BUNDOORA ENDOSCOPY
A.B.N. 81796273454
119 Plenty Rd, Bundoora VIC 3083
(Ph) 03 9466 8466 (Fax) 03 9466 8455
Email: reception@vicgut.com.au

INSTRUCTIONS FOR PATIENTS:
1. Please fill-out required information and return completed form to Bundoora Endoscopy by *mail/fax/email* **no later than *7 business days*** prior to your admission to avoid cancellation.
2. Please contact Bundoora Endoscopy for any inquiries.
3. Please bring your Medicare, Health Fund details and GP referral letter on the day of appointment.
4. Please wear *comfortable clothing* and *(flat) shoes do not bring valuables with you*.
5. *All doctors try to keep to time but sometimes there are unexpected delays due to unavoidable circumstances.*

PREVIOUS PATIENT? ☐Yes ☐No ☐Open Access ☐Private ☐Rebate Only **DATE OF ADMISSION**:_____

PROCEDURE: ☐Gastroscopy ☐Colonosopy ☐Flexible Sigmoidoscopy ☐Iron Infusion

Personal Details			
SURNAME	TITLE	GIVEN NAME/S	PREFERRED NAME
ADDRESS		STATE	POSTCODE

SEX: ☐ M ☐ F	**HEIGHT:** CM	COUNTRY OF BIRTH
DATE OF BIRTH: DD / MM / YEAR AGE:	**WEIGHT:** KG	Are you a resident of Australia? ☐YES ☐NO Are you of Torres Strait/Aboriginal descent? ☐YES ☐NO
	BMI	Do you live alone? ☐YES ☐NO Do you need an interpreter on admission day? ☐YES ☐NO

CONTACT DETAILS *Please tick preferred contact.*

HOME PH: ☐	WORK PH: ☐	MOBILE: ☐	EMAIL: ☐

REFERRING GP

NAME:		
ADDRESS:		
PHONE:	FAX:	EMAIL:

MEDICARE **EXPIRY DATE**

											(NO. IN FRONT OF NAME)	

PRIVATE HEALTH INSURANCE

INSURANCE FUND:	MEMBERSHIP NUMBER:
DO YOU HAVE AN EXCESS? ☐YES ☐NO $ _____ DO YOU HAVE A CO-PAYMENT? ☐YES ☐NO $ _____	HAVE YOU CHANGED COVER RECENTLY? ☐YES ☐NO HAVE YOU CONFIRMED YOUR COVERAGE? ☐YES ☐NO
DEPARTMENT OF VETERAN AFFAIRS	Does your policy Support Gap Coverage ☐YES ☐NO
DVA CARD NUMBER:	AMBULANCE COVER ☐YES ☐NO
CARD COLOUR: ☐GOLD ☐WHITE	MEMBERSHIP NUMBER:

PENSION CARD NUMBER **HEALTH CARE CARD NUMBER**

☐WORKCOVER ☐ TAC **/** CLAIM ACCEPTED? ☐ YES ☐ NO (*If YES, please attach approval letter)* **/** CLAIM NO.

NATURE OF INJURY:	DATE:
INSURANCE COMPANY:	
EMPLOYER:	Ph:
CONTACT PERSON:	Ph:

As you will not be able to return home by public transport or drive after your procedure, arrangements must be made for you to be collected post-op and cared for *overnight*. Failure to do so may result in cancellation of your procedure.

Who will be taking you home? *A nurse will ring to give approximate pick-up time.*		
Name:	Ph:	Relationship:
Who will stay with you overnight:	Ph:	Relationship:

NEXT OF KIN/EMERGENCY CONTACT

Name:	Ph:	Relationship:

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Patient Full Name: _____

AFFIX PATIENT LABEL HERE

DO YOU HAVE OF HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

(If YES to any condition indicated please give further details on the space provided.)

Cardiovascular	**YES**	**NO**	**If Yes Please Provide Details**
Blood pressure problems: High □ Low □			
Cardiac conditions: Heart attack □ Congestive Heart Failure □ Chest pain □ Angina □ Pacemaker □ Internal Defibrillator □ Coronary stents □			
Cardiac Irregularities: Palpitations □ Irr.Heart Beat □ Atrial Fibrillation □			
Respiratory			
Asthma □ Emphysema □ COPD □ Home Oxygen □			
Other lung problems eg TB □			
Shortness of breath when walking more than 100 metres, climbing a flight of stairs/uphill			
Do you suffer from sleep apnoea?			
Endocrinology			
Diabetes Type 1 □ Type 2 □			
Thyroid problems: Do you have a Goitre □ Nodules □ Do you have an over active or underactive thyroid?			
Gastrointestinal			
Hiatus Hernia □ Reflux□ Ulcer □ Heartburn □			
Bowel problems eg Stoma □ IBS □ Crohns □ Ulcerative colitis □			
Liver disease □ Weight loss surgery □			
Genitourinary			
Kidney disease □ Dialysis □ Renal Impairment □			
Bladder problems: Incontinence □ Urinary Retention □ Stoma □			
Haematology/Oncology			
Blood clots: lungs (Pulmonary Emboli) □ legs (DVT) □			
Blood disorders : Anaemia □ Low Iron □ Bruising or bleeding tendency			
Cancer, (location, date of diagnosis, treatment received)			
Musculoskeletal			
Arthritis: Rheumatoid □ Osteo □			
Back or neck injury or other problems			
Neurology			
Stroke □ Mini Stroke □ TIA □			
Limb paralysis or weakness			
Epilepsy □ fits □ Blackouts □ Dizziness □ balance problems □			
Short term memory loss □ Dementia □			
Prosthetics/Aids/Other			
Visual aids – Glasses □ Contact Lenses □ Visual Impairment □			
Hearing Aids □ Hearing Impairment □			
Dentures □ Caps □ Crowns □ Implants □			
Other			
Depression □ other mental illness □			
Lymphoedema □			
Advanced care directive or treatment limiting order			If YES, please bring a copy on admission.

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FALLS ASSESSMENT	YES	NO	FURTHER DETAILS
Have you had a fall in the last 6 months?			
Do you use a walking aid?			
Do you need help walking, moving, dressing or undressing?			
SKIN ASSESSMENT			
Do you have wounds or breaks in your skin?			
INFECTION PREVENTION			
Have you been unwell in the past 2 weeks?			
Have you or a family member been exposed to an infectious disease in the last 2 weeks? e.g. Chickenpox, Measles, Shingles, Whooping Cough, Scabies			
Have you returned from an overseas trip in the past 30 days?			
Have you been hospitalised overseas or in another facility in the past 12 months?			
Do you have HIV, Hepatitis A/B/C, MRSA, VRE, CRE, C. Difficile?			

ANAESTHETIC HISTORY	YES	NO	
Do you smoke?			If yes, how many a day?
Do you use recreational drugs?			
Do you drink alcohol?			Amount and type?
Do you take any blood thinning medications other than aspirin?			Specify
Are you on insulin?			Specify
Have you or any of your family ever had problems with anaesthetics?			
If yes, please give details			
Have you or family been diagnosed with Malignant Hyperthermia?			
Have you had recent dental treatment or current loose/chipped tooth			Details
ALLERGY OR ADVERSE REACTION	**YES**	**NO**	**FURTHER DETAILS**
Do you have a medical dietary restriction eg Lactose intolerant, Coeliac Disease			
Do you have allergies to medications, food, sticking plaster, latex or other substances?			**If yes please list details below**
MEDICATIONS			
*Please list all medications, including **inhalers,** over the counter drugs, vitamins and supplements that you are currently taking*			
SURGICAL HISTORY			
Please list any previous operations or procedure and dates.			

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TO BE COMPLETED BY CONSULTANT
HISTORY:
FAMILY HISTORY:

EXAMINATION	
RECOMMENDATIONS:	
Date:	Time:
Physician Name:	Signature:

PATIENT'S DECLARATION		
I hereby declare that the above information are true and correct to the best of my knowledge.		
Name	Signature	Date
OFFICE USE ONLY		
Patient ID and procedure confirmed? ☐YES ☐NO	Admin initials:	Date/Time

PRE-ADMISSION NURSE TO COMPLETE			
Is the patient suitable for admission?			☐YES ☐NO
Comments:			
Name:	Signature:	Designation:	Date/Time:
ADMISSION NURSE			
Name:	Signature:	Designation:	Date/Time: