



Coburg
ENDOSCOPY
Centre

Coburg Endoscopy & Day Centre Pty Ltd
A.B.N. 74 124 050 804
15 Munro Street Coburg 3058
Telephone: 9386 4422 Facsimile: 9386 4433

Patient Label

• PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN 7 DAYS PRIOR TO THE ADMISSION DATE
• PLEASE TELEPHONE THE CENTRE TO CONFIRM YOUR APPOINTMENT 2 DAYS PRIOR TO YOUR PROCEDURE
FAILURE TO DO SO MAY RESULT IN CANCELLATION OF YOUR PROCEDURE

Doctor: _____ Procedure: _____

Date: _____ Time: _____

Surname: _____ Contacted Patient: _____

Given Name: _____ M F

Have you previously been a patient at the Centre before? Yes No

Address: _____

Suburb: _____ Postcode: _____

Telephone Home: _____ Telephone Work: _____

Mobile phone number: _____ Occupation: _____

Date of Birth (DD/MM/YY): _____ Country of Birth: _____

Are you Torres Strait Islander/Aboriginal? Yes No Australians only: State Born _____

Marital Status: Married Single Defacto Separated Widowed Divorced

Next of kin: _____ Relationship: _____

Will You have overnight company after your procedure Yes No

Transport Home/Carer: _____ Phone Number: _____

GP/Family Doctor's Name: _____

Address: _____

Please complete your details below:

Height	Weight	BMI

Phone Number: _____

Medicare Number: _____ No. next to your Name: _____ Expiry Date: _____

Pension Number: _____

Private Health Fund: _____
Table: _____
Membership No: _____
Excess Applicable: Yes No
Confirmed: Yes No
Health Fund Contact Name: _____
Date Joined: _____

Workcover/TAC: _____ Claim Number: _____
Employer Name: _____
Employer Address: _____
Date of Accident: _____
Insurance Company: _____
Contact Name/Phone Number: _____

Financial Consent:
I agree that I am personally responsible for payment of all hospital treatment (including pathology services where necessary) irrespective of any claim I may have against any health funds or other third party. I agree that I am personally responsible for payment of any additional doctors or anaesthetists fees. I agree that I am personally responsible for the costs of transfer to another hospital if necessary. I understand that Coburg Endoscopy Centre will not be liable for any valuables I bring to the Centre.

Patient Signature: _____ Date: _____

ADMISSION FORM

Medical History:

Have you ever suffered any of the following?

Complaint	YES	No
High Blood Pressure		
Heart Problems		
Stroke		
Rheumatic Fever		
Blood Clots – Lungs / Legs		
Kidney Disease		
Anaemia		
Diabetes: Insulin <input type="checkbox"/> Tablet <input type="checkbox"/> Diet <input type="checkbox"/>		
Asthma / Bronchitis		
Sleep Apnoea / CPAP		
Chest Infections		
Epilepsy / Fits		
Heartburn / Reflux		
Recent cold / cough / sore throat		
Chest pain / Angina		
Fallen/Nearly fallen in last 12 months		
Hepatitis		
Recent Dental Treatment		
Pacemaker		
If yes - Defibrillating <input type="checkbox"/> Fixed <input type="checkbox"/>		
Is there a possibility you may be pregnant		
Are you currently breastfeeding		

Anaesthetic History

Have you, or any member of your family suffered complications from an anaesthetic? Yes No

If yes, please give details:

Creutzfeldt Jakob Disease

YES NO

Have you had a dura mater graft between 1972-1989?		
Have you had Brain or Back Surgery between 1972-1989?		
Do you have a family history of two or more relatives with CJD or unspecified progressive neurological disorder?		
*Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?		
*Has the patient suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?		
*Have you had a corneal transplant (eye surgery)?		

* This related to mad cow's disease, if you have any questions regarding this question ask the nurse

ID Label

Surgical History

Please list previous operations/procedures and dates

Are you allergic to Latex or Rubber? Yes No

Are you allergic to any drugs / tapes / food / lotions or other substances? Yes No

Please list _____

Have you been given any cortisone / steroids in the past three (3) months? Yes No

If yes, were you given _____ creams / tablets / injection?

Do you bruise easily or have a bleeding tendency? Yes No

Have you taken any aspirin in the last 7 days? Yes No

Are you currently taking Warfarin, Plavix, Iscover or any other anti-platelet drugs? Yes No

Do you smoke? Yes No

If yes, how many cigarettes per day _____

Do you drink alcohol? Yes No

If yes, indicate daily alcohol intake _____

Current Medications:

Drug	Dose	Frequency

Declarations:

The answers I have given are, to the best of my knowledge true, and I have not withheld any information. I have arranged for a responsible adult to accompany me home following my procedure and to stay with me overnight. I understand that following my procedure my judgement may be impaired for several hours due to the anaesthetic administered.

Signed: _____ Date: _____

Checked by (R.N. Signature): _____ Print: _____ Designation: _____