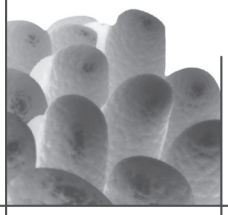
Admission Date:_____ Endoscopist: _____

Previous Patient: YES NO Known to Endoscopist: YES NO

Procedure: Gastroscopy Colonoscopy

Pre-Admission Form



119 Plenty Road
Bundoora 3083
A.B.N 28 121 644 497
Telephone: 03 9466 8466
Fax: 03 9466 8455

BUNDOORA ENDOSCOPY

INSTRUCTIONS FOR PATIENT:

- ***Please complete both sides of this form and return to Bundoora Endoscopy at least 5 working days prior to your admission.***
- *Bring your Medicare, Health Care and Health Fund details on the day of admission.*
- *Do not bring valuables with you.*
- *Wear comfortable clothing.*
- ***Hospital accounts are to be settled on the day of your procedure.***
- ***Please be advised that all doctors try to keep to time but sometimes there are unexpected delays due to unavoidable circumstances.***

IMPORTANT PATIENT INFORMATION

Gatroscopy: Nothing to eat or drink for 6 hours prior to your procedure time.
Colonoscopy: Please refer to the detailed instruction sheet inside the bowel preparation kit.

Allow 2 hours for this procedure.
If you have any questions at any stage do not hesitate to ask.

SURNAME **TITLE** **GIVEN NAMES**

MEDICARE NUMBER **EXPIRY** **SEX** **D.O.B** **COUNTRY OF BIRTH**

/ M F / /

ADDRESS

VIC NSW SA WA QLD NT ACT TAS
PLEASE CIRCLE

MARITAL STATUS
Married/De-facto
Never Married
Widowed
Divorced
Separated
Unknown

Are you of Aboriginal or Torres Straight Islander Descent?
YES NO

STATE **POSTCODE**

PHONE HOME **PHONE WORK** **MOBILE** **EMAIL**

REFERRING GP PH:

ADDRESS:

HEALTH FUND MEMBER NO LEVEL

PENSION: TYPE NUMBER

PERSON RESPONSIBLE FOR ACCOUNT: **PATIENT** **OTHER** ***please specify*** ……

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME PHONE RELATIONSHIP

I have someone to take me home NAME PHONE

OR

I will be going home by taxi Do you live alone? YES NO

DO YOU HAVE ANY ALLERGIES (Food, Medication, Tape, Latex)**?** YES NO

Please Specify: _____

PATIENT DECLARATION:

I agree to be personally responsible for payment of all hospital treatment irrespective of any claim I may have against any health funds or third party. The answers that I have given to all questions are true to the best of my knowledge and I have not withheld any information. I understand that should I require admission to another hospital for further care I will be responsible for the costs involved. Following the procedure I will have a responsible adult take me home. I realise that impairment of full mental alertness may persist for the rest of the day. **I will not drive a car, operate machinery, drink alcohol or sign any legal documents on the same day after the procedure. I will not leave the hospital unescorted.**

Print Name: _____ **Signature:** _____ **Date:** _____
(If under 18, Parent or Guardian to sign)

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Please tick Yes or No as applicable

	Yes	No
High Blood Pressure		
Pacemaker		
Heart murmur/irreg/palps		
Heart Bypass		
Valve Replacement		
Heart Attack		
Chest pain/angina		
Stroke		
Diabetes		
Epilepsy/Fits		
Asthma/Bronchitis		
Shortness of Breath		
Obstructive Sleep Apnoea		
Persistent cough		
Emphysema		
Gastrointestinal disorder		
Bleeding tendency		
Hepatitis A, B, C		
Tuberculosis		
Psychiatric illness		
Rheumatic fever		
Pregnant		
Kidney/Bladder problems		
Fainting		
Migraine		
Arthritis		
Ankle/leg swelling		
Physical handicap		
Prosthesis		
Dentures		
Crowns/Caps		
Loose/chipped teeth		
Hearing aid		
Glasses		
Contact lenses		
Walking Aid		

Other_____

Pre-Admission Nurse:

Date:_____

Name:_____

Sign:_____

Admitting Nurse:

Name:_____

Sign:_____

Date:_____

Time:_____

Attach Bradma Here

Please answer the questions below as accurately as possible

Your weight _____kg Your height _____cm BMI _____

Why are you having this procedure? _____

Have you had this procedure before? YES NO

What was the result? _____

Do you drink coffee? YES NO Quantity per day _____

Do you smoke? YES NO EX Quantity per day _____

How often do you drink alcohol? _____

Have you ever had any serious illness or disease? YES NO
Please give details: _____

Have you had previous surgery? YES NO
Please specify:_____

Have you ever had problems with an anaesthetic? YES NO
Please give details:_____

Are you currently taking any medications, vitamins or natural remedies? YES NO
Please list: _____

Are you currently taking blood thining/aspirin based medication? YES NO
Are you currently taking MAOI medication? YES NO

Do you have any reason to believe that you may have been exposed to a virus which causes:

HIV (Aids) YES NO
CJD (Creutzfeldt-Jakob) YES NO

Have you had a dura mater or corneal graft? YES NO
Have you received human growth hormone? YES NO

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