VICTORIAN GUT CENTRE
Digestive Health & Endoscopy

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

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 on the day of appointment.
4. Please wear *comfortable clothing* and *(flat) shoes do not bring valuables with you*.
5. *All doctors try to keep to time but sometimes there are unexpected delays due to unavoidable circumstances.*

IRON INFUSION

DATE OF ADMISSION: _____

How did you hear about the Victorian Gut Centre? (select one)	1. ☐ GP	2. ☐ Specialist / Surgeon	3. ☐ Google
	4. ☐ Social Media	5. ☐ Friend / Relative	6. ☐ Previous Patient

Personal Details

SURNAME:	TITLE:	GIVEN NAME/S:	PREFERRED NAME:

ADDRESS	STATE	POSTCODE

DATE OF BIRTH: DD / MM / YEAR AGE:	Gender: M ☐ F ☐ ☐ _____	Are you a resident of Australia? ☐YES ☐NO Are you of Torres Strait/Aboriginal descent? ☐YES ☐NO
Height _____ CM **Weight** _____ KG	BIRTH COUNTRY	Do you live alone? ☐YES ☐NO Do you need an interpreter on admission day? ☐YES ☐NO

CONTACT DETAILS *Please tick preferred contact.*

HOME PH: ☐	WORK PH: ☐	MOBILE: ☐	EMAIL: ☐

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? ☐ YES ☐ NO $_____	HAVE YOU CHANGED COVER RECENTLY? ☐ YES ☐ NO
DO YOU HAVE A CO-PAYMENT? ☐ YES ☐ NO $_____	HAVE YOU CONFIRMED YOUR COVER? ☐ YES ☐ NO
DEPARTMENT OF VETERAN AFFAIRS	Does your policy Support Gap Coverage? ☐ YES ☐ NO
DVA CARD NUMBER:	AMBULANCE COVER? ☐ YES ☐ NO
CARD COLOUR: ☐ GOLD ☐ WHITE	MEMBERSHIP NUMBER:
PENSION CARD NUMBER	**HEALTH CARE NUMBER**

NEXT OF KIN / EMERGENCY CONTACT:

Name:	Phone:	Relationship:

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

Cardiovascular	**YES**	**NO**	**If Yes Please Provide Details**
Blood pressure problems: High □ Low □			
Cardiac conditions: Heart attack □ Congestive Heart Failure □ Chest pain □ Angina □ Pacemaker □ Internal Defibrillator □ Coronary stents □			
Cardiac Irregularities: Palpitations □ Irr.Heart Beat □ Atrial Fibrillation □			
Respiratory			
Asthma □ Emphysema □ COPD □ Home Oxygen □			
Other lung problems eg TB □			
Endocrinology			
Diabetes Type 1 □ Type 2 □ Insulin □			
Genitourinary			
Kidney disease □ Dialysis □ Renal Impairment □			

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Patient Full Name: _____

AFFIX PATIENT LABEL HERE

	YES	NO	If Yes Please Provide Details
Haematology/Oncology			
Have you had an Iron Infusion in the past- if YES, did you have a reaction □ Blood disorders : Anaemia □ Low Iron □ Bruising or bleeding tendency			
Neurology			
Stroke □ Mini Stroke □ TIA □			
Epilepsy □ fits □ Blackouts □ Dizziness □ balance problems □			
Short term memory loss □ Dementia □			
Prosthetics/Aids/Other			
Visual aids – Glasses □ Contact Lenses □ Visual Impairment □			
Hearing Aids □ Hearing Impairment □			
Dentures □ Caps □ Crowns □ Implants □			
Other			
Depression □ other mental illness □			
Pregnant			If YES, what trimester_____
Advanced care directive or treatment limiting order			If YES, please bring a copy on admission.
FALLS ASSESSMENT			
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?			
INFECTION PREVENTION			
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?			
ALLERGY OR ADVERSE REACTION			
Do you have allergies to medications, food, sticking plaster, latex or other substances?			**If yes please list details below**

MEDICATIONS

*Please list all medications, including **inhalers,** over the counter drugs, vitamins and supplements that you are currently taking*

PATIENT'S DECLARATION

I hereby declare that the above information is true and correct to the best of my knowledge.

Name Signature Date

OFFICE USE ONLY

Patient ID and procedure confirmed? ☐YES ☐NO	Admin initials:	Date/Time

PRE-ADMISSION NURSE TO COMPLETE

Is the patient suitable for admission?			☐YES ☐NO
Comments:			
Name:	Signature:	Designation:	Date/Time:

ADMISSION NURSE

Name:	Signature:	Designation:	Date/Time: