

**Formerly Bundoora Endoscopy**

A.B.N. 81796273454  
119 Plenty Rd, Bundoora VIC 3083  
(Ph) 03 9466 8466 (Fax) 03 9466 8455  
Email: [reception@vicgut.com.au](mailto:reception@vicgut.com.au)

**INSTRUCTIONS FOR PATIENTS:**

1. Please fill-out required information and return completed form to Victorian Gut Centre by mail/fax/email **no later than 7 business days** prior to your admission to avoid cancellation.
2. Please contact Victorian Gut Centre for any inquiries.
3. Please bring your **Medicare, Health Fund details, GP referral letter & payment preference (if app)** on the day of appointment.
4. Please wear *comfortable clothing* and (*flat – no thongs*) shoes do not bring *valuables* with you.
5. All doctors try to keep to scheduling but sometimes there are unexpected delays due to unavoidable circumstances.

**Have you seen a Gastroenterologist in the last 30 days?**  NO  YES

**PATIENT IS..**  Open Access  Private  Rebate Only      **DATE OF ADMISSION:** \_\_\_\_\_

**PROCEDURE: (Check all that apply)**  Gastroscopy  Colonoscopy  Flexible Sigmoidoscopy  Iron Infusion

How did you hear about the Victorian Gut Centre? (select one)	1. <input type="checkbox"/> GP	2. <input type="checkbox"/> Specialist / Surgeon	3. <input type="checkbox"/> Google	4. <input type="checkbox"/> Social Media	5. <input type="checkbox"/> Friend / Relative	6. <input type="checkbox"/> Previous Patient
Personal Details						
SURNAME	TITLE	GIVEN NAME/S			PREFERRED NAME	
ADDRESS				STATE	POSTCODE	
DATE OF BIRTH: <u>DD</u> / <u>MM</u> / <u>YEAR</u>	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Are you a resident of Australia?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
AGE:	<input type="checkbox"/> _____	Are you of Torres Strait/Aboriginal descent?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
Height _____ CM	BMI _____	BIRTH COUNTRY		Do you live alone? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Weight _____ KG				Do you need an interpreter on admission day? <input type="checkbox"/> YES <input type="checkbox"/> NO		

CONTACT DETAILS <i>Please tick preferred contact.</i>						
HOME PH: <input type="checkbox"/>	WORK PH: <input type="checkbox"/>	MOBILE: <input type="checkbox"/>	EMAIL: <input type="checkbox"/>			
REFERRING GP						
NAME:						
ADDRESS:						
PHONE:	FAX:	EMAIL:				
MEDICARE						EXPIRY DATE
						(NO. IN FRONT OF NAME) _____
PRIVATE HEALTH INSURANCE						
INSURANCE FUND:			MEMBERSHIP NUMBER:			
DO YOU HAVE AN EXCESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	HAVE YOU CHANGED COVER RECENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DO YOU HAVE A CO-PAYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	HAVE YOU CONFIRMED YOUR COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DEPARTMENT OF VETERAN AFFAIRS			Does your policy Support Gap Coverage <input type="checkbox"/> YES <input type="checkbox"/> NO			
DVA CARD NUMBER:			AMBULANCE COVER <input type="checkbox"/> YES <input type="checkbox"/> NO			
CARD COLOUR: <input type="checkbox"/> GOLD <input type="checkbox"/> WHITE			MEMBERSHIP NUMBER:			
PENSION CARD NUMBER			HEALTH CARE CARD NUMBER			
<input type="checkbox"/> WORKCOVER <input type="checkbox"/> TAC / CLAIM ACCEPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO ( <i>If YES, please attach approval letter</i> ) / CLAIM NO.						
NATURE OF INJURY:			DATE:			
INSURANCE COMPANY:						
EMPLOYER:			Ph:			
CONTACT PERSON:			Ph:			
<b>As you <u>will not</u> be able to return home by public transport or drive after your procedure, arrangements <u>must</u> be made for you to be collected and <u>cared for during the day and overnight post procedure</u>. Failure to do so may result in cancellation of your procedure.</b>						
Who will be taking you home? A nurse will ring to give approximate pick-up time.						
Name:		Ph:		Relationship:		
Who will stay with you overnight:		Ph:		Relationship:		
NEXT OF KIN/EMERGENCY CONTACT						
Name:		Ph:		Relationship:		

**Patient Full Name:** \_\_\_\_\_

**Formerly Bundoora Endoscopy**

A.B.N. 81796273454  
119 Plenty Rd, Bundoora VIC 3083  
(Ph) 03 9466 8466 (Fax) 03 9466 8455  
Email: [reception@vicgut.com.au](mailto:reception@vicgut.com.au)

AFFIX PATIENT LABEL HERE

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?**

*(If YES to any condition indicated please give further details on the space provided.)*

<b>Cardiovascular</b>	<b>YES</b>	<b>NO</b>	<b>If Yes Please Provide Details</b>
Blood pressure problems: High <input type="checkbox"/> Low <input type="checkbox"/>			
Cardiac conditions: Heart attack <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Chest pain <input type="checkbox"/> Angina <input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal Defibrillator <input type="checkbox"/> Coronary stents <input type="checkbox"/>			
Cardiac Irregularities: Palpitations <input type="checkbox"/> Irr.Heart Beat <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/>			
<b>Respiratory</b>			
Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Home Oxygen <input type="checkbox"/>			
Other lung problems eg TB <input type="checkbox"/>			
Shortness of breath when walking more than 100 metres, climbing a flight of stairs/uphill			
Do you suffer from sleep apnoea?			
<b>Endocrinology</b>			
Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>			
Thyroid problems: Do you have a Goitre <input type="checkbox"/> Nodules <input type="checkbox"/> Do you have an over active or underactive thyroid?			
<b>Gastrointestinal</b>			
Hiatus Hernia <input type="checkbox"/> Reflux <input type="checkbox"/> Ulcer <input type="checkbox"/> Heartburn <input type="checkbox"/>			
Bowel problems eg Stoma <input type="checkbox"/> IBS <input type="checkbox"/> Crohns <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/>			
Liver disease <input type="checkbox"/> Weight loss surgery <input type="checkbox"/>			
<b>Genitourinary</b>			
Kidney disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Renal Impairment <input type="checkbox"/>			
Bladder problems: Incontinence <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Stoma <input type="checkbox"/>			
<b>Haematology/Oncology</b>			
Blood clots: lungs (Pulmonary Emboli) <input type="checkbox"/> legs (DVT) <input type="checkbox"/>			
Blood disorders : Anaemia <input type="checkbox"/> Low Iron <input type="checkbox"/>			
Bruising or bleeding tendency			
Cancer, (location, date of diagnosis, treatment received)			
<b>Musculoskeletal</b>			
Arthritis: Rheumatoid <input type="checkbox"/> Osteo <input type="checkbox"/>			
Back or neck injury or other problems			
<b>Neurology</b>			
Stroke <input type="checkbox"/> Mini Stroke <input type="checkbox"/> TIA <input type="checkbox"/>			
Limb paralysis or weakness			
Epilepsy <input type="checkbox"/> fits <input type="checkbox"/> Blackouts <input type="checkbox"/> Dizziness <input type="checkbox"/> balance problems <input type="checkbox"/>			
Short term memory loss <input type="checkbox"/> Dementia <input type="checkbox"/>			
<b>Prosthetics/Aids/Other</b>			
Visual aids – Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Visual Impairment <input type="checkbox"/>			
Hearing Aids <input type="checkbox"/> Hearing Impairment <input type="checkbox"/>			
Dentures <input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Implants <input type="checkbox"/>			
<b>Other</b>			
Depression <input type="checkbox"/> other mental illness <input type="checkbox"/>			
Lymphoedema <input type="checkbox"/>			
<b>Advanced care directive or treatment limiting order</b>			If YES, please bring a copy on admission.

Patient Full Name: \_\_\_\_\_

**Formerly Bundoora Endoscopy**

A.B.N. 81796273454  
119 Plenty Rd, Bundoora VIC 3083  
(Ph) 03 9466 8466 (Fax) 03 9466 8455  
Email: [reception@vicgut.com.au](mailto:reception@vicgut.com.au)

AFFIX PATIENT LABEL HERE

<b>FALLS SCREENING</b>	<b>YES</b>	<b>NO</b>	<b>FURTHER DETAILS</b>
Have you had a fall in the last 12 months?			
Do you use a walking aid? If YES, you MUST bring on Admission Day			
Do you need help walking, moving, dressing or undressing?			
<b>SKIN ASSESSMENT</b>			
Do you have wounds or breaks in your skin?			
<b>INFECTION PREVENTION</b>			
Have you been unwell in the past 2 weeks?			
Have you or a family member been exposed to an infectious disease in the last 2 weeks? e.g. Chickenpox, Measles, Shingles, Whooping Cough, Scabies			
Have you returned from an overseas trip in the past 30 days?			
Have you been hospitalised overseas or in another facility in the past 12 months?			
Do you have HIV, Hepatitis A/B/C, MRSA, VRE, CRE, C. Difficile?			
<b>ANAESTHETIC HISTORY</b>	<b>YES</b>	<b>NO</b>	
Do you smoke?			If yes, how many a day?
Do you use recreational drugs?			
Do you drink alcohol?			Amount and type?
Do you take any blood thinning medications other than aspirin?			Specify
Are you on insulin?			Specify
Have you or any of your family ever had problems with anaesthetics?			
<i>If yes, please give details</i>			
Have you or family been diagnosed with Malignant Hyperthermia?			
Have you had recent dental treatment or current loose/chipped tooth			Details
<b>ALLERGY OR ADVERSE REACTION</b>	<b>YES</b>	<b>NO</b>	<b>FURTHER DETAILS</b>
Do you have a medical dietary restriction eg Lactose intolerant, Coeliac Disease			
Do you have allergies to medications, food, sticking plaster, latex or other substances? <b>If yes please list details</b>			
<b>MEDICATIONS</b>			
<i>Please list all medications, <b>inhalers</b>, over the counter drugs, vitamins and supplements that you are currently taking</i>			
Medication	Dose	Medication	Dose
<b>SURGICAL HISTORY</b>			
<i>Please list any previous operations or procedure and dates.</i>			
<b>PATIENT'S DECLARATION</b>			
I hereby declare that the above information is true and correct to the best of my knowledge.			
Name	Signature	Date: DD / MM / YYYY	

**Patient Full Name:** \_\_\_\_\_

**Formerly Bundoora Endoscopy**

A.B.N. 81796273454  
119 Plenty Rd, Bundoora VIC 3083  
(Ph) 03 9466 8466 (Fax) 03 9466 8455  
Email: [reception@vicgut.com.au](mailto:reception@vicgut.com.au)

AFFIX PATIENT LABEL HERE

**TO BE COMPLETED BY CONSULTANT**

**HISTORY:**


**FAMILY HISTORY:**


**EXAMINATION**


**RECOMMENDATIONS:**


Date:

Time:

Physician Name:

Signature:

**OFFICE USE ONLY**

Patient ID and procedure confirmed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Admin initials:	Date/Time
Patient has read Rights & Responsibilities? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**PRE-ADMISSION NURSE TO COMPLETE**

Is the patient suitable for admission?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

Comments:

--

Name:	Signature:	Designation:	Date/Time:
-------	------------	--------------	------------

**ADMISSION NURSE**

Name:	Signature:	Designation:	Date/Time:
-------	------------	--------------	------------