Chelsea Heights Day Surgery & Endoscopy

'Patient Centred Care'

Pre-Admission Details

FORM MUST BE RETURNED AT LEAST 5 DAYS PRIOR TO ADMISSION TO CONFIRM BOOKING

PLEASE EMAIL TO reception@chds.net.au or ring (03) 9771 7177

Referring General Practitioner: (Name & Address)	
Date of Admission/ Operation/ Procedure:	Interpreter required Yes ☐ No ☐
Operation/Procedure:	

Have you been hospitalised anywhere in the last seven days? ☐ Yes ☐ No If yes, Hospital _____

PATIENT DETAILS – *please print as your name appears on your Medicare card*

Title:	Surname:	Previous Surname
Given Names:		
Address:		Age:
Phone (H)	Phone (B)	Phone (Mobile)
Sex ☐ Male ☐ Female ☐ Unspecified	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 Straight Island Descent? ☐ Yes ☐ No	
Medicare No.:	Patient's Reference No	Expiry Date .
Pension No./Health Care Card ☐ Full ☐ Part	Expiry Date Safety Net No.	Veteran's Affairs No

If you are diabetic, state if ☐ on diet only ☐ diabetic medication ☐ on insulin

If you are on blood thinning tablets ☐ Warfarin (Coumadin), ☐ Plavic (Clopidogrel), ☐ Apixaban (Eliquis), ☐ Dabigatran (Pradaxa), ☐ Edoxaban (Savaysa), ☐ Rivaroxaban (Xarelto)

HEALTH FUND INSURER

Fund:	Membership No.:	Level of Cover:

CONTACT PERSON / NEXT OF KIN / DISCHARGE PLANNING ORGANISED BEFORE PROCEDURE

Name:	Relationship	Contact No.:

CONSENT FOR AMBULANCE VICTORIA (AV)

DIRECTIVES FROM THE STATE GOV. FROM 1 JULY 2014 REGARDING AMBULANCE VICTORIA

Ambulance subscription: Yes / No If yes, (please circle) Ambulance Victoria or Private Health Fund (Name) ……

Ambulance Victoria membership no. …… Date joined: …….
If at anytime our Staff have to ring **Ambulance Victoria** for **Emergency or Non-Emergency Transport**, the cost of the Ambulance Service will be sent to us. We will then forward the bill to you. This has to be paid within a week. (**Note* AV does not cover Pensioners and HCC holders anymore and you may be out of pocket more than $560 for each transport**)

I have read and understand the TERM AND CONDITION of booking Ambulance Victoria transport and agree to be bound by these.

Patient to Sign…… DATE……..

NOTE* NIL INSURED PATIENTS FOR GASTROSCOPY & COLONOSCOPY

In order to be more efficient and a saving for all nil insured patients, there will be an extra fee of $100 to be paid on the day, after the procedure**, if polyps are removed**. This is so you do not have to come in another day to have the procedure done. You do not have to go through all the trouble of another appointment, taking another day off, another bowel preparation (for colonoscopy patients), organise transport, etc. The procedure may however take a little longer but a saving for you and well worth the hassle of coming in again. **PTO**

Chelsea Heights Day Surgery
& Endoscopy
'Patient Centred Care'

Patient Privacy Information

DEAR PATIENT,

Please make an appointment to see your GP before your procedure and **request a copy of your current Medical history** and the **pathology report** if you **had a colonoscopy in the past 5 years**, to be attached to these forms for our records.

If **you are a diabetic, having colonoscopy** and taking any of these new drugs (**Forxiga, Xigduo XR, Jardiance, Jardiamet, Steglatro, Segluromet or Steglujan**) you need to **see your GP or Endocrinologist.** You will need to **stop these 3 days before** admission and **will need a substitute drug** to control your diabetes.

If you are taking **any blood thinning tablets such as** Plavix, Iscover, Clopidogrel, Coplavix, Prasegrel, Pradexa or Warfarin, you **need to see your GP or Cardiologist** to **stop at least 5 days before** as they can cause excessive bleeding. You **may need a substitute drug**.

The following describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Your health information is information about you collected by Chelsea Heights Day Surgery in providing a health service to you. Typically, it includes information relating to your symptoms, examination and test results, diagnosis, treatment and care information as well as admission and registration information.

Chelsea Heights Day Surgery proposes to collect *health information* from you for the following purposes:

- To process you registration, admission and discharge
- To ensure that each health care professional involved in your care has all the facts

The intended recipients of your health information are:

- Clinical staff within Chelsea Heights Day Surgery
- Data service providers engaged by Chelsea Heights Day Surgery from time to time
- Department of Human Services or other governmental departments, where disclosure is obliged by law

The supply of the information by you is voluntary, except where required under law. However, should you not supply the information, or supply only part of it; it may compromise your future care or treatment, particularly where the information is necessary for your required care or treatment.

If you have already provided information and consent for its use and disclosure but you have changed your mind, you can make a written application to revoke your earlier consent.

You have a right to request access to, and to request correction of, your health information in accordance with the relevant legislation. Further information about these procedures and privacy protection in general is available from the Director of Nursing.

Your can be assured that the privacy and confidentiality of the health information held about you will be respected.

You can access your **Rights & Responsibilities information** on
(Australian Charter of Healthcare Rights in Victoria in 25 community languages: https://www.safetyandquality.gov.au/publications-and-resources/resource-library?f%5B0%5D=publication_date%3A99&f%5B1%5D=topics%3A59)

Contact Details
In Person or By Mail:
Director of Nursing
Chelsea Heights Day Surgery
93 Wells Road
Chelsea Heights, VIC 3196

Chelsea Heights Day Surgery & Endoscopy

'Patient Centred Care'

PATIENT LABEL

Patient Admission Form

PATIENT'S MEDICAL HISTORY – PATIENT TO COMPLETE & SIGN

This information is to assist our staff to care for you in the best possible way. It is important that all questions are answered accurately. ***If you have any infectious diseases, please inform the staff immediately****.*

**** Please note:*** *Damage to capped, loose, or teeth in poor condition may occur during the procedure when biting down on the mouthguard that will be placed in your mouth to stop you chewing on the scope. Although we make every effort to protect your teeth, such damage is a recognized and accepted hazard. We cannot accept responsibility for injury to teeth, dental caps, crowns, or bridges. No responsibility will be taken for the lost of patient valuables.*

Your Weight (kg):	Your Height (cm):	Had colonoscopy in the past 5 years? ☐ Yes ☐ No

SURGICAL HISTORY (Previous surgical procedures/operations):

MEDICAL HISTORY & MEDICATION (✓ if yes):

	✓	When/Medication		✓	When/Medication
Rheumatic fever			Sleep Apnoea		
Heart murmur			HIV/AIDS		
High blood pressure			Hepatitis / Jaundice		
Blood clots (legs/lungs)			Fainting / Confusion		
Angina/Heart attack			Pregnant or breast feeding?		
Stroke			Other problems?		
Anaemia			**Are you on:**		**Stopped when?**
Bleeding tendency			Blood thinning tabs/ Warfarin		
Gastric ulcers/Reflux			Aspirin		
Kidney disease			Prednisolone		
Diabetes (Insulin/non-insulin)			**Any reaction to:**		
Asthma			Blood Transfusion		
Pneumonia / Contact with SARS			Gen.Anaes/Family history		
Tuberculosis			**Prostheses/pacemaker?**		
Back pain / Arthritis			**Family history of:**		
Epilepsy			CJD / Mad Cow's disease		
Do you smoke? Do you drink alcohol?		_____ per day _____glasses/day	Did you receive before 1989 pituitary growth hormone?		
Any infectious diseases? MRSA/ VRE/ CRE / Others			Admitted for recent progressive dementia		

OTHER MEDICATION, COMPLEMENTARY OR ALTERNATIVE MEDICATION

DRUG ALLERGY & STATE REACTION (eg. Medication, tapes, lotions, etc.)

Patient's Signature: …… **Date:** ……

HOSPITAL USE ONLY:

ADMISSION CHECKLIST - RECEPTION STAFF TO COMPLETE

- ☐ Requires medical certificate: YES / NO
- ☐ Patient read and understood informed consent
- ☐ Bowel prep (if applicable)
- ☐ Discharge planning organised

Reception Staff Name/ Signature: ……

ALERTS CHECKLIST (✓ if yes)

- ☐ Drug Allergy (see medical history)
- ☐ Latex Allergy
- ☐ Falls risk:……
- ☐ Pressure injury risk: .....
- ☐ Infectious risk:.....
- ☐ Other allergy & risks

RN / EN Name/Signature:……..…