Form must be returned at least 5 days prior to admission.

Patient Admission Form

Windsor Avenue Day Surgery
17 Windsor Avenue, Springvale (03) 9548 5555

Mornington Endoscopy
350 Main Street, Mornington (03) 5973 4444

Rosebud SurgiCentre
1537 Point Nepean Rd, Rosebud West (03) 5986 4444

PATIENT ADMISSION DETAILS

GME Admitting Doctor:			
General Practitioner (Name & Address):			
Date of Admission:	**Time:**	**Date of Procedure:**	
Operation/Procedure:			
Have you been hospitalised anywhere in the last seven days? Yes No If yes, where:			
PATIENT DETAILS-*Please print as your name appears on Medicare Card*			
Title:	**Surname:**	**Previous Surname:**	
Given Names:			
Address:		**Postcode**	
Phone (H)	**Phone (B)**	**Phone (M)**	
Sex: Male Female	**Date of Birth:**	**Marital Status:**	
Country of Birth (if Australia, which state)? **Religion:**		**Are you an Australian Resident? Yes No** **Are you of Aboriginal/Torres Strait Island Descent? Yes No**	
Medicare Number:	**Reference No:**	**Expiry Date:**	**Veteran's Affairs No:**
Pension No: **Full Part** **Health Care Card : Yes No**			**Expiry Date:**
HEALTH FUND INSURER			
Fund:		**Membership Number:**	
Level of Cover:			
Do you have Ambulance Cover? Yes / No Who with: Membership NO:			
NEXT OF KIN			
Surname:	**Given Name:**	**Relationship:**	
Contact Number:		**Alternative contact number:**	
ESCORT CONTACT DETAILS			
Surname:	**Given Name:**	**Relationship:**	

Address:		
Contact Number:	**Alternative contact number:**	
Office Use ONLY: **Last Meal:** **Last Fluids:**	**Pick Up Details**	

PATIENT PRE-ADMISSION HISTORY

Approx Weight: **Approx Height :** **BMI (office use only):**

ALLERGIES (Food, Medications)

Do you have x-rays, blood tests or ultrasounds relevant to your admission? **Yes, please bring on admission** **No**

ADMISSION DIAGNOSIS: What condition are you being admitted to hospital for?

MEDICAL HISTORY: Patient to complete. Please tick Y or N to indicate whether you have ever had any of the following:

	Y	N		Y	N		Y	N
Diabetes			**Blood Transfusion**			**Pneumonia/Bronchitis/Asthma**		
Epilepsy or Fits			**Anaemia**			**Kidney Disease**		
Pacemaker/ Internal Defibrillator			**Bleeding disorder**			**Tuberculosis**		
CPAP machine/ Sleep Apnoea			**Rectal Bleeding**			**Rheumatic Fever**		
Taking Blood Thinners			**Stomach Ulcer**			**History of anaesthetic problems**		
CVA (stroke)/ Blood Clots/DVT			**Jaundice/hepatitis**			**Psychiatric Treatment**		
Heart Problems			**Mobility issues**			**Are you or could you be pregnant?**		
Airways Disease (COAD/COPD)			**High Blood Pressure**			**Gastro Oesophageal Reflux**		

Are you suffering from any pre-existing health care associated infection or communicable disease?

1. **Have you been suffering any fevers or flu like symptoms in the last 28 days?**

Please give details:

2. **Have you been in contact with anyone in the past month suffering from a severe infectious disease?**

Please give details:

3. **Have you had 2 or more accidental falls in the past 12 months?**

Please give details:

4. **Do you have any special needs?**

Please give details:

5. **Do you have a treatment limiting Order/Advanced Care Order?**

Please give details:

6. **Have you ever been diagnosed with MRSA or VRE?**

7. Do you have any other pre-existing conditions that may affect your procedure (e.g. Addisons Disease)		
Please give details:		
SURGICAL HISTORY		
Have you ever had previous surgery?	**Yes**	**No**
Please give details of previous surgery (state year)		

ANAESTHETIC HISTORY		**YES**	**NO**
Have you ever had any previous anaesthetics?			
Have you or any member of your family had problems with anaesthetics?			
Do you smoke?	**How many per day?**		
Do you consume alcohol?	**How much per week?**		
Do you take any sedatives or sleeping medications?			
MEDICATIONS		**YES**	**NO**
Are you taking any medications at present?			
Please give details (including contraceptive pill, herbal remedies, vitamins, blood thinning eg Aspirin, Warfarin, Plavix)			

OFFICE USE ONLY:				**YES**	**NO**
Nurse Admission	**YES**	**NO**	**Has patient been offered rights & responsibilities info**		
Medical History checked			**Suitable escort arrangements**		
Observations documented					
Prep as instructed					

Allergies/Sensitivities:	**Reaction:**
Medication **TYPE:**	
Food **TYPE:**	
Latex	

Allerts:	**Comments/Strategies:**
Falls Risk	

Pressure Injury Risk	
Malignant Hyperthermia	
Difficult Intubation	
Lymphodoema	
Advanced Care Plan/NFR	
Infection Risk (Hepatis)	
Other Special Needs	
Impaired Vision	
Dentures	
Loose Teeth	
Hearing Aid	
NURSE NOTES:	
Print Name:	**Nurse Signature:**

CONSENT FOR PROCEDURE

PART A: To be completed by Patient

The doctor whose name appears in Part B and I have discussed my present condition and the ways which it might be treated. The doctor has told me that

1. The administration of an anaesthetic and medicines may be needed in association with this procedure and these carry some risks.
2. Additional procedures or treatment may be needed if the doctor finds something unexpected and I agree to these additional procedures and/or treatment being carried out if required.
3. The procedure carries certain risks, the nature of those risks, and complications that may occur.

I agree that I have been given the opportunity to ask questions of the doctor whose name appears below and understand the nature of the procedure and undergoing the procedure carries risks. I am satisfied with the answers and information I have received.

I have been advised of the material risks associated with this procedure.

I understand that whilst I am in hospital, I will receive care, medications, tests and examinations as necessitated by the procedure I am undertaking.

I acknowledge that the hospital has made available to me Patient Rights and Responsibilities, details on how to make a complaint as well as Health Information Collection Disclosures.

Dated this……day of ……201……. Patient Signature……

OR I certify the patient is unable to sign Authorised Signature…….

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Authorised Signature Relationship to patient……

Witness Name…… **Witness Signature……**
*witness is verifying that they have witnessed the patient/guardian signing the form

PART B: To be completed by Proceduralist

I, Doctor have informed (Patient)

Of the nature and material risks of the recommended procedure. The agree procedure and treatment that the patient is to undergo is

Gastroscopy / Colonoscopy / Flexible Sigmoidoscopy / Iron Infusion / Vedolizumab Infusion

……

Endoscopist's Signature……Date:……

I have discussed with the patient the relevant aspects and risks of the anaesthetic and he/she has given consent to proceed.

Anaesthetist's Signature……..Date:……

Print Name……

Please tick if you would like to subscribe to our newsletter:
To subscribe please provide your email address: _____

Fee Estimation Form

Patient Details	
Admission Date:	
Patient Name:	
D.O.B:	UR No:

Health Fund Details	
Name of Health Fund:	
Membership Number:	
Membership Verification Number:	
Fund Table:	Fund Excess:

Procedure Details (please circle)			
Procedure	Item Number	Bed Charge	Anticipated length of stay to be claimed
Gastroscopy	30473		1

Colonoscopy	32090		1
Gas & Col	30473 + 32090		1
Iron Infusion			1
Vedolizumab Infusion			1
Other			

Hospital Quotation			
	Estimated Cost	Fund Rebate	Patient Cost
Episodic Payment			
Consumables			
Other			
Fund Excess			
TOTAL			
Additional fees for Polyp removal			$80 / $120
Additional fees for injecting of Haemorrhoids			$80 / $120

All patients with NIB, Latrobe, GMHBA and HCF will need to contact their health fund to enquire if they will have an out of pocket expense for Melbourne Pathology Histology.

Patient/Guardian to complete	
I have been financially consented to the costs relating to the above procedure(s) and acknowledge that I undertake to pay the patient payment as indicated above, including all POLYP and HAEMORRHOID FEES, <u>together with any unforeseen costs which may arise as a consequence of the procedure(s) such as SPOT/TATTOO FEES ($150) etc.</u>	
Please Sign here: _____	Date:
Financial consent given verbally:_____	Date: