	Specify
16. Weight loss surgery	☐ Yes ☐ No	Details
17. Kidney disease	☐ Yes ☐ No	☐Dialysis ☐Renal Impairment ☐Other, specify
18. Bladder problems	☐ Yes ☐ No	☐Incontinence ☐Urinary Retention ☐Stoma
19. Blood clots in the ☐legs or ☐lungs or ☐ Stroke	☐ Yes ☐ No	When? Resolved?
20. Blood disorders	☐ Yes ☐ No	☐Anaemia ☐Low Iron ☐Bruising or bleeding tendency
21. Cancer	☐ Yes ☐ No	Location and treatment received:
22. Arthritis: ☐Rheumatoid ☐Osteo	☐ Yes ☐ No	
23. ☐Back or ☐neck injury or other problems	☐ Yes ☐ No	Do you have any limitation in neck movement? ☐Yes ☐No Can you tolerate laying on your left side? ☐Yes ☐No
24. Difficulty swallowing or opening your mouth	☐ Yes ☐ No	Specify
25. ☐Epilepsy ☐Seizures (Fits)	☐ Yes ☐ No	When?
26. ☐Blackouts ☐Dizziness ☐Balance problems	☐ Yes ☐ No	Specify
27. ☐Short term memory loss ☐Dementia	☐ Yes ☐ No	Specify
28. Visual condition	☐ Yes ☐ No	☐Glasses ☐Contact Lenses ☐Other, specify
29. Hearing condition	☐ Yes ☐ No	☐Hearing Aids ☐Other, specify
30. Dental condition	☐ Yes ☐ No	☐Dentures ☐Caps ☐Crowns ☐Implants ☐Recent dental treatment ☐Loose/chipped tooth

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

31. Lymphoedema (swelling in arms or legs)	☐ Yes ☐ No	Location:
32. Other medical conditions or disabilities not already mentioned	☐ Yes ☐ No	Specify:
33. Do you suffer from ☐anxiety, ☐depression, ☐ other mental conditions?	☐ Yes ☐ No	Specify:
34. Do you ☐smoke or ☐vape?	☐ Yes ☐ No	How many cigarettes per day? **PLEASE STOP SMOKING 2 DAYS BEFORE YOUR PROCEDURE**
35. Do you use recreational drugs?	☐ Yes ☐ No	What do you take and how often? **PLEASE DO NOT TAKE 2 DAYS BEFORE YOUR PROCEDURE**
36. Do you drink alcohol?	☐ Yes ☐ No	How often?
37. Have ☐you or a ☐family member ever had problems with anaesthetics?	☐ Yes ☐ No	☐ Nausea or vomiting ☐ Malignant Hyperthermia ☐Others:
38. Have you had an episode of delirium or aggression after anaesthetics?	☐ Yes ☐ No	Specify:
39. Could you be pregnant?	☐ Yes ☐ No	
40. Do you have an advanced care directive or treatment limiting order?	☐ Yes ☐ No	***This is a document that lists your preferences for future medical treatment i.e. consenting to or refusing specific types of treatment, should you lose decision-making capacity. If yes, please attach a copy to this form.***
41. **Infection:** Do you have any multi-resistant infections?	☐ Yes ☐ No	☐MRSA ☐VRE ☐CRE ☐C. Difficile ☐Other, specify: Active or inactive?
42. Do you have/have you had COVID-19?	☐ Yes ☐ No	When? Symptoms? Did you receive treatment in hospital? Fully recovered?
43. Have you been unwell in the past 2 weeks?	☐ Yes ☐ No	Details:
44. Have ☐you or a ☐family member been recently exposed to a communicable disease?	☐ Yes ☐ No	☐ Shingles ☐ Chickenpox ☐ Measles ☐ Whooping cough ☐ Other, specify
45. Have you returned from an overseas trip in the past 30 days?	☐ Yes ☐ No	Country: Have you been unwell since return?
46. Have you been hospitalised overseas or in another facility in the past 12 months?	☐ Yes ☐ No	Hospital: Reason: Date:
47. **Skin integrity:** Do you have wounds or breaks in your skin?	☐ Yes ☐ No	Details: **Please cover with dressing, if possible.**
48. **Falls history:** Have you had a fall in the last 12 months?	☐ Yes ☐ No	☐Slipped ☐Tripped ☐Lost balance - when? Did you sustain an injury?
49. Limb paralysis or weakness - ☐right ☐left	☐ Yes ☐ No	Any limitations in movement?
50. Do you use a walking aid?	☐ Yes ☐ No	☐ Stick ☐ Frame ☐ Other, specify **MUST BRING ON ADMISSION DAY**
51. Do you need help with ☐moving ☐dressing or ☐undressing?	☐ Yes ☐ No	Details:
52. Do you have anaphylaxis?	☐ Yes ☐ No	Details: **PLEASE BRING YOUR ADRENALINE AUTOINJECTOR, IF ANY**
53. Do you have any known allergy or adverse reaction?	☐ Yes ☐ No	Details: Reactions:
54. Do you have a dietary restriction or food intolerance?	☐ Yes ☐ No	Details: Reactions:

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

CURRENT MEDICATIONS		PLEASE TICK BOX IF THIS APPLIES	
Please list all medications below. Include blood thinners, steroids, diabetic medications, over the counter medications, inhalers, topical, eye drops, pain relievers, herbal medication. **PLEASE ATTACH A SEPARATE SHEET IF REQUIRED**		**If you are diabetic or on blood thinners:** ☐ I have discussed a diabetes / blood thinners management plan with a doctor/nurse.	
MEDICATION	DOSE	MEDICATION	DOSE

SURGICAL HISTORY
Please list any previous operations or procedure and dates. Attach a separate sheet if required.

PATIENT'S DECLARATION		
I hereby declare that the above information is true and correct to the best of my knowledge.		
Name:	Signature:	Date: dd / mm / yyyy

PRE-ADMISSION NURSE TO COMPLETE THIS SECTION (TICK ALL THAT APPLIES)	
☐No change in condition or health since completion of last health assessment </= 12 months	☐Current medications list attached and patient has not started taking new medication ☐Not Applicable
Alert Form ☐Completed ☐Not Applicable	☐Patient is currently well (no cough, cold or other illness)
☐Weight and BMI within admission criteria	☐Suitable for admission ☐Not suitable for admission
☐Patient has arranged for pick-up person and overnight carer at home	☐Referred to anaesthetist for review Via ☐Phone ☐Email ☐Text Message ☐Face-To Face ☐Outcome Recorded
Pre-admission notes:	
Pre-admission completed by (initials):	Date: dd/mm/yyyy Time:

RECEPTION - ADMISSION		
Patient ID and procedure confirmed	Admin initials:	Time:

Patient Rights

My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights.**

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access
- Healthcare services and treatment that meets my needs

Safety
- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect
- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership
- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information
- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy
- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback
- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

PUBLISHED JULY 2019

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information ask a member of staff or visit safetyandquality.gov.au/your-rights

Patient Responsibilities

Patients play a vital role in ensuring a smooth and successful healthcare experience. Here's a breakdown of key patient responsibilities while in our care:

Communication and Information Sharing:

- **Provide Accurate Information:** Share complete and accurate medical history, including medications, allergies, and past procedures. This helps us make informed decisions about your treatment.
- **Ask Questions:** Don't hesitate to ask questions about your diagnosis, treatment options, potential risks and benefits, and anything else you're unsure about.
- **Express Concerns:** Clearly communicate any concerns you have about your care or well-being.
- **Be an Active Participant:** Engage in discussions with our team and participate in decision-making as much as you're able and comfortable.

Treatment and Follow-Through:

- **Follow Instructions:** Adhere to prescribed medications, treatment plans, and follow-up appointments.
- **Inform Staff of Changes:** Report any changes in your health condition, side effects you experience, or new medications you start taking.

Respect and Courtesy:

- **Arrive Prepared:** Bring necessary documents (insurance information, referral papers) and arrive on time for appointments.
- **Be Respectful:** Treat our staff with courtesy and respect, even during stressful situations.
- **Be Patient:** Understand that things may not go as planned and there may be wait times.

Safety and Well-being:

- **Disclose Advance Directives:** If you have an Advanced Directive or Tretament Limiting Order, inform us and/or your family members.
- **Maintain a Safe Environment:** Do not bring in dangerous items or substances to the facility.
- **Be Mindful of Others:** Respect the privacy and well-being of other patients when sharing personal information or making noise.

Financial Responsibility:

- **Understand Billing:** Familiarize yourself with potential healthcare costs and insurance coverage beforehand.
- **Inquire About Costs:** Don't hesitate to ask about the cost of procedures or medications before you consent to them.

By understanding and upholding these rights and responsibilities, you contribute to a more efficient, effective, and positive healthcare experience for yourself and our team.