

Patient Admission Form

Please PRINT clearly. Your responses are very important in planning your admission and caring for you during your stay.

UR No: _____
 Surname: _____
 Given Names: _____
 Date of Birth: _____ Doctor: _____

Please complete and return your completed Patient Admission Form, Financial & Privacy Consent Form and Health Questionnaire to the Northern Endoscopy Centre at least **FIVE (5) days prior** to your admission. You can do this by delivering the forms in person to our reception staff, via post or by emailing bookings@northernendoscopy.com.au

PERSONAL DETAILS

Title	Surname	
Previous surname (if applicable)		
Given names		Preferred name
Date of Birth	/ /	Age Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		
Suburb	State	Post Code
Postal Address (if different to above)		
Suburb	State	Post Code
Phone Home ()	Work ()	Mobile
Email		
Country of Birth	Are you a Permanent Resident of Australia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Main language spoken at home?	Do you require an interpreter?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Occupation	Religion	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married or Defacto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Race (required by SA health)	<input type="checkbox"/> Caucasian <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Asian <input type="checkbox"/> Other	

PERSON TO CONTACT (NEXT OF KIN)

Title	Surname	Given name
Relationship to patient		
Address		
Suburb	State	Post Code
Phone Home ()	Work ()	Mobile
Alternative contact person	Phone	Relationship

WHO IS YOUR GP/LOCAL DOCTOR

Full name of Doctor		
Address		
Suburb	State	Post Code
Phone ()	Fax ()	Email

HOSPITAL PRE ADMISSION PLANNING

Have you been a patient at any other hospital within the past (7) days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES , which hospital:	Dates of hospitalisation / / to / /
During this hospitalisation, were you admitted as a	<input type="checkbox"/> Private patient, or <input type="checkbox"/> Public patient
Do you have any of the following directives relating to the management your care and health?	
<input type="checkbox"/> Enduring Power of Attorney (Financial Decisions) <input type="checkbox"/> Advance Care Directive / Advance Care Plan (Medical)	

IF YES TO ANY OF THESE, PLEASE PROVIDE A COPY OF THE DOCUMENTATION / DIRECTIVES TO THE HOSPITAL

Patient Admission Form

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UR No: _____
 Surname: _____
 Given Names: _____
 Date of Birth: _____ Doctor: _____

AFFIX PATIENT LABEL

ENTITLEMENTS															
Medicare No.												No. Prefixing name (IRN) []	Valid to	/	
Department of Veterans' Affairs file No.												Expiry date		/	
Department of Veterans' Affairs health card classification: <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Other															
If DVA , Do you require transport to be booked and organised for you? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Pensioner Concession Card (CRN) No.												[]	Expiry date		/
PERSON RESPONSIBLE FOR THE FINANCIAL ACCOUNT															
Is the patient responsible for this account? <input type="checkbox"/> Yes (go to next section) <input type="checkbox"/> No (complete this section)															
Title	Surname					Given name									
Relationship to patient															
Address															
Suburb						State			Post Code						
Phone Home ()				Work ()				Mobile							
HEALTH INSURANCE DETAILS															
INSURED PATIENTS: it is recommended that you contact your health fund prior to completing this section to check your level of cover, particularly if you have been a member for less than 12 months or have changed your cover in the same period. Please be aware of the PRE-EXISTING CONDITION RULE . It is important that you are aware of all financial costs relating to your stay in hospital. Accepted methods of payment on admission are: Cash, EFTPOS, or Credit Card (VISA or MasterCard). Payment via Direct Deposit (EFT) is permitted, however funds must be received and cleared by our finance team 3 days prior to your admission. We DO NOT accept personal cheques.															
Health fund name:						Membership number:									
Have you had private health insurance with the same provider for over 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Do you have an excess or co-payment to pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , how much? \$															
ANY HOSPITAL EXCESS OR CO-PAYMENT MUST BY PAID PRIOR TO YOUR ADMISSION															
OUT OF POCKET EXPENSES FOR PATIENTS															
Have the hospital staff and or treating physician explained to you the financial account details in relation to your admission and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No															
IF YOU ANSWERED NO, IT IS RECOMMENDED YOU TALK TO THE HOSPITAL STAFF WELL PRIOR TO YOUR PLANNED ADMISSION TO OBTAIN DETAILED INFORMATION ABOUT ANY OUT OF POCKET EXPENSES THAT MAY APPLY															
SELF FUNDED (UNINSURED) PATIENTS															
Please obtain information regarding your planned procedure from your referring doctor or doctor's rooms, and then contact the hospital for an estimate of costs.															
ALL COSTS FOR UNINSURED PATIENTS ARE PAYABLE PRIOR TO ADMISSION AND ARE NOT COVERED BY MEDICARE															
COMPENSABLE ADMISSIONS (IF APPLICABLE)															
If your planned procedure is as a result of a Return to Work SA (Workcover) or third party insurance claim, then please contact the hospital to discuss your circumstances in conjunction with the required booking process.															
Name of insurance company															
Insurance claim or reference number:						Date of accident / /									
Claim contact person				Phone ()				Fax ()							
Claim email															
WRITTEN APPROVAL FOR THIS ADMISSION (FROM YOUR INSURANCE COMPANY) MUST ACCOMPANY THIS FORM															

Patient Financial and Privacy Consent Form

UR No: _____
 Surname: _____
 Given Names: _____
 Date of Birth: _____ Doctor: _____

AFFIX PATIENT LABEL

The Federal Privacy Act 1988 (Privacy Act) with amendments, states that your consent needs to be obtained prior to our collecting personal and health information about you. Please read carefully the Privacy Policy Information, which provides details related to the management of your Personal Health Information, prior to signing this consent form.

I, _____ (being the Authorised Person)
 (print full name)
 being the patient, or parent, or guardian of _____
 (print full name of patient if the Authorised Person is the patient's parent or guardian)
 acknowledge and consent to the following:

FINANCIAL CONSENT

- I agree to take full responsibility for any financial accounts rendered by the Northern Endoscopy Centre, including any shortfall in reimbursement by my health fund or any insurance company gap following settlement by the health fund and/or insurance company.
- I have had the financial costs of my hospitalisation and procedure clearly explained to me and understand that:
 - total costs cannot be quoted, but only estimated in advance of my procedure;
 - my obligation to pay for my hospitalisation is independent of any benefits I may be able to claim for my private health insurance and that I will be liable for any debt collection and or legal fees incurred in the collection of these accounts.
- I acknowledge that if I have been a member of a private health fund for less than 12 months or have changed cover in the same period, that I am fully aware of the PRE-EXISTING CONDITION RULE regarding eligible benefits payable by my health fund.
- I understand that any excess payable under my private health insurance fund will be paid on or prior to admission.
- I understand that I may be required to pay for some prosthetics or speciality items deployed in theatre that may not be covered by my health fund.

PRIVACY AND PERSONAL INFORMATION CONSENT

- I have read the hospital information booklet provided to me and are aware of the Northern Endoscopy Centre policy for the management of personal health information.
- I understand I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the healthcare and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my personal and health information is to be used for any other purpose than set out in the information provided, my further consent will be obtained.
- I understand that I may notify the hospital of specific limitations on access or disclosure which will be documented in my health record.
- I consent to the handling of my personal health information by the Northern Endoscopy Centre for the purposes set out in the information provided, subject to any limitations on access or disclosure that I notify the hospital of.

**SIGNATURE OF PERSON RESPONSIBLE *
(FINANCIAL AND PRIVACY CONSENT)**



DATE / /

* A "person responsible" means a person defined as a "person responsible" under the Federal Privacy Act 1988 (Privacy Act) with amendments including the patient's partner, family member, carer, guardian, close friend and a person exercising power under an enduring power of attorney.

Should you require any assistance or clarification regarding any aspects of your financial requirements or personal information usage within the hospital, please do not hesitate to contact our staff.

Health Questionnaire

Please PRINT clearly. Your responses are crucial to ensure we care for you during your stay.

UR No: _____
Surname: _____
Given Names: _____
Date of Birth: _____ Doctor: _____

IMPORTANT: We depend on you to provide accurate health screening information. To help us streamline your hospital admission and discharge and allow nursing care to be planned to meet your individual needs, you are required to complete and return this Questionnaire along with your other preoperative admission forms at least **(5) days prior** to your procedure. Please complete **ALL** pages. If you have any questions, please contact the hospital for assistance.

PATIENT NAME:			
Date of Birth	/ /	Contact telephone	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

MEDICAL HISTORY

Have you ever had a reaction to:	If Yes , please specify details of any allergies or sensitivities	STAFF USE
DRUGS <input type="checkbox"/> Yes <input type="checkbox"/> No		
FOOD <input type="checkbox"/> Yes <input type="checkbox"/> No		
LATEX <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your weight? _____ kilograms	What is your height? _____ centimetres	BMI: _____
Have you had an anaesthetic before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you, or any blood relatives, had problems with anaesthetics in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you smoke or have you smoked in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes , specify daily quantity: _____ date ceased: _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol ? If Yes , daily amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

CVS	Have you ever had a heart attack ? If Yes , year: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you undergone heart surgery within the past 6 months ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	●
	Have you <u>ever</u> undergone any heart surgery prior to 6 months? (e.g. bypass, stent) If Yes , year and specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have a pacemaker or implanted defibrillator ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have angina ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Yes , do you use GTN patches / sublingual spray / tablets ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an irregular heart rate, murmur or heart palpitations ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had a stroke / CVA ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
RESP	Do you have a tendency to bleed, clot or bruise easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had high blood pressure ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have any other heart problems ? If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have any lung or chest conditions? (e.g. asthma, bronchitis, emphysema) If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have sleep apnoea ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MET / RENAL	Have you ever had throat, nose or lung surgery? If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you use a nebuliser, puffer or EPAP/CPAP machine or use home oxygen ? If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you had a cold, flu or unexplained temperature in the past 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	●
	Do you have diabetes ? <input type="checkbox"/> Insulin <input type="checkbox"/> Tablet <input type="checkbox"/> Diet Controlled <i>Please discuss with your doctor both prior to and after your procedure</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any kidney or thyroid problems? If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any bladder problems? (e.g. incontinence, catheter, urgency) If Yes , specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Health Questionnaire

Please PRINT clearly. Your responses are crucial to ensure we care for you during your stay.

UR No: _____

Surname: _____

Given Names: _____

Date of Birth: _____

Doctor: _____

AFFIX PATIENT LABEL

		STAFF USE
GI	Do you have jaundice, hepatitis (specify HEP type A, B, C) or liver disease? If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any gastric problems? (e.g. hiatus hernia, stomach ulcers, reflux) If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any bowel problems? (e.g. diarrhoea, constipation, incontinence, diverticulitis/stomas) If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any recent unintentional weight loss ? If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
FALLS RISK	Do you have any numbness or tingling problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you experienced fainting or dizziness in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any fits, convulsions or blackouts ? (e.g. epilepsy) If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had any falls in the past 12 months? If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any vision problems? (e.g. limited vision, cataracts, glaucoma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have problems weight bearing ?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
ASSISTANCE	Do you wear glasses / contact lenses ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a hearing aid or other hearing appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any dentures / caps / crowns / loose teeth ? (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any artificial joints or limbs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had back / neck / jaw surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have mobility problems ? (e.g. arthritis, back pain or leg weakness?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use any mobility aids ? (e.g. frame, stick, crutches, wheelchair etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
CJD RISK	Do you or any members of your family have a history of Creutzfeld Jakob Disease (CJD) or other unspecified neurological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Have you had a dura mater graft between 1972-1989?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Have you been assessed for CJD or do you have a "medical in confidence letter" regarding your risk of CJD?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
OTHER	Have you ever had a multi-resistant organism infection ? (MRSA, golden staph, VRE or CRE?) <i>If you are unsure, please contact the hospital immediately to discuss</i> If Yes , specify type and year (when):	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Do you have or have you had any other infections or infectious diseases ? If Yes , specify type and year (when):	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Have you been in contact with anyone over the past 3 months who has had an infection or infectious disease? (e.g. Chicken Pox, Measles) If Yes , specify type:	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Do you have any skin wounds, pressure sores or skin ulcers ?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Do you have an intellectual disability ?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Do you have Alzheimer's / dementia ?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	Have you ever experienced an episode of delirium ?	<input type="checkbox"/> Yes <input type="checkbox"/> No ●
	[Female patients] : Are you or could you be pregnant ? If Yes , weeks:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any other medical conditions not specified above that we should be aware of? If Yes , specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health Questionnaire

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AFFIX PATIENT LABEL

MEDICATIONS

Please remember to bring with you all your current medication (in original labelled containers) and any current or relevant medical reports to hospital. It is advisable that you **DO NOT** bring any valuable items into hospital, as the centre does not assume any responsibility for any valuables.

Do you take any anti-coagulant or blood thinning medications ? (e.g. Coumadin (warfarin), Xarelto (rivaroxaban), Eliquis (apixaban), Pradaxa (dabigatran), Iscover / Plavix (clopidogrel), Aspirin etc.) If Yes , name of medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any steroids , anti-inflammatory drugs or cortisone / prednisolone tablets / injections? If Yes , name of medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use recreational drugs ? If Yes , what type and how much/frequency:	<input type="checkbox"/> Yes <input type="checkbox"/> No

LIST OF CURRENT MEDICATIONS

Please list all medications you are currently taking
 (prescription, non-prescription, including herbal – Krill / Fish Oil, Olive Leaf and vitamins)

MEDICATION	DOSE	DIRECTIONS	MEDICATION	DOSE	DIRECTIONS

FAMILY MEDICAL HISTORY

YOUR FATHER	YOUR MOTHER
<input type="checkbox"/> Alive , current age: _____	<input type="checkbox"/> Deceased , at age: _____
<input type="checkbox"/> Deceased , at age: _____	<input type="checkbox"/> Alive , current age: _____
If alive , please specify any illnesses:	If alive , please specify any illnesses:
If deceased , please specify cause of death:	If deceased , please specify cause of death:
SIBLINGS (IF APPLICABLE)	YOUR CHILDREN (IF APPLICABLE)
<input type="checkbox"/> Brothers = _____	<input type="checkbox"/> Sons = _____
<input type="checkbox"/> Sisters = _____	<input type="checkbox"/> Daughters = _____
Please specify any illnesses (if applicable):	Please specify any illnesses (if applicable):
Please specify any cause of death (if applicable)	Please specify any cause of death (if applicable)

PATIENT CONFIRMATION

I confirm my understanding and agree that:

- Following any procedure performed under IV sedation at this hospital, I will have a responsible adult drive me/accompany me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia; and
- I have answered all the questions above to the best of my knowledge and have not purposely withheld any information that may compromise the quality of the healthcare and treatment given to me.

SIGNATURE OF PATIENT



DATE / /