VICTORIAN GUT CENTRE
Digestive Health & Endoscopy

Formerly 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 Victorian Gut Centre by *mail/fax/email* **no later than *7 business days*** prior to your admission to avoid cancellation.
2. Please contact Victorian Gut Centre for any inquiries.
3. Please bring your **Medicare card, Health Fund details, GP referral letter & payment preference (if app)** on the day of appointment. Try not to bring any valuables with you
4. Please wear *comfortable clothing* and *(flat – no thongs) shoes.*
5. *All doctors try to keep to scheduling but sometimes there are unexpected delays due to unavoidable circumstances.*

Have you seen a Gastroenterologist in the last 30 days? ☐ NO ☐ YES

PATIENT IS..☐Open Access ☐Private ☐Rebate Only **DATE OF ADMISSION**:_____

PROCEDURE: (Check all that apply) ☐ Gastroscopy ☐ Colonoscopy ☐ Flexible Sigmoidoscopy ☐ Iron Infusion

How did you hear about the Victorian Gut Centre? (select one)	1. ☐ GP	2. ☐ Specialist / Surgeon	3. ☐ Google
	4. ☐ Social Media	5. ☐ Friend / Relative	6. ☐ Previous Patient

Personal Details

SURNAME	TITLE	GIVEN NAME/S	PREFERRED NAME

ADDRESS:	STATE	POSTCODE

SUBURB:

DATE OF BIRTH: DD / MM / YEAR AGE:	Gender: M ☐ F ☐ ☐ _____	Are you a resident of Australia? ☐YES ☐NO Are you of Torres Strait/Aboriginal descent? ☐YES ☐NO
Height _____ CM **Weight** _____ KG **BMI** _____	BIRTH COUNTRY	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: **No. IN FRONT OF NAME:** **EXPIRY DATE:**

PRIVATE HEALTH INSURANCE:	**DEPARTMENT OF VETERAN AFFAIRS:**
INSURANCE FUND:	DVA CARD NUMBER:
MEMBERSHIP NUMBER:	CARD COLOUR: ☐GOLD ☐WHITE
DO YOU HAVE AN EXCESS? ☐YES ☐NO $ _____	AMBULANCE COVER: ☐YES ☐NO
DO YOU HAVE A CO-PAYMENT? ☐YES ☐NO $ _____	IF YES, MEMBERSHIP NUMBER:_____
HAVE YOU CHANGED COVER RECENTLY? ☐YES ☐NO	**PENSION CARD NUMBER (If applicable):**
HAVE YOU CONFIRMED YOUR COVERAGE? ☐YES ☐NO	**HEALTH CARE CARD NUMBER (If applicable):**
Does your policy Support Gap Coverage ☐YES ☐NO	

☐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 and *cared for during the day and overnight post procedure*. 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 OR 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 SCREENING	YES	NO	FURTHER DETAILS
Have you had a fall in the last 12 months?			
Do you use a walking aid? If YES, you MUST bring on Admission Day			
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**			

MEDICATIONS

*Please list all medications, **inhalers,** over the counter drugs, vitamins and supplements that you are currently taking*

Medication	Dose	Medication	Dose

SURGICAL HISTORY

Please list any previous operations or procedure and dates.

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

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TO BE COMPLETED BY CONSULTANT
HISTORY:
FAMILY HISTORY:

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

OFFICE USE ONLY		
Patient ID and procedure confirmed? ☐YES ☐NO	Admin initials:	Date/Time
Patient has read Rights & Responsibilities? ☐YES ☐NO		

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: