NORTHERN ENDOSCOPY CENTRE

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: _____

AFFIX PATIENT LABEL

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 ☐ Male ☐ 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 ☐ No ☐

Main language spoken at home? Do you require an interpreter? Yes ☐ No ☐

Occupation Religion

Marital status ☐ Single ☐ Married or Defacto ☐ Widowed ☐ Divorced ☐ Separated

Race ☐ Caucasian ☐ Asian ☐ Aboriginal ☐ TSI ☐ Other (specify) ☐ Decline to Answer

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? ☐ Yes ☐ No

If **YES**, which hospital: Dates of hospitalisation / / to / /

During this hospitalisation, were you admitted as a ☐ Private patient, or ☐ Public patient

Do you have any of the following directives relating to the management your care and health? (tick) ☐ None

☐ Enduring Power of Attorney (Financial Decisions) ☐ Advance Care Directive / Advance Care Plan (Medical)

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

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AFFIX PATIENT LABEL

Patient Admission Form

ENTITLEMENTS

Medicare No.		No. Prefixing name (IRN) [ ]	Valid to /
Department of Veterans' Affairs file No.			Expiry date /
Department of Veterans' Affairs heath card classification: ☐ Gold ☐ White ☐ Other			
If **DVA**, do you require transport to be booked and organised for you? ☐ Yes ☐ No			
Pensioner Concession Card (CRN) No.		[ ]	Expiry date /

PERSON RESPONSIBLE FOR THE FINANCIAL ACCOUNT

Is the patient responsible for this account? ☐ **Yes** (go to next section) ☐ **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. Doctors and Anaesthetists are covered under the no gap scheme. Accepted methods of payment on admission are: **Cash**, **EFTPOS**, or **Credit Card** (VISA or MasterCard).

Health fund name: Membership number:

Have you had private health insurance with the same provider for over 12 months? ☐ Yes ☐ No

Do you have an **excess** or **co-payment** to pay? ☐ Yes ☐ 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? ☐ Yes ☐ 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

NORTHERN ENDOSCOPY CENTRE

Patient Financial and Privacy Consent Form

UR No: _____

Surname: _____

Given Names: _____

Date of Birth: _____ Doctor: _____

AFFIX PATIENT LABEL

Financial & Privacy Consent Form

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

1. 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.
2. I have had the financial costs of my hospitalisation and procedure clearly explained to me and understand that:
   a. total costs cannot be quoted, but only estimated in advance of my procedure;
   b. 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.
3. 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.
4. I understand that any excess payable under my private health insurance fund will be paid on or prior to admission.
5. 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

1. 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.
2. 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.
3. 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.
4. 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.
5. I understand that I may notify the hospital of specific limitations on access or disclosure which will be documented in my health record.
6. 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)

SIGN HERE

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.

NORTHERN ENDOSCOPY CENTRE

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

Health Questionnaire

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 ☐ Male ☐ Female

MEDICAL HISTORY

Have you ever had a **reaction** to:		If **Yes**, please specify details of any allergies or sensitivities	**STAFF USE**
DRUGS	☐ Yes ☐ No		
FOOD	☐ Yes ☐ No		
LATEX	☐ Yes ☐ No		
OTHER	☐ Yes ☐ No		

What is your weight? kilograms	What is your height? centimetres	BMI:

Have you had an **anaesthetic** before?	☐ Yes ☐ No	
Have you, or any blood relatives, had **problems with anaesthetics** in the past?	☐ Yes ☐ No	
Do you **smoke** or have you **smoked** in the past?	☐ Yes ☐ No	
If **Yes**, specify daily quantity: date ceased: / /	☐ Yes ☐ No	
Do you **drink alcohol**? If **Yes**, daily amount:	☐ Yes ☐ No	

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

NORTHERN ENDOSCOPY CENTRE

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

Health Questionnaire

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

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UR No: _____

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Given Names: _____

Date of Birth: _____ Doctor: _____

AFFIX PATIENT LABEL

Health Questionnaire

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:	☐ Yes ☐ No
Do you take any **steroids**, **anti-inflammatory** drugs or **cortisone** / **prednisolone** tablets / injections? If **Yes**, name of medication:	☐ Yes ☐ No
Do you use **recreational drugs**? If **Yes**, what type and how much/frequency:	☐ Yes ☐ 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	
☐ **Alive**, current age:	☐ **Deceased**, at age:	☐ **Alive**, current age:	☐ **Deceased**, at 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)	
☐ **Brothers** =	☐ **Sisters** =	☐ **Sons** =	☐ **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 SIGN HERE DATE / /