VICTORIAN GUT CENTRE

ADMISSION FORM

Please complete and return this form at least one week before your procedure.

☐PREADMISSION COMPLETE
☐ALERT PRESENT

Address: 119 Plenty Rd, Bundoora, VIC 3083
Ph: (03) 9466 8466 Fax: (03) 9466 8455
Email: reception@vicgut.com.au

Date of Admission: DD/MM/YYYY

GENERAL INFORMATION

How did you hear about us? ☐GP ☐Specialist/Surgeon ☐Internet ☐Friend/Relative ☐Previous Patient

Have you had a consult with a gastroenterologist or surgeon in the last 30 days? ☐Yes ☐No

Planned procedure/s: ☐Gastroscopy ☐Colonoscopy ☐Flexible Sigmoidoscopy ☐Iron Infusion

LAST NAME:	**TITLE**	**GIVEN NAME/S:**	**PREFERRED NAME:**

Home address:	**Suburb:**	**Postcode:**

Date of birth: dd/mm/yyyy	**Email:**	**Height**
Age:	**Mobile:**	**Weight**
Country of birth:	**Home Ph:**	**BMI**

Pronouns	☐She/her	☐He/him	☐They/them	☐Different term, specify:	☐By name
Gender	☐Female	☐Male	☐Non-binary	☐Different term, specify:	☐Prefer not to say
Sex at birth	☐Female	☐Male	☐Another term, specify		

Are you of Aboriginal or Torres Strait Islander Origin?
☐No ☐Yes, Aboriginal ☐Yes, Torres Strait Islander ☐Yes, Both Aboriginal and Torres Strait Islander ☐Decline to Answer

Do you have any religious/cultural needs? ☐Yes ☐No If yes, specify

Do you need an interpreter? ☐Yes ☐No If yes, ☐family to interpret ☐professional interpreter
Preferred language: (*Costs apply if no Medicare*)

Referring doctor's name: Address: Phone:

MEDICARE, HEALTH FUND AND OTHERS

Medicare Number:	**No. In Front of Name:**	**Expiry:** ☐ Do not have Medicare

Individual Health Identifier for My Health Record (MHR): ☐ Do not upload to MHR

Private Health Insurance: Yes / No	Fund Name:	Membership no:
Are you currently an in-patient in any hospital? Yes / No	Any excess paid in the last 12 months? Yes / No	Excess Or Co-Payment: $
Department Of Veterans Affair (DVA) Yes / No	DVA Card Number:	Card Colour: ☐ Gold ☐ White
Is this a Workcover or TAC:	Yes / No	Workcover or TAC approval number:

ALL PATIENTS RECEIVING SEDATION MUST HAVE A RESPONSIBLE ADULT TO ACCOMPANY THEM HOME AND STAY WITH THEM AT HOME OVERNIGHT

CERTIFICATE/S	☐Medical certificate ☐Carer certificate ☐Not Applicable		
REQUIRED: Pick-up person	Name:	Relationship	Contact no.
REQUIRED: Staying with you at home after discharge	Name:	Relationship	Contact no.
REQUIRED: Next of kin or emergency contact	Name:	Relationship	Contact no.

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

HEALTH QUESTIONNAIRE DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE PROVIDE FURTHER INFORMATION		
1. Blood pressure ☐ High ☐ Low	☐ Yes ☐ No	Is it controlled with medication?
2. Heart attack	☐ Yes ☐ No	When?
3. Arrhythmia or irregular heartbeat	☐ Yes ☐ No	Resolved? Is it controlled with medication?
4. Angina or chest pain	☐ Yes ☐ No	How frequently?
5. ☐Heart surgery ☐Pacemaker ☐Defibrillator ☐Stents	☐ Yes ☐ No	Last date of check up with cardiologist?
6. Other heart problems	☐ Yes ☐ No	If yes, specify
7. Asthma	☐ Yes ☐ No	Is it controlled with medication? When was the last asthma attack? **PLEASE BRING YOUR PUFFER**
8. Other lung issues or shortness of breath	☐ Yes ☐ No	Specify
9. Difficulty walking up more than two flights of stairs	☐ Yes ☐ No	What stops you from walking further?
10. Sleep apnoea	☐ Yes ☐ No	Do you use a CPAP machine?
11. Diabetes ☐Type 1 ☐Type 2	☐ Yes ☐ No	☐Diet controlled ☐Tablets ☐Insulin
12. Thyroid problems	☐ Yes ☐ No	Specify
13. Stomach problems	☐ Yes ☐ No	☐Hiatus hernia ☐Reflux ☐Ulcer ☐Heartburn ☐Other:
14. Bowel problems	☐ Yes ☐ No	☐Crohn's ☐Colitis ☐Stoma ☐Other, specify
15. Liver disease	☐ Yes ☐ No	Specify
16. Weight loss surgery	☐ Yes ☐ No	Details
17. Kidney disease	☐ Yes ☐ No	☐Dialysis ☐Renal Impairment ☐Other, specify
18. Bladder problems	☐ Yes ☐ No	☐Incontinence ☐Urinary Retention ☐Stoma
19. Blood clots in the ☐legs or ☐lungs or ☐ Stroke	☐ Yes ☐ No	When? Resolved?
20. Blood disorders	☐ Yes ☐ No	☐Anaemia ☐Low Iron ☐Bruising or bleeding tendency
21. Cancer	☐ Yes ☐ No	Location and treatment received:
22. Arthritis: ☐Rheumatoid ☐Osteo	☐ Yes ☐ No	
23. ☐Back or ☐neck injury or other problems	☐ Yes ☐ No	Do you have any limitation in neck movement? ☐Yes ☐No Can you tolerate laying on your left side? ☐Yes ☐No
24. Difficulty swallowing or opening your mouth	☐ Yes ☐ No	Specify
25. ☐Epilepsy ☐Seizures (Fits)	☐ Yes ☐ No	When?
26. ☐Blackouts ☐Dizziness ☐Balance problems	☐ Yes ☐ No	Specify
27. ☐Short term memory loss ☐Dementia	☐ Yes ☐ No	Specify
28. Visual condition	☐ Yes ☐ No	☐Glasses ☐Contact Lenses ☐Other, specify
29. Hearing condition	☐ Yes ☐ No	☐Hearing Aids ☐Other, specify
30. Dental condition	☐ Yes ☐ No	☐Dentures ☐Caps ☐Crowns ☐Implants ☐Recent dental treatment ☐Loose/chipped tooth

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

31. Lymphoedema (swelling in arms or legs)	☐ Yes ☐ No	Location:
32. Other medical conditions or disabilities not already mentioned	☐ Yes ☐ No	Specify:
33. Do you suffer from ☐anxiety, ☐depression, ☐ other mental conditions?	☐ Yes ☐ No	Specify:
34. Do you ☐smoke or ☐vape?	☐ Yes ☐ No	How many cigarettes per day? **PLEASE STOP SMOKING 2 DAYS BEFORE YOUR PROCEDURE**
35. Do you use recreational drugs?	☐ Yes ☐ No	What do you take and how often? **PLEASE DO NOT TAKE 2 DAYS BEFORE YOUR PROCEDURE**
36. Do you drink alcohol?	☐ Yes ☐ No	How often?
37. Have ☐you or a ☐family member ever had problems with anaesthetics?	☐ Yes ☐ No	☐ Nausea or vomiting ☐ Malignant Hyperthermia ☐Others:
38. Have you had an episode of delirium or aggression after anaesthetics?	☐ Yes ☐ No	Specify:
39. Could you be pregnant?	☐ Yes ☐ No	
40. Do you have an advanced care directive or treatment limiting order?	☐ Yes ☐ No	***This is a document that lists your preferences for future medical treatment i.e. consenting to or refusing specific types of treatment, should you lose decision-making capacity. If yes, please attach a copy to this form.***
41. **Infection:** Do you have any multi-resistant infections?	☐ Yes ☐ No	☐MRSA ☐VRE ☐CRE ☐C. Difficile ☐Other, specify: Active or inactive?
42. Do you have/have you had COVID-19?	☐ Yes ☐ No	When? Symptoms? Did you receive treatment in hospital? Fully recovered?
43. Have you been unwell in the past 2 weeks?	☐ Yes ☐ No	Details:
44. Have ☐you or a ☐family member been recently exposed to a communicable disease?	☐ Yes ☐ No	☐ Shingles ☐ Chickenpox ☐ Measles ☐ Whooping cough ☐ Other, specify
45. Have you returned from an overseas trip in the past 30 days?	☐ Yes ☐ No	Country: Have you been unwell since return?
46. Have you been hospitalised overseas or in another facility in the past 12 months?	☐ Yes ☐ No	Hospital: Reason: Date:
47. **Skin integrity:** Do you have wounds or breaks in your skin?	☐ Yes ☐ No	Details: **Please cover with dressing, if possible.**
48. **Falls history:** Have you had a fall in the last 12 months?	☐ Yes ☐ No	☐Slipped ☐Tripped ☐Lost balance - when? Did you sustain an injury?
49. Limb paralysis or weakness - ☐right ☐left	☐ Yes ☐ No	Any limitations in movement?
50. Do you use a walking aid?	☐ Yes ☐ No	☐ Stick ☐ Frame ☐ Other, specify **MUST BRING ON ADMISSION DAY**
51. Do you need help with ☐moving ☐dressing or ☐undressing?	☐ Yes ☐ No	Details:
52. Do you have anaphylaxis?	☐ Yes ☐ No	Details: **PLEASE BRING YOUR ADRENALINE AUTOINJECTOR, IF ANY**
53. Do you have any known allergy or adverse reaction?	☐ Yes ☐ No	Details: Reactions:
54. Do you have a dietary restriction or food intolerance?	☐ Yes ☐ No	Details: Reactions:

URN:
Name:
Date of birth:
[PLACE BRADMA HERE]

CURRENT MEDICATIONS		PLEASE TICK BOX IF THIS APPLIES	
Please list all medications below. Include blood thinners, steroids, diabetic medications, over the counter medications, inhalers, topical, eye drops, pain relievers, herbal medication. **PLEASE ATTACH A SEPARATE SHEET IF REQUIRED**		**If you are diabetic or on blood thinners:** ☐ I have discussed a diabetes / blood thinners management plan with a doctor/nurse.	
MEDICATION	DOSE	MEDICATION	DOSE

SURGICAL HISTORY
Please list any previous operations or procedure and dates. Attach a separate sheet if required.

PATIENT'S DECLARATION		
I hereby declare that the above information is true and correct to the best of my knowledge.		
Name:	Signature:	Date: dd / mm / yyyy

PRE-ADMISSION NURSE TO COMPLETE THIS SECTION (TICK ALL THAT APPLIES)	
☐No change in condition or health since completion of last health assessment </= 12 months	☐Current medications list attached and patient has not started taking new medication ☐Not Applicable
Alert Form ☐Completed ☐Not Applicable	☐Patient is currently well (no cough, cold or other illness)
☐Weight and BMI within admission criteria	☐Suitable for admission ☐Not suitable for admission
☐Patient has arranged for pick-up person and overnight carer at home	☐Referred to anaesthetist for review Via ☐Phone ☐Email ☐Text Message ☐Face-To Face ☐Outcome Recorded
Pre-admission notes:	
Pre-admission completed by (initials):	Date: dd/mm/yyyy Time:

RECEPTION - ADMISSION		
Patient ID and procedure confirmed	Admin initials:	Time: