the glen endoscopy centre

Admission Assessment Form

Name:

Appointment Day: Mon / Tue / Wed / Thu / Fri / Sat

Appointment Date: Time:

OFFICE USE: Confirm correct patient? Yes/No Seen By: _____ Time: _____

Time patient last ate: _____ last drank: _____ Bowel Prep: Complete/Incomplete

Pre-Admission Health Assessment – to be completed by Patient (Write answers or N/A if Not Applicable.)

Who is taking you home? Relationship to you: *Walking, unescorted in taxi & public transport not allowed*

I have read and understood the preparation instructions, risks and safety of procedures, and had an opportunity to ask any questions I may have.

Name: Sign: Date:

What procedure are you having: Colonoscopy / Gastroscopy Age:

OFFICE USE ONLY:

Reason for this test: (e.g. symptoms, family history, previous polyps etc)

Clinical indications:

Previous surgery and year of surgery:

Past surgical history:

Significant medical problems:

Past medical history:

Relevant family history

First degree relative cancers: Yes / No If yes, specify:

First degree relative early heart disease (under 65yo): Yes / No

Relevant family history:

MEDICATIONS YOU TAKE:

You must list all prescribed, over-the-counter and complementary medications that you are taking.

Medication history:

Name of medication	No. of tablets	Freq. per day	Reason for medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Has there been any change to your medicines in last 3 months?

If yes, what has changed? _____

ALLERGIES – Do you have allergies to any of these?

Allergy history:

Eggs Yes / No	Soya Yes / No	Medications Yes / No	Anaesthetic agents Yes / No
Tapes Yes / No	Hay fever Yes / No	Chlorhexidine Disinfectant Yes / No	Latex Yes / No

If any allergies, please provide name of medication & describe the reaction you get: **If significant allergy, staff change to red ID band**

Intake

Smoking Yes / No If yes, how much? per day	Recreational drugs Yes / No If yes, specify:
Alcohol Yes / No If yes, how much? of times per	Relevant consumption history:

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Name:

To be completed by Patient (as best as you can) – please tick yes or no to the following:

CARDIOVASCULAR – Heart Issues	**Yes**	**No**	**RESPIRATORY – Lungs or Breathing**	**Yes**	**No**
Shortness of breath at rest/lying flat/mild exertion			Hay fever, sinus problems		
High blood pressure			Asthma		
Chest tightness, chest pains, angina, heart attack, heart disease			Chronic bronchitis, emphysema, chronic Airway disease, bronchiectasis		
Rheumatic fever, heart murmur			Moderate-heavy snoring		
Irregular pulse, palpitations, arrhythmia			Obstructive sleep apnoea		
Ankle swelling			CPAP, BiPAP at night, Home oxygen		
Pacemaker, artificial heart valve, Implanted devices			Gastrointestinal: Hiatus Hernia, Reflux, Gastric ulcers,		
METABOLIC/ENDOCRINE			**TEETH, SKIN, MUSCULOSKELETAL**		
Could you be pregnant now?			Any skin conditions, broken skin, wounds		
Contraceptive pill (oral contraceptive may not be effective during the bowel preparation)			Pressure areas, reddened skin due to friction/rubbing/pressure		
Breastfeeding			Loose teeth, chipped teeth		
Liver conditions, fatty liver, jaundice, hepatitis, cirrhosis			Caps, crowns, veneers, dentures, bridge, implant, other dental works		
Diabetes? Diet/Medications/Insulin (pls circle)			Neck trouble? A bit / Some / A lot		
Kidney conditions, kidney impairment			Jaw trouble? E.g. Pain, click, locking		
Lap band surgery, gastric banding surgery?			**BLEEDING/CLOTTING**		
NEUROLOGICAL, MENTAL HEALTH, SEDATION			Blood thinning medications? Anti-platelet medications? Bleeding tendency? **Any of: Clopidogrel / Plavix / Iscover / Apixaban / Dabigatran / Rivaroxaban, Prasugrel & Ticagrelor / Warfarin, Coumadin?**		
Past sedation or anaesthetic difficulties					
Post-anaesthetic confusion / delirium					
History of mental illness, e.g., depression, anxiety, psychosis			Deep venous thrombosis DVT, Pulmonary embolism i.e. Blood clots in legs or lungs		
Faints, funny turns, dizzy spells			Have you brought an *Advance Care Directive* (living will) with you?		
Memory issues, dementia			**INFECTIONS**		
Intellectual disability			Past 12 months, any admission (overnight or more) to any overseas healthcare facility		
Fits, epilepsy, TIA, strokes, Parkinson's			Past 12 months, any CRE infections or contact with any patient with CRE		
MOBILITY, FITNESS & WELL-BEING			Are you currently being treated for any infections? Ever had TB/Tuberculosis?		
Do you use a mobility aid? e.g., a walking stick			Have you been overseas in the last month?		
Weight: ____ kg Height: ____ cm			In the last 10 days, have you had any respiratory infection (cold, sore throat, runny nose, sinusitis, cough, flu) or gastroenteritis (vomiting, diarrhoea)?		
Have you had any falls in the last 12 months? None (0) / One fall (1) / Two (2) / Three or more (3)					

I acknowledge I must not drive/operate machinery/sign legally binding documents within 24 hours of my anaesthetic.
I acknowledge I must have a responsible adult stay with me on the day of my procedure and overnight.
Acknowledgment that the patient/representative has filled in this form:

Patient name: Sign: Date:

Office use only Pre-Admission completed by: Name: _____ Sign: _____ Date: _____

☐ Pick up & Carer overnight
☐ 24 hrs rest after anaesthetic – no work/ drive/ exercise etc
☐ Bowel prep instructions and risk informed consent

Notes/Actions:

Sign: _____ Date: _____ Approved for admission YES / NO PAC required YES /NO

PATIENT REGISTRATION

You have the rights to expect quality, courteous, safe and efficient medical services from the staff of the centre; have clear explanation of your procedures; have the choice of doctors who are accredited with the centre; ask for referral for a second medical opinion; refuse the presence of any health workers not directly involved in your care; ask your doctor and hospital of the expected treatment costs; refuse to have the procedure; have your personal details kept strictly confidential according to the 'Privacy Law'; expect the staff to respect your beliefs, ethnic, cultural and religious practices; and comment on, or complain about, the services you received in the centre.
The Centre expects its patients, their relatives and friends to treat the staff of the centre, other patients, their relatives and friends with courtesy and consideration.

Title: Mr/Ms/Miss/Mrs	Given Name:	Surname:
Address:	Suburb:	Postcode:
Phone No.:	Date of Birth (DD/MM/YYYY):	Marital Status:
Email:	Country of Birth:	

Are you [is the person] of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to answer

Medicare No.: *please advise staff if your Medicare card is reciprocal as it will not cover for this procedure	Reference No.:	Expiry Date:
Private Hosp Insurance Fund & Membership No.:	Ambulance Cover: Yes ☐ No ☐ * In the unforeseen event that an ambulance is required, please note that it will be at the patient's expense.	

Escort Contact Details (Person taking you home)

Name: Relationship to you: Contact Number:

Emergency Contact Details

Same as above? Yes ☐ No ☐ If not, please fill below:

Name: Relationship to you: Contact Number:

Power of Attorney (A legal document to appoint someone to make decisions on your behalf)

Do you have a Power of Attorney? No ☐ Yes ☐ If yes, please fill in:

Name: Relationship to you: Contact Number:

Note: In accordance with The Privacy Act 1988, the Privacy Amendment (Enhancing Privacy Protection) Act 2012, and Victorian Privacy Principles, the management of The Glen Endoscopy Centre would like to inform you that we gather information from you, when you elect to be a patient of the centre, in order to enable us to provide efficient, safe and effective quality health service to you. Some of the information that we asked from you are needed by government departments which require us to submit information to them as we are registered with the health department as Day Hospital. The information that we gather may be passed on to other health care providers such as pathologists in order to provide the required services for you.

I, _____ give consent to the management of The Glen Endoscopy Centre to provide information regarding myself to health workers, government and statutory bodies in order to provide efficient, Safe and effective qualify health services to myself and to satisfy government and statutory laws and regulations.

I acknowledge that I have reviewed the information on patient rights provided above and staff were available to answer my questions

Signed _____ dated _____

the glen endoscopy centre

ABN No.: 47164437709
Hospital Provider No: 0043580H

302 Springvale Road
Glen Waverley Vic 3150

Telephone – 03 9545 0569
Facsimile – 03 9590 0147
Email – glenendo@gmail.com

Screening Questionnaire - Information for patients

Your doctor will use this questionnaire to assess whether it is safe for you to have your test or surgery, in relation to risk of transmission of COVID-19.

Name: _____

Date of birth: _____

1. **In the last 14 days,** have you had any of the following:
   - Fever (temperature) Yes / No
   - Night sweats Yes / No
   - Chills Yes / No
   - Cough Yes / No
   - Shortness of breath Yes / No
   - Sore throat Yes / No

2. **In the last 14 days** have you:
   - Travelled internationally/interstate Yes / No

     If yes, where? _____

     what date? _____
   - Been on a cruise ship Yes / No
   - Been in self-isolation or quarantine for any reason Yes / No

3. Have you ever:
   - Had a COVID-19 swab test Yes / No

     If yes, please select Positive / Negative

     Date of positive swab test result:
   - Been in close contact with a person with COVID-19 Yes / No

4. Have you visited any of the Department of Health and Human Services (DHHS) listed exposure sites during the date and time indicated? Yes / No

5. In the last 14 days, have you been unwell? Yes / No

Note: When you attend the hospital, your temperature will be checked. This is to ensure that our hospitals are safe for all patients and staff, and to minimise the risk of transmission of COVID-19.

Copied from Australian Commission on Safety and Quality in Health Care 2020

NSQHS STANDARDS