WEST GIPPSLAND Endoscopy

Patient Label

Patient Registration & Pre-admission Health Assessment

You are booked for a: Please select

☐ Colonoscopy ☐ Gastroscopy ☐ Flexible Sigmoidoscopy

Have you tested positive to Covid-19? ☐ Yes - Date: ☐ No - Please call if this changes

Procedure Booked on (Date) at (Time)

PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE. YOUR PROCEDURE CANNOT GO AHEAD UNTIL WE HAVE RECEIVED THIS FORM. IF EMAILING THIS TO US, PLEASE BRING THE ORIGINAL FORM WITH YOU ON THE DAY OF YOUR PROCEDURE.

Email: info@wgendo.com.au Fax: 03 56230666 Mail: West Gippsland Endoscopy, Landsborough Rd Warragul 3820. Ph 03 5623 0868

Title: Please select Mr Mrs Ms Miss Dr Other:	First Name:	Surname:	DOB:
Residential address:			
Mailing address:			
Email address:			
Telephone (H):	Mobile:	Medicare Care Number:	
Concession Card Number:	Private Health Fund Name:	Member Number:	
Are you (is the person) of Aboriginal or Torres Strait origin? Please tick	☐ No ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Decline to answer		
Sex at Birth:	Gender Identity:	Marital Status: (Married/Separated/Divorced/Single/Defacto/Widowed)	
Language Spoken:	Religion:	Country of Birth:	
Next of Kin:	Relationship:	Contact number:	

Height (cm) *Mandatory Field*	Weight (kg) **(Limit 135kg):** *Mandatory Field*	BMI (if known) **(Limit 42):**

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING RECENT TRAVEL HISTORY AND YOUR CURRENT STATE OF HEALTH.

	Yes	No
Do you have significant signs and symptoms of a respiratory infection (cough, sore throat, runny nose) or fever and/or any other infections?		
Have you in the last 12 months been notified by a hospital that you were in contact with a person who had CPO (Carbapenemase-producing organism) or C. auris?		
Have you had an overnight stay in an overseas hospital or overseas aged care facility in the last 12 months.		

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Do you suffer from any of the following?	Yes	No	If yes, please provide details
Epilepsy?			
Stroke or TIA?			
Dementia, confusion, disorientation?			
Have you had an episode of Delirium?			
Heart trouble (Have you had any recent Heart tests? If YES please return results with this form)			☐ Angina ☐ Atrial fibrillation ☐ Chest pain ☐ High blood pressure ☐ Stents (Year) Details:
Pacemaker or implanted defibrillator inserted?			
Breathing difficulties (Have you had any recent Lung tests? If YES please return results with this form)			Do you use a CPAP machine? ☐ Asthma ☐ Sleep apnoea ☐ Home oxygen ☐ Emphysema Details:
Bleeding disorder, clotting disorder, DVT			
Are you taking blood thinners e.g., Warfarin, Plavix, Iscover, Xarelto, Aspirin or similar			
Do you have thyroid problems?			
Are you Diabetic?			Do you take insulin?
Do you take any of the following, Dapagliflozin (Forxiga, Xigduo) Empaglifozin (Jardiance, Jardiamet or Glyxambi)			**If YES** these need to be ceased 3 days prior to your procedure. Please seek advice from your medical practitioner.
Do you take Ozempic or any medication containing Semaglutide for either diabetes or weight loss?			**If YES** please see fasting instructions for patients taking GLP 1RA
Do you have Coeliac disease?			
Do you have any Allergies?			☐ Medication ☐ Food ☐ Tapes ☐ Latex/Rubber Details:
Are you part of the National Bowel Cancer Screening Program?			
Do you have Kidney/Renal disease?			If so, are you on dialysis? Y N

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Do you suffer from any of the following?	**Yes**	**No**	**If yes, please provide details**
Do you require a mobility aide?			☐ Walking frame ☐ Walking stick ☐ Wheelchair ☐ Other:
Have you had a fall in the past 12 months?			Fall caused by: ☐ Trip ☐ Dizziness ☐ Loss of balance ☐ Other: ☐ Collapse/legs gave way If Yes, date of last fall?
Have you experienced or been diagnosed with any of the following?			☐ Heartburn ☐ Ulcerative colitis ☐ Hiatus hernia ☐ Diverticulitis ☐ Gastric ulcer ☐ Irritable bowel syndrome ☐ Gastric reflux ☐ Crohn's disease
Any other serious medical condition?			Please specify:
Do you have any current Mental Health issues?			
Do you have an Advanced Care Directive or Treatment Limiting Order?			
Have you previously had a Colonoscopy or Gastroscopy?			If so where was it performed and when?
Have you had other previous surgery, or procedures?			

ANAESTHETIC HISTORY/REVIEW	**Yes**	**No**	
Have you or any blood relatives ever had a problem with anaesthetic previously?			Please specify:
Do you wear dentures or have a bridge, plate, caps, or crowns?			
Do you currently smoke cigarettes, or have you ever smoked cigarettes?			Cigarettes per day? If you have quit, when did you last smoke?
Do you currently drink alcohol?			If so, how many alcohol drinks do you have a week?
Could you be pregnant?			

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MEDICATION LIST *Please complete or attach a list from your GP*	**DOSE**	**HOW OFTEN**

Privacy Statement

West Gippsland Endoscopy Centre is committed to providing quality health care to patients. West Gippsland Endoscopy Centre staff regards patient health information as confidential and only collect health information with patient's consent. A patient's personal health information is handled in accordance with this policy which is consistent with the Privacy and Data Protection Act 2014 (Vic) and the Health Records Act 2001 (Vic) as well as the Australian Privacy Principles. These principles set the standards by which we handle personal information collected from our patients. A copy of these Principles is available upon request.

OFFICE USE ONLY Reviewed by Date

Further follow up required by ☐ Nil ☐ Consulted date: ☐ RN ☐ Anaesthetist ☐ Other

COMMENTS

Signature:

Approved for admission ☐ Yes ☐ No *(details)*

Alert Form generated ☐ Not applicable ☐ Yes

Prep required ☐ Not applicable ☐ Yes

Bowel Prep information sent ☐ Not applicable ☐ Yes *(details)*