



# Patient Admission Form

## PATIENT'S MEDICAL HISTORY – PATIENT TO COMPLETE & SIGN

**\* Please note for scope patient:** 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):	<b>For scope patient only:</b> Have you had colonoscopy in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes where:
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## RECENT RELEVANT SURGICAL HISTORY:

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## MEDICAL HISTORY & MEDICATION (✓ if yes):

	✓	When/Medication		✓	When/Medication
Rheumatic fever			Sleep Apnoea / CPAP machine		
Heart murmur / palpitations / AF			Pneumonia / COVID 19		When:
High blood pressure			Hepatitis / Jaundice		
Stroke / Blood clots (legs/lungs)			HIV/AIDS		
Angina/Heart attack			Pregnant or breast feeding?		
History of malignant hyperthermia			Other problems?		
Anaemia			<b>Are you on:</b>		<b>Stopped when?</b>
Bleeding tendency			Some blood thinning tabs		<b>If yes, see GP to stop</b>
Gastric ulcers/Reflux			Injection of Trulicity or Ozempic		<b>If yes, need to stop for 1 week</b>
Kidney disease			Prednisolone		
Diabetes (Insulin OR non-insulin)			<b>Any reaction to:</b>		
Asthma / emphysema			Blood Transfusion		
Breathlessness at rest/ lying flat/ going upstairs/ walking,			Anaes / vomiting /confusion / delirium		
Tuberculosis			<b>Prostheses / pacemaker?</b>		
Back pain / Arthritis			<b>Family history of:</b>		
Epilepsy / Fainting / Confusion			CJD / Mad Cow's disease		
Do you smoke?		_____ per day	Did you receive before 1989 pituitary growth hormone?		
Do you drink alcohol?		_____ glasses/day	Admitted for recent progressive dementia		
Any infectious diseases? MRSA/ VRE/ CRE / Others					

## OTHER MEDICATION, COMPLEMENTARY OR ALTERNATIVE MEDICATION

**Note\*** Some **new Diabetic drugs** need to be stopped 2-3 days before procedure. Check with your GP. **Weight loss injections** to stop 2 weeks before procedure.

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

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**Patient's Signature:** ..... **Date:** .....

<p><b>HOSPITAL USE ONLY:</b></p> <p><b>ADMISSION CHECKLIST - RECEPTION STAFF TO COMPLETE</b></p> <p><input type="checkbox"/> Requires medical certificate: YES / NO</p> <p><input type="checkbox"/> Patient read and understood informed consent</p> <p><input type="checkbox"/> Bowel prep (if applicable)</p> <p><input type="checkbox"/> Discharge planning organised</p> <p>Reception Staff Name/ Signature: .....</p>	<p><b>ALERTS CHECKLIST (✓ if yes)</b></p> <p><input type="checkbox"/> Drug Allergy (see medical history)</p> <p><input type="checkbox"/> Latex Allergy</p> <p><input type="checkbox"/> Falls risk:.....</p> <p><input type="checkbox"/> Pressure injury risk: .....</p> <p><input type="checkbox"/> Infectious risk:.....</p> <p><input type="checkbox"/> Other allergy &amp; risks</p> <p>RN / EN Name/Signature:.....</p>
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